



COACHCARE | SERVICE LINE STRATEGY

Piedmont Rockdale Hospital

A 161-bed not-for-profit acute-care hospital in Conyers, Georgia, part of Piedmont Healthcare since 2017 and the only acute-care hospital in Rockdale County, with a 34-bed emergency department, a certified Chest Pain Center, a Primary Stroke Center and interventional cardiology

Remote Care Service Line Performance & Optimization

2026 Strategy Report

The 30 days after discharge: a transitional care lane owned by the Piedmont Conyers practices, fed from the hospital's own discharge list, with remote monitoring and chronic care management for the patients who go home, priced at Atlanta rates and run inside Epic

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Piedmont Rockdale Hospital and the Piedmont practices in Conyers. It brings together the hospital's own Medicare discharge record, the CMS readmission and emergency-department measures that describe the weeks after discharge, the CY2024 claims of the Conyers practices, the policy calendar for 2026 and 2027, a 24-month Value Analysis for a remote care service line anchored on the discharge, the clinical governance that would run it, and the Epic integration it lives in.

The argument is short. The hospital knows the day every patient goes home. In CY2024 nobody billed for the thirty days after it.

Prepared by CoachCare for discussion with Piedmont Rockdale Hospital. © 2026 CoachCare.

Table of Contents

Executive Summary.....	3
1. Piedmont Rockdale Today.....	5
1.1 The only acute-care hospital in Rockdale County.....	5
1.2 Whom the hospital discharges: the CY2024 Medicare profile.....	6
1.3 Readmissions: the FY2026 program file and the excess days.....	6
1.4 The emergency department at 222 minutes.....	7
1.5 The Conyers practices in CY2024 claims.....	8
1.6 Rockdale County: 65.2% Medicare Advantage.....	9
2. The 30 Days After Discharge.....	9
2.1 The loop.....	9
2.2 Three touches inside 14 days.....	10
2.3 Transitional care management: the mechanics and the Atlanta rates.....	10
3. Service Line Architecture.....	11
3.1 Lane one: the discharge.....	11
3.2 Lane two: the office follow-up.....	11
3.3 Build and partner: what the system program covers, and what it does not.....	12
3.4 One coordination rule, set at enrollment.....	12
3.5 Staffing: nobody is hired.....	12
4. Policy: What Moves the Math in 2026 and 2027.....	13
4.1 The CY2026 remote monitoring codes.....	13
4.2 The Ambulatory Specialty Model: heart-failure episodes from CY2027.....	13
4.3 Piedmont Clinic ACO: shared savings with no downside.....	14
4.4 The CY2027 proposed rule, repriced on this forecast.....	14
5. Epic Integration: The Program Lives in the Record.....	15
6. Clinical Governance and Escalation.....	15
6.1 One shared escalation engine.....	15
6.2 The emergent pathway.....	16
6.3 Qualification, device assignment and routing.....	16
6.4 Program discharge and continuity.....	16
7. Value Analysis: The 24-Month Forecast.....	17
7.1 Headline economics.....	17
7.2 Economics by line and by year.....	18
7.3 The ramp: both ceilings inside eight months.....	20
7.4 What the program produces.....	20
7.5 What moves the number.....	21
7.6 Model inputs.....	21
8. Implementation Roadmap.....	22
9. Recommendations.....	23
10. What We Would Confirm Together.....	24
Appendix A. Rates: CY2026 Physician Fee Schedule, Georgia Locality 01.....	24
Appendix B. Sources and Data Vintages.....	25

Executive Summary

Piedmont Rockdale Hospital is a 161-bed not-for-profit acute-care hospital in Conyers, Georgia, part of Piedmont Healthcare since October 2017 and the only acute-care hospital in Rockdale County.¹ It runs a 34-bed emergency department that sees about 50,000 visits a year, a certified Chest Pain Center, a Primary Stroke Center with on-site neurohospitalists, interventional cardiology and a Level III NICU. U.S. News & World Report rates it High Performing for 2025–26 in heart attack, heart failure, pneumonia, stroke and diabetes, and its emergency department was the first in the Piedmont system to earn the Emergency Nurses Association's Lantern Award.² In its most recent fiscal year it earned \$30.2 million on \$293.3 million of revenue.³ The hospital and the Piedmont practices around it run on one Epic record.

That is the machinery a readmission-prevention program needs, already running. What is missing is the month after the patient leaves. In CY2024 the hospital discharged 1,662 Medicare fee-for-service patients, 1,164 people with an average risk score of 2.32, roughly 320 of them heart-failure index stays, 265 pneumonia and 85 COPD once the suppressed cells are counted.⁴ CMS penalizes the hospital in FY2026 on heart-failure and COPD readmissions, discharged patients accumulate excess days back in acute care after pneumonia and heart attack, and the emergency department holds a discharged patient for a median of 222 minutes.⁵ Against all of that, the Piedmont-employed practices in Conyers billed **no transitional care management, no remote monitoring, and chronic care management at trace volume in CY2024**; CMS suppresses any provider-and-code line under 11 beneficiaries, and the file predates the system program launched in August 2025, so the precise claim is that there was no program at meaningful scale in CY2024.⁶

¹ CMS Care Compare, Hospital General Information (dataset xubh-q36u), retrieved September 22, 2026: Piedmont Rockdale Hospital, CCN 110091, 1412 Milstead Avenue NE, Conyers, Georgia 30012, acute care hospital, Rockdale County. Piedmont Healthcare, Piedmont Rockdale Hospital location and news pages, retrieved September 2026: 161 licensed beds; Primary Stroke Center with on-site neurohospitalists; certified Chest Pain Center; Level III NICU; interventional cardiology; serving the community since 1954; part of Piedmont Healthcare since October 2, 2017; U.S. News & World Report 2025–26 High Performing in diabetes, heart attack, heart failure, pneumonia and stroke.

² Emergency Nurses Association Lantern Award, 2023, Piedmont Rockdale Hospital emergency department (the first in the Piedmont system), award writeup: 34-bed emergency department, about 50,000 visits a year, more than 1,000 employees.

³ IRS Form 990, Piedmont Rockdale Hospital Inc., fiscal year ending June 2025 (ProPublica Nonprofit Explorer): total revenue \$293.3 million, expenses \$263.1 million, net \$30.2 million.

⁴ CMS Medicare Inpatient Hospitals by Provider and by Provider and Service, CY2024 (retrieved September 22, 2026), CCN 110091: 1,662 Medicare fee-for-service discharges, 1,164 distinct beneficiaries, 8,231 covered days, average beneficiary age 73.7, average HCC risk score 2.32, 28.6% of admitted beneficiaries carrying the COPD chronic-condition flag; discharges by MS-DRG published only where a DRG has 11 or more discharges. CMS Care Compare, Unplanned Hospital Visits (dataset 632h-zaca), retrieved September 22, 2026: 30-day readmission, July 2023–June 2025, heart failure 21.8% (639 index stays), COPD 19.8% (173), pneumonia 17.2% (528), AMI 14.9% (170), each no different than the national rate; excess days in acute care per 100 discharges, July 2022–June 2025, heart failure +8.4, pneumonia +31.5, AMI +33.2.

⁵ CMS FY2026 Hospital Readmissions Reduction Program Supplemental Data File and Payment Adjustment Factors (September 2025; performance period July 2021–June 2024), CCN 110091: payment adjustment factor 0.9969; excess readmission ratios heart failure 1.0674 against a peer-group median of 0.9922 (penalized), COPD 1.0049 against 0.9965 (penalized), pneumonia 0.9812 (not penalized), AMI 0.9931 (not penalized); dual proportion 16.5%, peer group 2 of 5. CMS Care Compare, Timely and Effective Care (dataset yv7e-xc69), October 2024–September 2025, CCN 110091: OP-18b median time from arrival to departure for discharged emergency patients 222 minutes (sample 384); OP-18a all patients 231 minutes; OP-22 left before being seen 1% (51,569); emergency department volume category high.

⁶ CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released 2026), rendering-provider city Conyers, Georgia: 295 billing NPIs, of which 70 resolve to Piedmont billing entities through the CMS Doctors & Clinicians file. Across those 70: no 99495 or 99496 lines, no 99453, 99454, 99457 or 99458 lines, no 99424–99427 lines, and 99490 at 52 beneficiaries and 83 services across four internists. CMS suppresses any provider-and-code line under 11 beneficiaries. The file predates the system program launched in August 2025.

The observation this report is built on

The hospital knows the day every patient goes home. In CY2024 nobody billed for the thirty days after it.

The discharge is the one hand-off the hospital controls end to end: the hospitalists and the emergency department produce the list, case management works it, and the Piedmont internists, family physicians and cardiologists in Conyers see the patient next. Medicare pays the practice that assumes care for exactly that month, \$223.60 or \$303.22 per episode at Atlanta rates, and pays again, monthly, for the remote monitoring and care management that follow. CMS's FY2026 penalty file, the excess-days measures and the 222-minute median are what the empty lane looks like from the outside.

Rockdale County's Medicare population is **65.2% Medicare Advantage** (July 2026), the highest share of any county in the hospital's draw area.⁷ That shapes the revenue math in one specific way. 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 puts the contract check in the first week of discovery.

What the Value Analysis returns

The forecast has two parts, priced separately and shown together. The recurring programs, remote physiologic monitoring and chronic care management, run on the 3,350 Medicare patients the hospital discharges in a year, referred by the 34 Piedmont-employed adult-medicine clinicians who bill office visits from a Conyers address, and delivered by CoachCare under those clinicians' direction. The transitional care layer bills one episode per captured discharge, 398 Medicare discharges a month at 50% capture.⁸

24 months	Net reimbursement	CoachCare fees	Net to the hospital	Margin
Transitional care management (TCM)	\$1,046,040	\$243,675	\$802,365	76.7%
Recurring programs (RPM + CCM)	\$3,267,017	\$1,881,418	\$1,385,599	42.41%
TCM + office-based programs	\$4,313,057	\$2,125,093	\$2,187,964	50.73%

CoachCare Value Analysis. CY2026 non-facility Physician Fee Schedule, Georgia locality 01 (Atlanta). Margin is net to the hospital divided by net reimbursement. The recurring-program margin runs 41.74% in Year 1 and 42.89% in Year 2; the combined figure runs 50.87% and 50.62%.

