COACHCARE | SERVICE LINE STRATEGY

Maury Regional Health

1224 Trotwood Avenue, Columbia, Tennessee — a county-owned health system with three hospitals, more than twenty employed medical group practices across five counties, ten federally qualified health center sites, seven rural health clinics, and its own Medicare Shared Savings ACO

Remote Care Service Line Performance & Optimization

2026 Strategy Report

Transitional care at the discharge, remote physiologic monitoring through the weeks that follow, and chronic care management for the months between visits — one service line, billed by Maury Regional, that also carries the two payment programs the organization is already scored on.

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the leadership of Maury Regional Health. It assembles the organization's own CY2024 Medicare service record, its verified position in two CMS programs, its published readmission and safety results, the CY2026 payment environment at the Tennessee locality, and a financial forecast into one argument: Maury Regional already does the discharge, and the thirty days after it are neither staffed nor billed.

Figures are drawn from CMS published files current to August 2026 and from Maury Regional's own published statements. The numbered footnotes give the specific file, query and vintage for each. A companion Disclosures and Assumptions document records the modeling assumptions and source vintages behind the forecast.

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Executive Summary

Maury Regional Health is a county-owned health system created by a Private Act of the Tennessee legislature in 1953 and run as an enterprise fund of Maury County, governed by nine trustees appointed by the County Commission. It closed FY2025 with $541.5 million of operating revenue and $30.5 million of operating income.[1] It operates a 255-bed acute care hospital in Columbia, a critical access hospital in Lewisburg and a rural emergency hospital in Waynesboro,[2] alongside ten federally qualified health center sites, seven rural health clinics, a Medicare-certified home health agency and a skilled nursing facility.[3] The employed medical group is 145 distinct clinicians, of whom 101 are internal medicine, family practice, nurse practitioners or physician assistants.[4]

The Medicare panel those clinicians carry is substantially sicker than the national average: a beneficiary-weighted HCC risk score of 1.600 against a national reference of 1.00, an average beneficiary age of 75.1, hypertension and hyperlipidemia at or above 75%, chronic kidney disease at 39.5%, heart failure at 31.8% and COPD at 26.3%.[5] Against that panel, the CY2024 claims record contains one line that frames this entire document: **3,914 hospital discharge-day-management services across 3,784 beneficiaries and 27 clinicians, and zero transitional care management claims.**[6]

The central argument

Maury Regional does the discharge. It does not bill the thirty days after it. Across all 145 employed clinician NPIs in CY2024 there is no remote-care or care-management program at meaningful scale — no remote monitoring, no chronic care management, no transitional care.

Two payment programs already price those thirty days. Maury Regional Hospital is a mandatory participant in the Transforming Episode Accountability Model, live since 1 January 2026. And the system owns its own Medicare Shared Savings ACO, now in its second performance year, with prospective assignment.

The safety record is strong and the readmission record is not. PSI-90 sits at 0.92 with every component measure no different than national, Leapfrog awarded an “A” in spring 2026, and CareChex ranked the hospital first in Tennessee for patient safety in cardiac care. Against that, five of the five reported HRRP excess readmission ratios exceed 1.0 and heart-failure excess days in acute care run 8.8 above average per 100 discharges. The gap is not what happens inside the hospital. It is the thirty days after it.

On fee-for-service economics alone, before any episode reconciliation or shared-savings settlement is counted, the service line returns $9.65 million of net reimbursement over 24 months, and Maury Regional keeps $4.08 million of it at a 42.24% margin. In full precision that is $9,650,455 of net reimbursement and $4,076,790 retained.

[1] Maury County, Tennessee, Annual Financial Report FY2025, Exhibit D-2 (hospital enterprise fund): total operating revenue $541,533,360; total operating expenses $511,039,412; operating income $30,493,948. Governance and the 1953 Private Act (Chapter 373, Private Acts of Tennessee) from the same report and from the Maury Regional Hospital Annual Financial Report transmittal letter, Tennessee Comptroller of the Treasury.

[2] CMS Hospital General Information, provider-data dataset xubh-q36u, retrieved 7 August 2026: CCN 440073 Maury Regional Hospital, Acute Care Hospital, Government – Local; CCN 441309 Marshall Medical Center, Critical Access Hospital; CCN 440780 Wayne Medical Center, Rural Emergency Hospital. Bed counts from Maury Regional Health, About Us.

[3] NPPES National Plan and Provider Enumeration System, organizational NPIs enumerated to MAURY REGIONAL HOSPITAL and MAURY REGIONAL HOSPITAL MARSHALL MEDICAL CENTER, retrieved 7 August 2026: 10 NPIs typed Clinic/Center – Federally Qualified Health Center, 7 typed Clinic/Center – Rural Health, plus Home Health (1528057791) and Skilled Nursing Facility (1700973039).

[4] CMS Doctors and Clinicians National Downloadable File, provider-data dataset mj5m-pzi6, rolled up on org_pac_id 7911810742 (Maury Regional Medical Group, Inc) and 4688569718 (Maury Regional Hospital), retrieved 7 August 2026. 145 distinct clinician NPIs after de-duplicating the 6 clinicians enumerated under both organizations; 101 are internal medicine, family practice, nurse practitioner or physician assistant.

[5] CMS Medicare Physician & Other Practitioners — by Provider, CY2024, dataset 8889d81e-2ee7-448f-8713-f071038289b5, released 21 May 2026, queried across the 145 employed clinician NPIs; 115 returned CY2024 activity. Values are beneficiary-weighted. CMS publishes chronic-condition prevalence with a 75.0% top-code.

[6] CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024, dataset 92396110-2aed-4d63-a6a2-5d6207d46a29, released 21 May 2026, queried across all 145 employed clinician NPIs: 772 provider-by-HCPCS lines, 202 distinct HCPCS codes, $7,080,435 in Medicare allowed charges, 110 of 145 clinicians present. CMS suppresses any provider-and-code line under 11 beneficiaries.

The exposures are verified, not inferred. CCN 440073 appears on the CMS participant list for the Transforming Episode Accountability Model in CBSA 34980, Nashville-Davidson–Murfreesboro–Franklin, for the performance period 1 January 2026 through 31 December 2030. Nineteen hospitals from that CBSA are listed and