- 1. The discharge lane pays from the first month; the recurring line pays from the second.** Transitional care nets \$10,497 to the hospital in month 1 and about \$36,700 a month at steady state. The recurring programs net -\$2,493 in month 1, because implementation lands before enrollment revenue does, turn positive in M2 at \$10,711, and from M9 hold at \$159,524 of monthly net reimbursement and \$68,418 net to the hospital.
- 2. Nobody is hired.** CoachCare delivers 26,958 hours of care-management work on the recurring programs over 24 months, about 13.0 full-time-equivalent years, plus 4,563 hours on the

⁷ CMS Medicare Advantage State/County Penetration, July 2026: Rockdale County 65.20% (11,933 enrolled of 18,302 eligible); Newton 65.6%, Henry 63.1%, DeKalb 60.1%. CMS Medicare Monthly Enrollment, May 2026, Rockdale County: 18,131 beneficiaries, 6,308 in Original Medicare, 3,121 dual-eligible.

⁸ CoachCare Value Analysis for Piedmont Rockdale Hospital, 2026. Basis: CY2026 non-facility Physician Fee Schedule at Georgia locality 01 (Atlanta); 3,350 Medicare patients in scope (one year of the hospital's Medicare discharged patients); an established Medicare panel of about 10,470 across the Piedmont Conyers practices; 34 referring clinicians; RPM and CCM on the Primary Care / Internal Medicine eligibility row (RPM 65%, CCM 75%; acceptance 35% and 30%); one CoachCare-funded on-site enrollment specialist at 80 enrollments a month, placed at the hospital; telephonic outreach on; 1.5% monthly attrition. CoachCare Value Analysis, transitional care management layer: 398 Medicare discharges a month (1,662 CY2024 fee-for-service discharges grossed up for the county's 65.2% Medicare Advantage share, divided by 12); 50% captured into a completed episode; 30% billed as 99496 and 70% as 99495; ramp 30 / 50 / 70 / 85 / 100% over the first five months; the same denial, coinsurance and bad-debt waterfall as the recurring programs; a per-episode management fee and no platform fee; 60 care-team minutes per episode. 24 months: 4,563 episodes, \$1,129,328 gross, \$1,046,040 net reimbursement, \$243,675 fees, \$802,365 net to the hospital; \$229.23 net per episode.

transitional care episodes, including an on-site enrollment specialist at the hospital carried at CoachCare's expense.

3. **The cohort enrolls inside eight months.** RPM reaches its ceiling of 762 enrollments in M7 and CCM its 754 in M8. At M24 the program holds 1,516 active program enrollments across 988 unique patients, the same 988 it holds at M12. The binding constraint is the size of the discharge cohort, not enrollment pace.
4. **The clinical return is concrete.** The forecast projects 105.5 avoided hospitalizations over 24 months, roughly \$1.58 million at \$15,000 per admission, from 166,222 device readings worked through one escalation protocol, with the discharge as the trigger.
5. **The policy calendar runs the right way.** The CY2026 remote monitoring codes 99445 and 99470 fit the post-discharge window and carry 9.0% of the recurring line. The Ambulatory Specialty Model's heart-failure episodes begin in CY2027 for the Piedmont Heart physicians named on the preliminary list, and transitional care and chronic care management are the codes that open those episodes. Piedmont Clinic ACO shares in the readmission savings with no downside.
6. **Co-exist with the system program, do not replace it.** Piedmont's system-wide chronic care management and remote monitoring program, launched in August 2025 with an outside partner, holds the office layer for primary care. CoachCare's lane is the discharge itself and the enrollment that starts there; where the system program already holds a patient's care management, the transitional care hand-off lands in that program.

1. Piedmont Rockdale Today

1.1 The only acute-care hospital in Rockdale County

Piedmont Rockdale has served Conyers since 1954 and joined Piedmont Healthcare on October 2, 2017. A \$12.6 million intermediate-care and medical-surgical project completed in August 2022 took it to 161 licensed beds. It holds Primary Stroke Center certification with neurohospitalists on site, a certified Chest Pain Center, interventional cardiology and a Level III neonatal intensive care unit, and employs more than 1,000 people.⁹ Its 34-bed emergency department sees about 50,000 visits a year and in 2023 became the first in the Piedmont system to earn the Emergency Nurses Association's Lantern Award. U.S. News & World Report rates the hospital High Performing for 2025–26 in five conditions: heart attack, heart failure, pneumonia, stroke and diabetes.

What the hospital runs	Why it matters to a discharge-led service line
34-bed emergency department, about 50,000 visits a year	The largest single source of discharges home, and the place a decompensating patient returns to
Certified Chest Pain Center; interventional cardiology; Piedmont Heart clinic on campus	The heart-failure and heart-attack cohorts are discharged and followed by the same organization
Primary Stroke Center with on-site neurohospitalists	Stroke discharges carry hypertension follow-up that remote monitoring is built for
Hospitalist service and case management	The discharge list exists today; the program reads it rather than reconstructing it
Piedmont primary care and specialty practices in Conyers, on one Epic record	The 7- and 14-day transitional care visit has a home, and the chart is shared

⁹ Piedmont Healthcare, Piedmont Rockdale Hospital location and news pages, retrieved September 2026: 161 licensed beds; Primary Stroke Center with on-site neurohospitalists; certified Chest Pain Center; Level III NICU; interventional cardiology; serving the community since 1954; part of Piedmont Healthcare since October 2, 2017; U.S. News & World Report 2025–26 High Performing in diabetes, heart attack, heart failure, pneumonia and stroke. Emergency Nurses Association Lantern Award, 2023, Piedmont Rockdale Hospital emergency department (the first in the Piedmont system), award writeup: 34-bed emergency department, about 50,000 visits a year, more than 1,000 employees.

What the hospital runs	Why it matters to a discharge-led service line
Fiscal year 2025: \$293.3 million of revenue, \$30.2 million net	A service line funded from reimbursement, with no capital request

Piedmont Healthcare location and news pages; ENA Lantern Award writeup; IRS Form 990, fiscal year ending June 2025.

1.2 Whom the hospital discharges: the CY2024 Medicare profile

Medicare's own inpatient file describes the population this service line is built for. In CY2024 Piedmont Rockdale discharged **1,662 Medicare fee-for-service patients, 1,164 distinct people**, with an average age of 73.7, an average HCC risk score of 2.32 against a national mean of 1.00, and an average stay of about five days. More than a quarter of the admitted beneficiaries, 28.6%, carry a COPD chronic-condition flag.¹⁰ CMS publishes discharges by MS-DRG only where a DRG has 11 or more, so 533 of the 1,662 sit in cells too small to print. Read against Care Compare's measure denominators, which count every index stay, the hospital runs roughly 320 heart-failure, 265 pneumonia and 85 COPD Medicare index admissions a year.¹¹

Condition (CY2024, Medicare fee-for-service)	Published discharges	Working annual volume
Heart failure (DRG 291 published; 292 and 293 suppressed)	119	about 320 index stays
Pneumonia (DRG 193 published; 194 and 195 suppressed)	32	about 265
COPD (DRG 190 published; 191 and 192 suppressed)	13	about 85
Heart attack (DRGs 280, 281)	64	—
Sepsis (DRGs 870–872)	375	—
Stroke and TIA (DRGs 064, 065, 069)	72	—
Renal and CKD (DRGs 682, 683, 698, 699)	73	—
Arrhythmia, hypertension, diabetes, syncope and chest pain	123	—

CMS Medicare Inpatient Hospitals by Provider and Service, CY2024; Care Compare readmission-measure denominators, July 2023–June 2025, divided by two for an annual figure. The county is 65.2% Medicare Advantage, so the fee-for-service file is about a third of the hospital's Medicare discharges.

Two things about this population matter for the design. First, it is multi-morbid: a risk score of 2.32 describes a patient carrying several chronic conditions at once, which is why the office follow-up in this report lands in primary care and internal medicine, with cardiology owning the heart-failure cohort. Second, it is discharged into a county where two of every three Medicare beneficiaries are in Medicare Advantage, so the fee-for-service file understates the flow by about two-thirds. The forecast in Section 7 sizes the cohort at 3,350 Medicare patients a year for that reason.

1.3 Readmissions: the FY2026 program file and the excess days

Two CMS sources describe the weeks after discharge, and they measure different things. Care Compare runs a categorical test against the national rate on a two-year window and rates the hospital's 30-day readmission for heart failure (21.8%), COPD (19.8%), pneumonia (17.2%) and heart attack (14.9%) as no

¹⁰ CMS Medicare Inpatient Hospitals by Provider and by Provider and Service, CY2024 (retrieved September 22, 2026), CCN 110091: 1,662 Medicare fee-for-service discharges, 1,164 distinct beneficiaries, 8,231 covered days, average beneficiary age 73.7, average HCC risk score 2.32, 28.6% of admitted beneficiaries carrying the COPD chronic-condition flag; discharges by MS-DRG published only where a DRG has 11 or more discharges.

¹¹ CMS Care Compare, Unplanned Hospital Visits (dataset 632h-zaca), retrieved September 22, 2026: 30-day readmission, July 2023–June 2025, heart failure 21.8% (639 index stays), COPD 19.8% (173), pneumonia 17.2% (528), AMI 14.9% (170), each no different than the national rate; excess days in acute care per 100 discharges, July 2022–June 2025, heart failure +8.4, pneumonia +31.5, AMI +33.2.

different than national.¹² The Hospital Readmissions Reduction Program file is the one that sets payment. For FY2026 it computes an excess readmission ratio against the hospital's dual-proportion peer group and finds **heart failure at 1.067, 7.6% above the peer median, and COPD at 1.005, both penalized**; pneumonia (0.981) and heart attack (0.993) are not. The resulting payment adjustment factor is 0.9969, a 0.31% reduction on every Medicare inpatient payment in FY2026, and heart failure is the largest driver.¹³

Measure	Window	Value	Read
HRRP excess readmission ratio, heart failure	Jul 2021–Jun 2024	1.067	Penalized; peer median 0.992
HRRP excess readmission ratio, COPD	Jul 2021–Jun 2024	1.005	Penalized; peer median 0.997
HRRP excess readmission ratio, pneumonia / heart attack	Jul 2021–Jun 2024	0.981 / 0.993	Not penalized
HRRP payment adjustment factor, FY2026	—	0.9969	0.31% reduction on Medicare inpatient payments
Excess days in acute care per 100 discharges, heart failure	Jul 2022–Jun 2025	+8.4	More days than average
Excess days in acute care per 100 discharges, pneumonia	Jul 2022–Jun 2025	+31.5	More days than average
Excess days in acute care per 100 discharges, heart attack	Jul 2022–Jun 2025	+33.2	More days than average
30-day readmission, heart failure / COPD / pneumonia	Jul 2023–Jun 2025	21.8% / 19.8% / 17.2%	No different than national (Care Compare)

CMS FY2026 HRRP Supplemental Data File and Payment Adjustment Factors (September 2025); Care Compare Unplanned Hospital Visits, retrieved September 22, 2026.

The excess-days measures are the more useful signal. A heart-failure readmission rate no different than national beside +8.4 excess days per 100 discharges, and pneumonia and heart-attack patients accumulating +31.5 and +33.2, is the signature of patients coming back through the emergency department and observation rather than being readmitted outright: decompensation discovered in the ED on day nine rather than at a kitchen table on day four. That is what a device reading and a phone call in the first two weeks are for. In the FY2026 Hospital Value-Based Purchasing program the hospital's total performance score is 32.9, with efficiency and cost reduction its lowest domain at 20; the spending that measure counts is largely the spending that happens after discharge.¹⁴ The FY2027 program will score the July 2022–June 2025 window, the same window as the excess-days figures above, so the number the hospital is now being paid on was set by discharges that have already happened. Every discharge from here forward is the FY2028 and FY2029 number.

1.4 The emergency department at 222 minutes

Care Compare's timeliness file puts the median time from arrival to departure for a discharged emergency patient at Piedmont Rockdale at **222 minutes**, 231 minutes for all patients, with 1% leaving before being seen across a sample of 51,569 encounters, which matches the hospital's own figure of about 50,000 visits a year.¹⁵ A full, slow emergency department that sends most of its patients home is exactly where a

¹² CMS Care Compare, Unplanned Hospital Visits (dataset 632h-zaca), retrieved September 22, 2026: 30-day readmission, July 2023–June 2025, heart failure 21.8% (639 index stays), COPD 19.8% (173), pneumonia 17.2% (528), AMI 14.9% (170), each no different than the national rate; excess days in acute care per 100 discharges, July 2022–June 2025, heart failure +8.4, pneumonia +31.5, AMI +33.2.

¹³ CMS FY2026 Hospital Readmissions Reduction Program Supplemental Data File and Payment Adjustment Factors (September 2025; performance period July 2021–June 2024), CCN 110091: payment adjustment factor 0.9969; excess readmission ratios heart failure 1.0674 against a peer-group median of 0.9922 (penalized), COPD 1.0049 against 0.9965 (penalized), pneumonia 0.9812 (not penalized), AMI 0.9931 (not penalized); dual proportion 16.5%, peer group 2 of 5.

¹⁴ CMS FY2026 Hospital Value-Based Purchasing program, total performance score file (dataset ypbt-wvdk), CCN 110091: total performance score 32.875; unweighted domain scores clinical outcomes 37.5, person and community engagement 34, safety 40, efficiency and cost reduction 20.

¹⁵ CMS Care Compare, Timely and Effective Care (dataset yv7e-xc69), October 2024–September 2025, CCN 110091: OP-18b median time from arrival to departure for discharged emergency patients 222 minutes (sample 384); OP-18a all patients 231 minutes; OP-22 left

discharge sweep lands: the patient is already in the record, already has a diagnosis, and is about to go home with instructions and, in CY2024, no follow-up that anyone billed. An emergency-department discharge does not open a transitional care episode on its own, but it opens the remote monitoring and care-management enrollment, and it is the return visit that a transitional care episode is designed to prevent.

1.5 The Conyers practices in CY2024 claims

Medicare's professional-claims file for CY2024 lists 295 clinicians billing from a Conyers address; 70 of them resolve to Piedmont billing entities. Across those 70, the file shows **no transitional care management (99495 or 99496), no remote physiologic monitoring on any code, no principal care management, and chronic care management (99490) at 52 beneficiaries and 83 services across four internists**, about 1.6 claims per beneficiary, a few pilots rather than a program.¹⁶ CMS suppresses any provider-and-code line under 11 beneficiaries, so the honest reading is that there was no remote-care or care-management program at meaningful scale in CY2024. The file also predates the system program launched in August 2025 (Section 3.3). Across every clinician billing from a Conyers address, Piedmont-employed or not, transitional care management appeared on 22 services for 19 beneficiaries in the whole year.

The same file sizes the office side. Forty-one Piedmont-employed clinicians bill established office visits from a Conyers address, and 5,203 fee-for-service beneficiaries appear on the two workhorse codes, 99213 and 99214. Grossed up for the county's Medicare Advantage share and de-duplicated across clinicians, that is an established Medicare panel of roughly 10,500 across the Conyers practices. The forecast's referral roster is the adult-medicine subset of those 41: **34 clinicians**, 10 in internal medicine, 8 in family medicine, 9 nurse practitioners and physician assistants, 3 in cardiology, and one each in endocrinology, neurology, pulmonology and gastroenterology. Oncology, surgery, orthopedics, intensivists and the hospitalists are outside the count; the hospitalists and the emergency department are the discharge feed, not the referrers.¹⁷

Code family, CY2024, Piedmont-employed Conyers clinicians	Beneficiaries	Services	Clinicians
Transitional care management, 99495 / 99496	—	—	—
Remote physiologic monitoring, 99453 / 99454 / 99457 / 99458	—	—	—
Principal care management, 99424–99427	—	—	—
Chronic care management, 99490	52	83	4
Established office visits, 99213 + 99214	5,203	—	41

CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, rendering city Conyers, Georgia; a dash is a code with no published line (under 11 beneficiaries per clinician, or none).

before being seen 1% (51,569); emergency department volume category high.

¹⁶ CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released 2026), rendering-provider city Conyers, Georgia: 295 billing NPIs, of which 70 resolve to Piedmont billing entities through the CMS Doctors & Clinicians file. Across those 70: no 99495 or 99496 lines, no 99453, 99454, 99457 or 99458 lines, no 99424–99427 lines, and 99490 at 52 beneficiaries and 83 services across four internists. CMS suppresses any provider-and-code line under 11 beneficiaries. The file predates the system program launched in August 2025.

¹⁷ Same CY2024 file: 41 Piedmont-employed clinicians bill established office visits (99212–99215) from a Conyers address; 5,203 beneficiaries on 99213 and 99214 combined. The forecast's 34 referring clinicians are the adult-medicine subset: 10 internal medicine, 8 family medicine, 9 nurse practitioners and physician assistants, 3 cardiology, and one each in endocrinology, neurology, pulmonology and gastroenterology; oncology, surgery, orthopedics, intensivists, hospitalists and the emergency department are outside the count.

1.6 Rockdale County: 65.2% Medicare Advantage

Rockdale County has 95,281 residents, 15.8% of them aged 65 or older, a median household income of \$77,247, a poverty rate of 10.8% and an uninsured rate of 13.1%.¹⁸ Its 18,302 Medicare eligibles were **65.2% enrolled in Medicare Advantage** in July 2026, against 65.6% in Newton, 63.1% in Henry and 60.1% in DeKalb; 6,308 county residents remain in Original Medicare, and 3,121 beneficiaries are dual-eligible.¹⁹ The hospital's draw area runs into Newton, Henry, DeKalb and Walton counties, and Piedmont owns the three nearest hospitals to the east and south, so leakage is largely within the system.

What 65.2% Medicare Advantage does to the revenue model

Medicare Advantage plans must pay at least the Medicare rate — a floor; individual contracts set their own terms for the care-management code families. That floor sits under two-thirds of the discharge cohort and two-thirds of the established panel.

The forecast in Section 7 prices the whole population at the fee schedule. The matching operational move is early: confirm transitional care, remote monitoring and chronic care management payment terms with the dominant Atlanta plans during discovery, contract by contract (Recommendation 4). The fee-for-service third of the cohort carries the forecast on its own terms today.

Georgia Medicaid fee-for-service does not reimburse remote physiologic monitoring, so the forecast is Medicare only and carries no Medicaid dollars; dual-eligible patients bill Medicare with Medicaid as secondary.²⁰

2. The 30 Days After Discharge

2.1 The loop

The service line is one loop, and every step of it is in Epic. An inpatient, observation or emergency-department discharge lands on the discharge list. CoachCare's on-site enrollment specialist, placed at the hospital and working that list with case management, enrolls the patient the same day, before they leave. An interactive contact follows within two business days. The patient sees their Piedmont internist, family physician or cardiologist within 7 or 14 days, and leaves that visit with a cellular device in hand and chronic care management, or principal care management for the heart-failure cohort, starting the same month. Readings, calls and escalations then run through one engine, and the next emergency-department visit, if there is one, is in the record before the patient is home.

Step	Who	When	What it bills
Discharge list	Hospitalists, emergency department, case management	Day 0	—
Same-day enrollment	CoachCare on-site enrollment specialist at the hospital	Day 0	—
Interactive contact	CoachCare care team on behalf of the practice	Within 2 business days	Required element of 99495 / 99496
Office visit	Piedmont internist, family physician or cardiologist in Conyers	Day 7 (high complexity) or day 14 (moderate)	99496 \$303.22 or 99495 \$223.60
Device in hand	CoachCare device logistics; setup and education	At the visit	99453 \$22.18 once

¹⁸ U.S. Census Bureau American Community Survey 2024 five-year estimates, profiles DP05 and DP03, Rockdale County, Georgia: population 95,281; 15,068 residents aged 65 and over (15.8%); median household income \$77,247; poverty 10.8%; uninsured 13.1% of the civilian non-institutional population.

¹⁹ CMS Medicare Advantage State/County Penetration, July 2026: Rockdale County 65.20% (11,933 enrolled of 18,302 eligible); Newton 65.6%, Henry 63.1%, DeKalb 60.1%. CMS Medicare Monthly Enrollment, May 2026, Rockdale County: 18,131 beneficiaries, 6,308 in Original Medicare, 3,121 dual-eligible.

²⁰ Center for Connected Health Policy, Georgia Medicaid policy summary (updated May 27, 2026): remote patient monitoring is not reimbursed under Georgia Medicaid fee-for-service.

Step	Who	When	What it bills
Monthly monitoring and management	CoachCare care team, practice oversight	Every month	99454 / 99445 \$53.00; 99457 \$52.58; 99470 \$26.46; 99458 \$42.06
Monthly care management	CoachCare care team, practice oversight	Every month	CCM 99490 \$67.19 + 99439 \$51.25; PCM 99426 \$68.89 + 99427 \$54.98 for heart failure (named, no revenue in the forecast)

CY2026 non-facility Physician Fee Schedule, Georgia locality 01 (Atlanta).

2.2 Three touches inside 14 days

Every discharge, whether or not it becomes a billed transitional care episode, gets the same cadence: 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 in the record, each one screens for symptoms and medication problems, and any clinical alert surfaced during a touch escalates under the shared logic in Section 6. The first touch is the interactive contact a transitional care episode requires; the third lands inside the 14-day visit window and confirms the visit happened. For a patient discharged with a device, the touches sit on top of daily readings, so the care team is calling about a number, not asking how the patient feels.²¹

2.3 Transitional care management: the mechanics and the Atlanta rates

Transitional care management pays the practice that assumes care after a discharge from an inpatient, observation or skilled-nursing stay for the 30 days that follow: an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days for moderate medical decision-making (99495) or within 7 days for high (99496). One claim per patient per 30-day period. At Georgia locality 01, the Atlanta locality that ZIP 30012 maps to, 99495 pays **\$223.60** and 99496 pays **\$303.22**.²² Since CY2020 CMS has allowed chronic care management and principal care management to be billed in the same month as a transitional care episode, so the office follow-up starts in the discharge month rather than waiting for it to close.

The forecast builds the layer from the hospital's own discharge count: 1,662 Medicare fee-for-service discharges in CY2024, grossed up for the county's 65.2% Medicare Advantage share, is **398 Medicare discharges a month**. Half of them, 199, become a completed episode with a Piedmont Conyers practice; 30% of those bill as 99496 and 70% as 99495; the layer ramps over five months. That produces **4,563 episodes over 24 months, \$1,046,040 of net reimbursement and \$802,365 net to the hospital**, at \$229.23 net per episode after denials, coinsurance and bad debt, with about 209 episodes a month at steady state. Every episode carries 60 minutes of CoachCare care-team work: the contact, the reconciliation, the scheduling, the documentation.²³

²¹ 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 and urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

²² CPT 99495 and 99496: interactive contact with the patient or caregiver within two business days of discharge; medication reconciliation no later than the face-to-face visit; a face-to-face visit within 14 calendar days (99495, moderate medical decision-making) or 7 calendar days (99496, high); one claim per patient per 30-day period, billed by the practice that assumes care after discharge. CMS has permitted chronic care management and principal care management to be billed in the same month as transitional care management since CY2020. CY2026 Physician Fee Schedule non-facility amounts (CMS RVU26A), Georgia locality 01 (Atlanta), Palmetto GBA Jurisdiction J; ZIP 30012 maps to carrier 10212 locality 01 in the April 2026 ZIP-to-locality crosswalk; GPCIs work 1.003, practice expense 1.016, malpractice 1.201; conversion factor \$33.4009. 99495 \$223.60; 99496 \$303.22.

²³ CoachCare Value Analysis, transitional care management layer: 398 Medicare discharges a month (1,662 CY2024 fee-for-service discharges grossed up for the county's 65.2% Medicare Advantage share, divided by 12); 50% captured into a completed episode; 30% billed as 99496 and 70% as 99495; ramp 30 / 50 / 70 / 85 / 100% over the first five months; the same denial, coinsurance and bad-debt waterfall as the recurring programs; a per-episode management fee and no platform fee; 60 care-team minutes per episode. 24 months: 4,563 episodes, \$1,129,328 gross, \$1,046,040 net reimbursement, \$243,675 fees, \$802,365 net to the hospital; \$229.23 net per episode.

Transitional care layer	Year 1	Year 2	24 months
Episodes completed	2,087	2,477	4,563
Net reimbursement	\$478,310	\$567,730	\$1,046,040
CoachCare episode fees	\$111,422	\$132,253	\$243,675
Net to the hospital	\$366,888	\$435,477	\$802,365
Episodes in months 1, 2, 3; month 12; month 24	60 · 100 · 140	204 → 209	—

CoachCare Value Analysis, transitional care layer: 398 Medicare discharges a month, 50% captured, 30% high complexity, five-month ramp, Atlanta rates.

3. Service Line Architecture

Two lanes, one engine. The discharge lane is owned by the Piedmont Conyers practices and fed from the hospital; the office lane is remote monitoring and care management for the discharged patient, through the internists and family physicians at Wellbrook and Sigman Road and the cardiologists at Piedmont Heart on campus. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare infrastructure for both, inside Epic.

3.1 Lane one: the discharge

The discharge lane starts at the hospital and ends at the 7- or 14-day visit. CoachCare's on-site enrollment specialist works the discharge list with case management, enrolls at the bedside, and hands the patient to the care team for the two-business-day contact. The practice that assumes care bills the transitional care episode; in this design that is the Piedmont Conyers practice the patient already belongs to, or the one the discharge assigns. For a heart-failure discharge the follow-up visit is with Piedmont Heart and the episode is one of the codes that count under the Ambulatory Specialty Model (Section 4.2). For an emergency-department discharge with no admission, the lane runs the same three touches and the same enrollment; there is no transitional care claim, and the value is the return visit that does not happen.

3.2 Lane two: the office follow-up

The office lane is the recurring service line, and it is built for the patient the hospital actually discharges: multi-morbid, average risk score 2.32, more likely than not to carry hypertension, diabetes, heart failure or COPD together. Remote physiologic monitoring supplies the daily signal; chronic care management supplies the monthly coordination wrapper. The forecast runs both on the Primary Care / Internal Medicine eligibility row, 65% of the cohort eligible for monitoring and 75% for care management, because the office follow-up lands in primary care. For the heart-failure cohort at Piedmont Heart, principal care management (99426 \$68.89, 99427 \$54.98) is the single-condition wrapper the cardiology practice would bill; it is named here and carries no revenue in the forecast.

Program	Who qualifies	What it is	Billing
TCM	Any inpatient or observation discharge home, about 398 Medicare discharges a month	Contact within two business days, medication reconciliation, a face-to-face visit within 7 or 14 days	99495 / 99496, per episode
RPM	2,178 of the 3,350 in scope (65%): hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, scale, glucose meter, pulse oximeter); readings against clinical thresholds; monthly management time	99453 setup; 99454 / 99445 supply; 99457 / 99470 / 99458 management

Program	Who qualifies	What it is	Billing
CCM	2,512 (75%): 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
PCM	The heart-failure cohort followed at Piedmont Heart	Monthly single-condition management by the cardiology practice	99426 + 99427, named, no revenue in the forecast

Eligible-pool counts from the Value Analysis eligibility model; pools overlap, billing does not (Section 3.4).

3.3 Build and partner: what the system program covers, and what it does not

Piedmont launched a system-wide chronic care management and remote monitoring program with an outside partner in August 2025, starting in primary care, with cardiology, endocrinology and obstetrics named as later phases. It is Epic-integrated. It is the incumbent at the office layer for primary-care patients, and this report credits it: a system that has already stood up monthly care management and monitoring for enrolled primary-care patients has done the hard organizational work of consenting patients, assigning care teams and billing monthly codes.

What that program does not cover is the discharge. The CY2024 claims file, which predates it, shows no transitional care management billed by any Piedmont Conyers clinician, no remote monitoring, and care management at trace volume; nothing published since describes the program reaching into the hospital's discharge list, enrolling at the bedside, or billing the 30-day episode. The motion in this report is co-existence, not replacement. CoachCare owns the discharge lane, the transitional care episode and the post-discharge enrollment that starts at the hospital. Where the system program already holds a patient's care management, the transitional care hand-off lands in that program and the monthly wrapper stays where it is. Which Conyers patients are already enrolled, and whether transitional care sits inside the program's scope, is the second item in Section 10.

3.4 One coordination rule, set at enrollment

One coordination rule

A patient carries one care-management wrapper, chronic care management or principal care management, never both in the same month. Remote monitoring stacks with either. A transitional care episode runs for 30 days after a discharge and, since CY2020, may be billed in the same month as the wrapper. One practice bills transitional care per discharge. The enrollment workflow assigns each patient a wrapper, a monitoring enrollment where clinically indicated, and a transitional care episode when there has been a discharge, so the code families never collide on a claim, and so a patient already inside the system program is routed there rather than enrolled twice.

3.5 Staffing: nobody is hired

CoachCare delivers 26,958 hours of care-management work on the recurring programs across the 24 months, about **13.0 full-time-equivalent years**, plus 4,563 hours on the transitional care episodes, without the hospital or the practices hiring anyone. The on-site enrollment specialist at the hospital is CoachCare's expense, not a program cost.²⁴ The division of labor is the design. CoachCare's staff carry the recurring work: monitoring review, outreach, documentation, escalation handling, claim generation. The hospital's case managers keep producing the discharge list they already produce. The practices' clinicians contribute the two things only they can: the visit that closes the transitional care episode and clinical judgment at the escalation points.

²⁴ CoachCare Value Analysis clinical-outcomes and operations modules, 24 months: 105.5 avoided hospitalizations valued at \$15,000 each; 60,445 claims; 166,222 device readings; 26,958 care-team hours (about 13.0 FTE-years) on the recurring programs and 4,563 on the transitional care layer.

4. Policy: What Moves the Math in 2026 and 2027

4.1 The CY2026 remote monitoring codes

CY2026 added two codes that fit the post-discharge window exactly. 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 to 19 minutes of monthly management time where 20 minutes is not reached. A patient discharged on the 20th of the month used to produce an unbillable partial month; now it bills, and so does the light-touch month that follows a stable one. In this forecast the two codes carry **\$293,595 of gross reimbursement over 24 months, about 9.0% of the recurring line's net reimbursement**, revenue that did not exist two years ago.²⁵

4.2 The Ambulatory Specialty Model: heart-failure episodes from CY2027

The Ambulatory Specialty Model is CMS's mandatory, episode-based model for heart failure and one other condition, running performance years 2027 through 2031 in selected geographies. Metropolitan Division 12054, Atlanta–Sandy Springs–Roswell, is a selected geography, and Rockdale County sits inside it.²⁶ **Sixteen physicians billing under Piedmont Cardiology of Atlanta, LLC are named on the CMS preliminary participant list for the Ambulatory Specialty Model, Heart Failure cohort; ten of them carry a Conyers practice location, and seven hold a Care Compare affiliation with Piedmont Rockdale.**²⁷ The model adjusts those physicians' Part B payment by up to $\pm 9\%$ in the first two performance years, rising to $\pm 12\%$, on a two-year lag: the first performance year is CY2027, paid in payment year 2029.²⁸

Two details make the discharge lane the relevant one. First, a heart-failure episode is attributed to the clinician who bills at least 30% of the trigger or confirming codes for that patient, and the trigger list is built from evaluation-and-management and care management: chronic care management, principal care management and transitional care management open episodes and count toward the threshold. Remote monitoring does not appear on that list; it does not open an episode and does not help a cardiologist clear 30%.²⁹ So the codes that matter for the Piedmont Heart physicians on the preliminary list are transitional care at every heart-failure discharge and principal care management in the clinic, with monitoring as the clinical layer that moves the cost measure underneath. Second, the model asks each participant for a collaborative care arrangement with a primary care practice under § 512.771(a)(2); that arrangement is between the cardiology practice and the primary care practice, and CoachCare is not a counterparty to it. CMS-1848-P proposes to broaden the arrangement to in-kind support such as care managers or technology infrastructure; that provision is proposed, not final.

²⁵ CY2026 Physician Fee Schedule final rule: CPT 99445 (device supply, 2–15 days of data in 30 days) and 99470 (treatment management, 10–19 minutes) added to the remote physiologic monitoring family. CoachCare Value Analysis, Financial Value detail: the two codes carry \$293,595 of gross reimbursement over 24 months against \$3,267,017 of net reimbursement from the recurring programs (9.0%).

²⁶ CMS Innovation Center, Ambulatory Specialty Model mandatory geographic areas file: Metropolitan Division 12054, Atlanta–Sandy Springs–Roswell, Georgia, is a selected geography. U.S. Census Bureau OMB delineation file (2023): Rockdale County is a central county of the Atlanta metropolitan statistical area and sits in Metropolitan Division 12054.

²⁷ CMS Ambulatory Specialty Model participants dataset, preliminary CY2027 list (vintage January 2, 2026), Heart Failure cohort, Metropolitan Division 12054: 16 physicians billing under Piedmont Cardiology of Atlanta, LLC; cross-referenced to the CMS Doctors & Clinicians file (10 with a Conyers practice location) and the CMS facility-affiliation file (7 with an affiliation to CCN 110091). The list is preliminary; the final CY2027 list is expected before the model starts.

²⁸ 42 CFR Part 512, Subpart E (Ambulatory Specialty Model), as finalized in the CY2026 Physician Fee Schedule final rule: performance years 2027–2031; payment adjustment applied two years after each performance year; maximum adjustment $\pm 9\%$ for the first two performance years, rising to $\pm 12\%$; episode attribution requiring at least 30% of trigger or confirming codes; § 512.771(a)(2) collaborative care arrangement between the participant and a primary care practice. CMS-1848-P (July 2026) proposes to broaden § 512.771 to in-kind support such as care managers or technology infrastructure; that provision is proposed, not final.

²⁹ CMS Ambulatory Specialty Model, heart-failure episode-based cost measure, proposed operational list of care episode and patient condition codes (June 2026): 99495, 99496, 99490, 99491, 99487, 99424 and 99426 are outpatient evaluation-and-management trigger codes; the remote physiologic monitoring family (99453, 99454, 99457, 99458, 99445, 99470, 99091) is absent from the trigger list.

4.3 Piedmont Clinic ACO: shared savings with no downside

The Piedmont Conyers practices participate in the Medicare Shared Savings Program through Piedmont Clinic ACO LLC (ACO ID A3250), BASIC track Level B, in the third year of a five-year agreement that began January 1, 2025, with 120 participant TINs across Georgia, Alabama and South Carolina.³⁰ Level B is upside-only: the ACO shares in savings and carries no downside risk. A transitional care episode and a prevented 30-day readmission both flow into that calculation for the fee-for-service beneficiaries assigned to the ACO, so the service line's readmission work and its professional-fee revenue point the same way. This report asserts nothing about Medicare Advantage risk contracts or other value-based arrangements; those are discovery items.

4.4 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 Atlanta locality on this account's own billing mix, with enrollment held constant.³¹

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	\$53.00 a month	\$42.10 a month, -20.6%	The code CMS proposes to cut
The remote monitoring arm	\$1,566,495 over 24 months	-9.4%, -\$147,769	Device supply is 32% of the remote monitoring basket; management time moves little
Chronic care management	\$1,700,522 over 24 months	-2.2%, -\$37,468	Conversion-factor and relative-value churn only; the proposal does not target these codes
The recurring service line	\$3,267,017 over 24 months	-5.7%, -\$185,237, to \$3,081,780	Remote monitoring is 48% of the recurring line
Transitional care management	\$1,046,040 over 24 months	-2.0%, -\$21,028	99495 \$223.60 → \$218.79; 99496 \$303.22 → \$297.86

CoachCare repricing of this forecast at the CY2027 proposed amounts, Georgia locality 01 (Atlanta), on the code frequencies in this Value Analysis. Locality amounts for each line; Appendix A shows the code-by-code table on the same basis.

Three numbers, each smaller than the last only because its base is larger. A 20.6% cut to one code is a 5.7% change to the recurring line, because the line is built on two programs and one of them is not the one being repriced, and a 2.0% change to the transitional care layer, which the proposal does not target at all.

³⁰ CMS Medicare Shared Savings Program, PY2026 ACO participants file (retrieved September 22, 2026): Piedmont Clinic ACO LLC, ACO ID A3250, BASIC track Level B, agreement period 3, current start January 1, 2025, 120 participant TINs, service area Alabama, Georgia and South Carolina. The Piedmont Conyers practices participate through their parent billing entities.

³¹ CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at Georgia locality 01 on this forecast's code frequencies: 99454 and 99445 from \$53.00 to \$42.10 (-20.6%); the remote monitoring arm -9.4% (-\$147,769); chronic care management -2.2% (-\$37,468); the recurring service line -5.7% (-\$185,237, from \$3,267,017 to \$3,081,780); 99495 from \$223.60 to \$218.79 and 99496 from \$303.22 to \$297.86, the transitional care layer -2.0% (-\$21,028). Enrollment held constant.

5. Epic Integration: The Program Lives in the Record

Piedmont runs one Epic record across its hospitals and practices, with Piedmont MyChart as the patient portal, so the Rockdale discharge and the Conyers office visit are already in the same chart.³²

CoachCare's Epic integration is direct and bi-directional, and it is priced from the integration catalog in this forecast at \$4,000 setup, \$150 a month and \$1.50 per patient. The program operates inside the record rather than beside it: practices enroll and monitor remote-care patients without learning a new system, and the whole program lives in the Epic environment.

- **Integrated enrollment.** Enrollment flags and trigger orders sit inside the clinical workflow; the discharge event is the trigger for this account. CoachCare's team enrolls qualified Medicare patients on the practice's behalf, and enrollment status is visible in Epic in real time.
- **Exchange of health history.** Bi-directional at intake, so the care team starts from the chart, not a questionnaire.
- **Integrated discrete vitals.** Device readings land as discrete vitals in the chart, not attached PDFs, where thresholds, trends and the escalation logic can read them.
- **Integrated care summary and compliance documentation.** Audit-ready documentation, time capture and the transitional care elements write back to the record.
- **Automated claim generation.** The CoachCare billing engine assembles the monthly claim lines and the per-episode transitional care claim, which is what makes 60,445 claims over 24 months workable. CoachCare is the only care-management application integrated with Epic that provides automated claims creation, which removes the manual claim step per patient per month and shortens the path to reimbursement.

Patients begin receiving chronic care management and remote monitoring services in under five days from the flag. The full-service wrapper applies throughout: telephonic and bedside enrollment, dedicated health coaches, cellular connected devices and automatic claims creation. What makes a program efficient, effective and sustainable is an intuitive experience for the patient and the clinician, and that is what the integration is for. CoachCare runs remote care programs for more than 500,000 patients across over 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.³³

6. Clinical Governance and Escalation

A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the hospital and the practices inherit on the first day: CoachCare's Care Management Programs standard operating procedures, March 2026 edition, rendered as seven process maps covering qualification, monitoring, escalation and discharge.³⁴ The post-discharge cadence in Section 2.2 is one of those maps; the rest follow.

6.1 One shared escalation engine

Every program, remote monitoring 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

³² Piedmont Healthcare, Epic at Piedmont page, retrieved September 2026: one Piedmont medical record across hospital and office, with the Piedmont MyChart patient portal. CoachCare Epic integration overview: integrated enrollment, bi-directional health-history exchange, discrete vitals, integrated care summary and compliance documentation, automated claim generation. Integration pricing as carried in the Value Analysis: \$4,000 setup, \$150 a month, \$1.50 per patient.

³³ CoachCare company statistics, 2026: more than 500,000 patients across over 400 managed conditions; 10,000+ providers on the platform; 1,000+ implementations; more than five million claims generated; over 100 million vitals recorded.

³⁴ 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 and urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

answers a symptom check, so the practice 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. For a heart-failure patient the reading that matters most is weight, and a climb over consecutive days is worked the same way.

6.2 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any practice-specific escalation preference: whichever practice the patient belongs to, the emergent floor does not move. In Rockdale County the ambulance goes to Piedmont Rockdale's own emergency department, where the patient's readings for the past month are already in the chart.

6.3 Qualification, device assignment and routing

Enrollment starts with the discharge list and 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 scale and the cuff the higher-acuity condition needs. Once monitoring runs, escalations route three ways: emergencies to the emergent pathway, non-critical clinical items to the practice for direction, and informational items documented to the chart. Escalation routing is localized per practice, so the Wellbrook internists, the Sigman Road family physicians and Piedmont Heart each set their own preferences above the emergent floor.

6.4 Program discharge and continuity

Discharge from the program is governed, not ad hoc. Discharge criteria and unreachable-patient timelines are defined per program, and the practice is notified in every case. For monitoring patients the sequence is explicit: a recommended discharge first escalates to the practice for instructions, re-escalates every 30 days, and if the practice 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.

7. Value Analysis: The 24-Month Forecast

7.1 Headline economics

Over 24 months the two lanes together produce **\$4,313,057 in net reimbursement** to Piedmont Rockdale and its Conyers practices. CoachCare's fees total \$2,125,093, and net to the hospital is **\$2,187,964, a 50.73% combined margin**. The two parts behave differently and are shown separately everywhere in this report. The recurring programs, remote monitoring and chronic care management, produce \$3,267,017 of net reimbursement, \$1,881,418 of fees including \$60,222 of ancillary items (implementation, the Epic integration and telephonic outreach), and \$1,385,599 net, a **42.41% margin**, 41.74% in Year 1 and 42.89% in Year 2. The transitional care layer produces \$1,046,040 of net reimbursement, \$243,675 of per-episode fees and \$802,365 net; it carries no platform fee, so its margin runs higher, at 76.7%.³⁵

	Year 1	Year 2	24 months
Transitional care management			
Net reimbursement	\$478,310	\$567,730	\$1,046,040
CoachCare fees	\$111,422	\$132,253	\$243,675
Net to the hospital	\$366,888	\$435,477	\$802,365
Recurring programs (RPM + CCM)			
Net reimbursement	\$1,352,735	\$1,914,282	\$3,267,017
CoachCare fees	\$788,155	\$1,093,264	\$1,881,418
Net to the hospital	\$564,580	\$821,018	\$1,385,599
Margin	41.74%	42.89%	42.41%
TCM + office-based programs			
Net reimbursement	\$1,831,045	\$2,482,012	\$4,313,057
CoachCare fees	\$899,577	\$1,225,517	\$2,125,093
Net to the hospital	\$931,468	\$1,256,496	\$2,187,964
Margin	50.87%	50.62%	50.73%

CoachCare Value Analysis. Margin is net to the hospital divided by net reimbursement. The recurring-program margin is the priced figure; the combined figure includes the transitional care layer at a per-episode fee.

³⁵ CoachCare Value Analysis, 24-month forecast, recurring programs: net reimbursement \$3,267,017; CoachCare fees \$1,881,418, including \$60,222 of ancillary items (implementation \$2,500; Epic integration \$4,000 setup, \$150 a month and \$1.50 per patient; telephonic outreach); net to the hospital \$1,385,599; margin 42.41% (Year 1 41.74%, Year 2 42.89%), defined as net to the hospital divided by net reimbursement. Combined with the transitional care layer: \$4,313,057 net reimbursement, \$2,125,093 fees, \$2,187,964 net to the hospital, 50.73%.

The 24-Month Ramp: Both Programs Reach Their Ceilings Inside Eight Months

CoachCare Value Analysis · 3,350 Medicare patients in scope · at M24: 1,516 active enrollments across 988 unique patients, plus 4,563 TCM episodes over 24 months

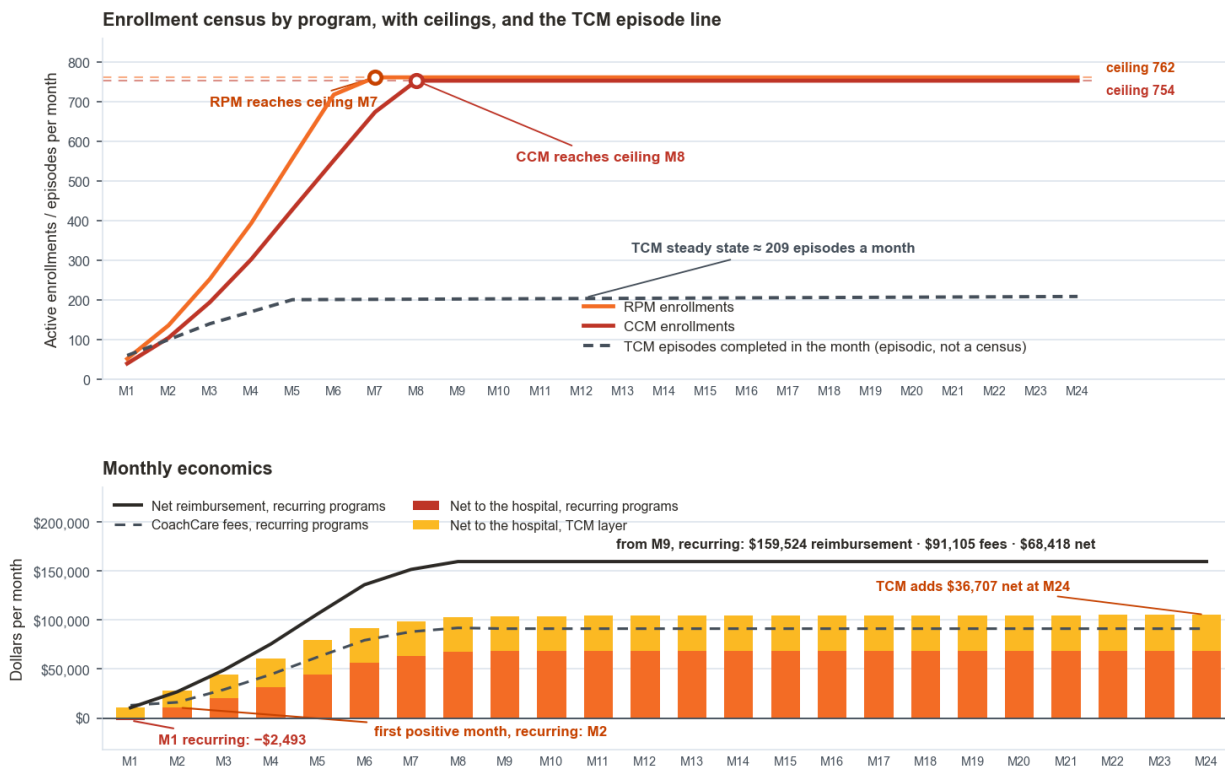


Figure 1. The 24-month ramp: enrollment census by program with ceilings and the transitional care episode line (above), and monthly economics with the recurring programs' net stacked under the transitional care net (below). Month 1 of the recurring line nets -\$2,493; its first positive month is M2; from M9 it holds at \$68,418 net per month, with transitional care adding \$36,707 at M24.

The shape of the curve is worth reading precisely. The recurring line's month 1 is negative, -\$2,493, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$10,711, month 3 nets \$19,967, and the line compounds as the two programs fill: from M9 it runs at \$159,524 of net reimbursement, \$91,105 of fees and \$68,418 net a month, once setup codes fall away and the census holds at ceiling. The transitional care layer has no such dip; it nets \$10,497 in month 1 on 60 episodes, \$35,801 in month 12 on 204, and \$36,707 in month 24 on 209.

7.2 Economics by line and by year

Line	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the hospital
TCM	\$478,310	\$567,730	\$1,046,040	\$243,675	\$802,365
RPM	\$670,223	\$896,272	\$1,566,495	\$928,131	\$638,364
CCM	\$682,511	\$1,018,010	\$1,700,522	\$893,065	\$807,457
Ancillary (implementation, Epic integration, outreach)	—	—	—	\$60,222	-\$60,222
Recurring programs	\$1,352,735	\$1,914,282	\$3,267,017	\$1,881,418	\$1,385,599
TCM + office-based programs	\$1,831,045	\$2,482,012	\$4,313,057	\$2,125,093	\$2,187,964

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

Line	Year 1 net reimbursement	Year 1 fees	Year 1 net to the hospital	Year 2 net reimbursement	Year 2 fees	Year 2 net to the hospital
TCM	\$478,310	\$111,422	\$366,888	\$567,730	\$132,253	\$435,477
RPM	\$670,223	\$391,819	\$278,405	\$896,272	\$536,312	\$359,960
CCM	\$682,511	\$358,435	\$324,076	\$1,018,010	\$534,630	\$483,380

CoachCare Value Analysis, per-line year splits read from the workbook. Ancillary items sit outside the program rows, so the recurring rows sum to the year totals before ancillary fees.

Chronic care management is the largest recurring line at \$1,700,522 and the higher-yield one at \$112.53 of net reimbursement per patient-month across 15,112 patient-months; remote monitoring runs \$98.95 across 15,831. Transitional care yields \$229.23 per episode across 4,563. Year 2 outruns Year 1 by \$561,547 of recurring net reimbursement because Year 1 carries the ramp and Year 2 runs at ceiling from its first month.

Service-Line Composition: RPM \$1,566,495 · CCM \$1,700,522 · TCM \$1,046,040

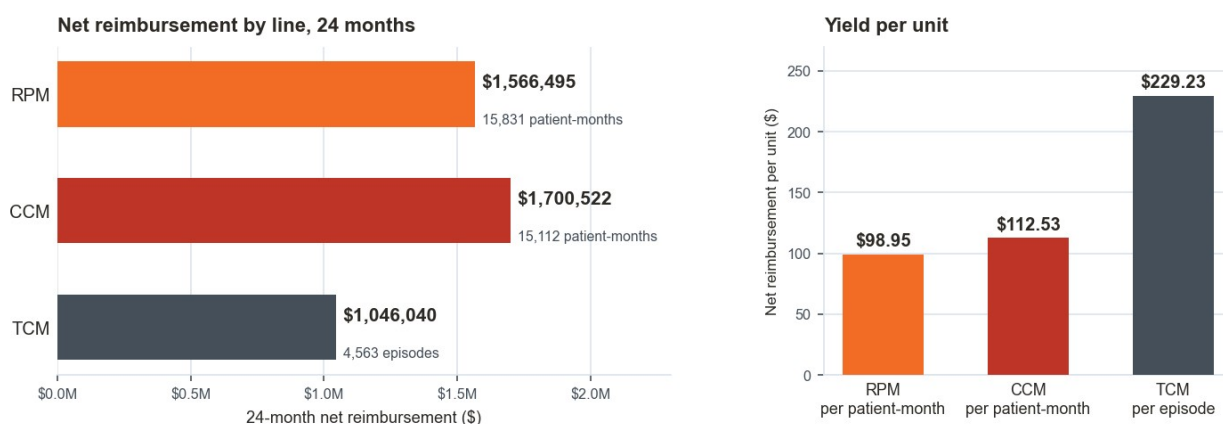


Figure 2. Service-line composition: 24-month net reimbursement by line, and net reimbursement per patient-month (RPM, CCM) and per episode (TCM).

7.3 The ramp: both ceilings inside eight months

This account is ceiling-limited in both recurring programs. RPM reaches its ceiling of 762 enrollments in month 7 and CCM its 754 in month 8; from M9 the forecast is flat because the in-scope cohort is enrolled.³⁶ The first 90 days move fast: 91 new enrollments across the two programs in month 1, 151 in month 2, 211 in month 3, peaking at 300 a month in months 5 and 6. The transitional care layer completes 60 episodes in month 1, 100 in month 2 and 140 in month 3, and reaches steady state in month 5.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	2,178	762	Month 7	762
CCM	2,512	754	Month 8	754
Both programs		1,516		1,516 enrollments · 988 unique patients

Enrollment counts are program enrollments, not unique patients; the 1,516 enrollments at M24 belong to 988 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Transitional care episodes sit outside the census.

Say the constraint out loud: what binds this program is the size of the discharge cohort, not enrollment capacity. That cuts two ways. It caps the forecast, and it de-risks it, because the model asks the practices for no heroic enrollment performance, only a cohort that the hospital already discharges. The on-site enrollment specialist cannot raise a ceiling, but reaches both months sooner, worth \$177,161 of 24-month net reimbursement against the no-specialist case in Section 7.5. What moves the ceilings is the cohort: the share of discharges that go home to a Piedmont Conyers practice, and the established panel behind them.

7.4 What the program produces

24-month output	Volume
Transitional care episodes completed	4,563
Claims generated, billing-ready (recurring programs)	60,445
Device readings monitored	166,222
Care-management tasks completed	120,891
Chart updates written to Epic	30,223
Patient conversations held	18,134 (1,007 hours of call time)
Care-team hours delivered	26,958 on the recurring programs (≈ 13.0 FTE-years) + 4,563 on transitional care
Hospitalizations avoided	105.5 · ≈ \$1.58 million at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

³⁶ CoachCare Value Analysis enrollment model: eligible pools RPM 2,178 and CCM 2,512; ceilings 762 (RPM, reached month 7) and 754 (CCM, month 8); 1,516 active program enrollments across 988 unique patients at month 24 (988 at month 12 as well). Dedup: 754 care-management enrollments plus the RPM enrollments not already carrying a wrapper (70% dual enrollment).

The avoided-admission line deserves its own sentence. 105.5 avoided hospitalizations over 24 months is roughly \$1.58 million of cost that never lands on anyone, not on Medicare, not on the plans that cover 65.2% of the county, and not on the hospital's own beds and emergency department. For a hospital penalized on heart-failure and COPD readmissions and accumulating excess days after pneumonia and heart attack, those are also the discharges that set the FY2028 and FY2029 program numbers.³⁷

7.5 What moves the number

Each row below is a full recalculation of the Value Analysis at the same pricing, changing one input.³⁸

Scenario	24-month net reimbursement	Net to the hospital	Margin	Ceiling reached RPM / CCM
Base: 3,350 in scope, 34 clinicians, 1 enrollment specialist (recurring programs)	\$3,267,017	\$1,385,599	42.41%	M7 / M8
No on-site enrollment specialist	\$3,089,856	\$1,307,294	42.31%	later
Second on-site enrollment specialist	\$3,367,990	\$1,429,932	42.46%	sooner
In scope 2,700	\$2,704,384	\$1,145,772	42.37%	—
In scope 4,500	\$4,180,777	\$1,774,334	42.44%	—
24 referring clinicians	\$3,145,331	\$1,332,997	42.38%	—
44 referring clinicians	\$3,347,074	\$1,420,271	42.43%	—
Transitional care capture 25% (transitional care layer only)	\$523,020	\$401,183	—	—
Transitional care capture 75% (transitional care layer only)	\$1,569,060	\$1,203,548	—	—

CoachCare Value Analysis recalculations at the same pricing. The binding constraint is the size of the discharge cohort, not enrollment capacity; the enrollment specialist changes when each ceiling is reached, not where it sits. The transitional care layer is linear in capture.

7.6 Model inputs

Input	Value
Medicare patients in scope	3,350: one year of the hospital's Medicare discharged patients, the cohort that flows discharge → transitional care → office follow-up
Established Medicare panel	About 10,470 across the Piedmont Conyers practices
Referring clinicians	34 Piedmont-employed adult-medicine clinicians billing office visits from a Conyers address (10 internal medicine, 8 family medicine, 9 nurse practitioners and physician assistants, 3 cardiology, 1 each endocrinology, neurology, pulmonology, gastroenterology)
Programs	RPM + CCM on the Primary Care / Internal Medicine row; TCM as its own layer; PCM named for the heart-failure cohort, no revenue
Program-eligible pools	RPM 2,178 (65%) · CCM 2,512 (75%)
Enrollment ceilings	RPM 762 (M7) · CCM 754 (M8)
Acceptance	RPM 35% · CCM 30% of the eligible pool

³⁷ CoachCare Value Analysis clinical-outcomes and operations modules, 24 months: 105.5 avoided hospitalizations valued at \$15,000 each; 60,445 claims; 166,222 device readings; 26,958 care-team hours (about 13.0 FTE-years) on the recurring programs and 4,563 on the transitional care layer.

³⁸ CoachCare Value Analysis recalculations at the same pricing: no on-site enrollment specialist \$3,089,856 / \$1,307,294 / 42.31%; second specialist \$3,367,990 / \$1,429,932 / 42.46%; in scope 2,700 \$2,704,384 / \$1,145,772 / 42.37%; in scope 4,500 \$4,180,777 / \$1,774,334 / 42.44%; 24 clinicians \$3,145,331 / \$1,332,997 / 42.38%; 44 clinicians \$3,347,074 / \$1,420,271 / 42.43%. Transitional care capture 25% / 75%: \$523,020 / \$1,569,060 net reimbursement, \$401,183 / \$1,203,548 net.

Input	Value
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month, placed at the hospital; telephonic outreach on; 1.5% monthly attrition
Transitional care layer	398 Medicare discharges a month; 50% captured; 30% billed as 99496, 70% as 99495; five-month ramp; 60 care-team minutes per episode; per-episode fee, no platform fee
Rate basis	CY2026 non-facility Physician Fee Schedule, Georgia locality 01 (Atlanta), Palmetto GBA Jurisdiction J, ZIP 30012
Medicare Advantage	65.2% of Rockdale County's Medicare (July 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	Epic; catalog integration at \$4,000 setup, \$150 a month, \$1.50 per patient

8. Implementation Roadmap

CoachCare delivers	Piedmont Rockdale and the Conyers practices keep
Bedside and telephonic enrollment; the on-site enrollment specialist at the hospital is CoachCare's expense	The discharge list from case management; the referral flag in Epic; clinical oversight under general supervision
The two-business-day contact, the three-touch cadence, medication reconciliation support and visit scheduling for every transitional care episode	The 7- or 14-day visit with the Piedmont internist, family physician or cardiologist; the transitional care claim
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences per practice
Monitoring, documentation and the escalation protocol of Section 6	Responses to practice-routed escalations
Billing-ready claim generation inside Epic for the monthly codes and the episode	Filing the claims; billing review; the revenue
Monthly operating reports against the dashboard below	Program governance

Days 0–30: foundation. Program agreement and the Epic integration workplan: the discharge-event trigger, the transitional care order set and the enrollment flag. Discharge disposition and payer mix by month from case management, and the confirmed clinician roster and chart counts by clinic, the inputs that move the model most. Reconciliation of the Conyers patients already enrolled in the system program. ICD-10 screening of the discharge cohort per the qualification map, device logistics staged, escalation routing localized per practice, and clinician orientation to the general-supervision workflow. The Medicare Advantage contract check with the dominant Atlanta plans starts in week one.

Days 31–60: enrollment live. The enrollment specialist working the discharge list; first transitional care episodes completed; first devices in homes; first billable service months. Month 1 nets –\$2,493 on the recurring line as implementation lands and \$10,497 on transitional care; month 2 turns the recurring line positive. The forecast carries 91 new enrollments in month 1, 151 in month 2, and 60 and 100 transitional care episodes.

Days 61–90: scale and file. 211 new enrollments in month 3 and 140 transitional care episodes, tracking toward transitional care steady state in month 5, the RPM ceiling in month 7 and the CCM ceiling in month 8. First monthly operating report against the dashboard. A plan with Piedmont Heart for the heart-failure discharges ahead of the CY2027 model start.

The operating dashboard from month one:

- Discharges captured: inpatient, observation and emergency-department discharges that entered the three-touch cadence, against the hospital's own discharge count
- Transitional care episodes completed against 199 a month at steady state; the two-business-day contact rate; the share of visits inside 7 and 14 days
- Enrollment census by program against ceiling (762 / 754)
- Time from discharge to first billable enrollment (target: under five days from flag to first service)
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, practice-routed, documented; 30-day returns to the emergency department among enrolled patients
- Claims generated against expected claims, and claims filed
- Net to the hospital per month against the \$68,418 recurring steady-state line and the transitional care line

9. Recommendations

1. **Make the discharge the front door.** Place the enrollment specialist at the hospital, wire the discharge-event trigger in Epic first, enroll at the bedside, and bill transitional care on every discharge home to a Piedmont Conyers practice. The layer nets \$802,365 over 24 months and pays from month 1.
2. **Stand up the recurring programs on the discharge cohort now.** The ramp is the ramp wherever it starts; each month of delay pushes the full \$1,385,599 of 24-month recurring net one month further out, and every discharge from here forward is an FY2028 or FY2029 readmission number.
3. **Co-exist with the system program by rule, not by exception.** Settle in the first 30 days which Conyers patients it already holds and whether transitional care sits inside its scope; route those patients' hand-offs into it, and run the discharge lane and the post-discharge enrollment for everyone else.
4. **Take the Medicare Advantage question to the plans early.** With 65.2% 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 transitional care, remote monitoring and chronic care management terms with the dominant Atlanta plans in the first two weeks of discovery.
5. **Put transitional care and principal care management on every heart-failure discharge at Piedmont Heart before CY2027.** Those are the codes that open Ambulatory Specialty Model episodes and count toward attribution; monitoring moves the cost measure underneath them. The preliminary list becomes final before the model starts.
6. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner, and is worth \$177,161 of 24-month net reimbursement against the no-specialist case in Section 7.5.
7. **Set the coordination rule at enrollment.** Each patient carries one care-management wrapper, chronic or principal, never both in a month, plus remote monitoring where indicated and a transitional care episode after a discharge, with one practice billing the episode. One rule, set once in the enrollment workflow, prevents every collision the code families allow and every double enrollment with the system program.

10. What We Would Confirm Together

Every item below is a discovery question, not a condition. The forecast stands on the figures in Section 7; these are the inputs that would move it, in the order they matter.

1. **Discharge disposition and payer mix by month, and the discharge-list workflow.** Home versus facility, fee-for-service versus Medicare Advantage, by month, from case management; this settles the 398 discharges a month and the 50% capture, and it settles where the enrollment specialist sits.
2. **The system program's footprint in Conyers.** Which Conyers patients are already enrolled in the system chronic care management and remote monitoring program, and whether transitional care is inside its scope.
3. **Chart counts by clinic and the confirmed clinician roster.** The Medicare chart count at Wellbrook, Sigman Road and Piedmont Heart, and the adult-medicine clinicians who will refer; this settles the 34 and the 10,470.
4. **Medicare Advantage contract terms for transitional care, remote monitoring and chronic care management.** Contract by contract with the dominant Atlanta plans, for 65% of the county.
5. **Piedmont Heart's plan for the heart-failure episodes at Rockdale.** The final CY2027 participant list is expected before the model starts; which cardiologists will follow Rockdale discharges, and how transitional care and principal care management are assigned.
6. **The Epic build.** The discharge-event trigger, the transitional care order set and the enrollment flag, and the interfaces the integration catalog covers.

Appendix A. Rates: CY2026 Physician Fee Schedule, Georgia Locality 01

The Value Analysis prices every code at the CY2026 non-facility Physician Fee Schedule for Georgia locality 01, Atlanta, in Palmetto GBA's Jurisdiction J; ZIP 30012 maps to that locality. The proposed CY2027 column is CMS-1848-P at the same locality.³⁹

Code	What it pays for	Cadence	CY2026, GA locality 01	Proposed CY2027
99495	Transitional care management, moderate complexity, visit within 14 days	Per discharge	\$223.60	\$218.79
99496	Transitional care management, high complexity, visit within 7 days	Per discharge	\$303.22	\$297.86
99453	RPM setup and patient education	One-time	\$22.18	\$20.41
99454	Device supply, 16–30 days of readings	Monthly	\$53.00	\$42.10
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	\$53.00	\$42.10
99457	RPM management, first 20 minutes	Monthly	\$52.58	\$50.43
99470	RPM management, 10–19 minutes (new 2026)	Monthly	\$26.46	\$21.01
99458	RPM management, each additional 20 minutes	Monthly	\$42.06	\$41.08
99490	CCM, first 20 minutes of clinical staff time	Monthly	\$67.19	\$65.00
99439	CCM, each additional 20 minutes	Monthly	\$51.25	\$50.72
99426	PCM, first 30 minutes of clinical staff time (named, no revenue)	Monthly	\$68.89	\$68.00

³⁹ CY2026 Physician Fee Schedule non-facility amounts (CMS RVU26A), Georgia locality 01 (Atlanta), Palmetto GBA Jurisdiction J; ZIP 30012 maps to carrier 10212 locality 01 in the April 2026 ZIP-to-locality crosswalk; GPCIs work 1.003, practice expense 1.016, malpractice 1.201; conversion factor \$33.4009. 99495 \$223.60; 99496 \$303.22.

Code	What it pays for	Cadence	CY2026, GA locality 01	Proposed CY2027
99427	PCM, each additional 30 minutes (named, no revenue)	Monthly	\$54.98	\$55.39

CY2026 non-facility amounts, CMS RVU26A, Georgia locality 01 (Atlanta); proposed CY2027 amounts from CMS-1848-P Addendum B at the same locality.

Appendix B. Sources and Data Vintages

- **CMS Care Compare, Hospital General Information (xubh-q36u), retrieved September 22, 2026:** Piedmont Rockdale Hospital, CCN 110091, Conyers, Georgia, acute care hospital.
- **Piedmont Healthcare, hospital location and news pages, retrieved September 2026:** 161 licensed beds; Primary Stroke Center; certified Chest Pain Center; Level III NICU; interventional cardiology; part of Piedmont Healthcare since October 2, 2017; U.S. News & World Report 2025–26 High Performing in five conditions; the 2022 intermediate-care and medical-surgical expansion.
- **Emergency Nurses Association Lantern Award, 2023, award writeup:** 34-bed emergency department; about 50,000 visits a year; more than 1,000 employees.
- **IRS Form 990, Piedmont Rockdale Hospital Inc., fiscal year ending June 2025:** revenue \$293.3 million, expenses \$263.1 million, net \$30.2 million.
- **CMS Medicare Inpatient Hospitals by Provider and by Provider and Service, CY2024, retrieved September 22, 2026:** 1,662 fee-for-service discharges; 1,164 beneficiaries; HCC risk score 2.32; average age 73.7; discharges by MS-DRG where 11 or more.
- **CMS Care Compare, Unplanned Hospital Visits (632h-zaca) and Complications and Deaths (ynj2-r877), retrieved September 22, 2026:** 30-day readmission, July 2023–June 2025; excess days in acute care, July 2022–June 2025.
- **CMS FY2026 Hospital Readmissions Reduction Program, Supplemental Data File and Payment Adjustment Factors, September 2025:** performance period July 2021–June 2024; excess readmission ratios, peer medians, penalty flags and the payment adjustment factor for CCN 110091.
- **CMS Care Compare, Timely and Effective Care (yv7e-xc69), October 2024–September 2025:** OP-18b, OP-18a, OP-22 and the emergency department volume category.
- **CMS FY2026 Hospital Value-Based Purchasing, total performance score file (ypbt-wvdk):** total performance score and unweighted domain scores for CCN 110091.
- **CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, rendering city Conyers, Georgia, retrieved September 22, 2026; CMS Doctors & Clinicians national file (mj5m-pzi6) and facility-affiliation file (27ea-46a8):** the code-by-code sweep of the 70 Piedmont-employed Conyers clinicians; the 41 who bill established office visits; the 5,203 beneficiaries on 99213 and 99214; the 34-clinician adult-medicine roster. CMS suppresses any provider-and-code line under 11 beneficiaries; the file predates the system program launched in August 2025.
- **CMS Medicare Advantage State/County Penetration, July 2026, and CMS Medicare Monthly Enrollment, May 2026:** Rockdale County 65.2%; neighboring counties; beneficiary, Original Medicare and dual-eligible counts.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates (DP05, DP03), Rockdale County:** population, age, income, poverty and insurance coverage.
- **Center for Connected Health Policy, Georgia Medicaid policy summary, updated May 27, 2026:** remote patient monitoring not reimbursed under Georgia Medicaid fee-for-service.

- **CMS Medicare Shared Savings Program, PY2026 ACO participants file:** Piedmont Clinic ACO LLC, A3250, BASIC Level B, agreement period 3, 120 participant TINs.
- **CMS Innovation Center, Ambulatory Specialty Model: mandatory geographic areas file; participants dataset, preliminary CY2027 list (vintage January 2, 2026); 42 CFR Part 512 Subpart E; the proposed operational list of care episode and patient condition codes for the heart-failure cost measure (June 2026); CMS-1848-P (July 2026):** Metropolitan Division 12054 selected; 16 physicians billing under Piedmont Cardiology of Atlanta, LLC in the Heart Failure cohort; payment adjustment schedule; the 30% attribution threshold; the trigger-code list; the collaborative care arrangement and its proposed broadening.
- **U.S. Census Bureau OMB delineation file, 2023:** Rockdale County as a central county of the Atlanta metropolitan statistical area, Metropolitan Division 12054.
- **CY2026 Physician Fee Schedule rate files (CMS RVU26A) and the April 2026 ZIP-to-locality crosswalk:** non-facility amounts for every code in this report at Georgia locality 01 (Atlanta), work GPCI 1.003, practice expense 1.016, malpractice 1.201, conversion factor \$33.4009.
- **CY2026 Physician Fee Schedule final rule:** CPT 99445 and 99470 added to the remote physiologic monitoring family.
- **CMS-1848-P, proposed CY2027 Physician Fee Schedule, July 2026, Addendum B:** proposed amounts repriced at Georgia locality 01 on this forecast's billing mix; comment period closed September 14, 2026.
- **CPT 99495 and 99496 requirements and CMS transitional care management guidance:** interactive contact within two business days; medication reconciliation; face-to-face visit within 14 or 7 days; one claim per 30-day period; concurrent billing with chronic and principal care management permitted since CY2020.
- **Piedmont Healthcare, Epic at Piedmont page, retrieved September 2026; CoachCare Epic integration overview:** one Piedmont record across hospital and office; the five integration pillars; under-five-day time to first service; automated claims creation; catalog integration pricing.
- **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 Sections 2 and 6.
- **CoachCare company statistics, 2026:** patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.
- **CoachCare Value Analysis for Piedmont Rockdale Hospital, 2026, including the transitional care layer and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 2, 3, 4, 7, 8 and 9, built on 3,350 Medicare patients in scope, an established panel of about 10,470, 34 referring clinicians, one on-site enrollment specialist, 398 Medicare discharges a month at 50% capture, and CY2026 non-facility fee schedule rates at Georgia locality 01 for RPM, CCM and TCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the recurring programs hold 1,516 active program enrollments belonging to 988 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. Transitional care episodes are counted separately and sit outside the census.

Two margins, and which is which. The recurring programs run at 42.41% over 24 months; that is the priced figure for remote monitoring and chronic care management. The combined figure, 50.73%, adds

the transitional care layer at a per-episode fee with no platform fee. Both appear wherever a margin is shown.

No individual is named anywhere in this report. Leadership, clinicians and model participants are described by count, role and billing entity only.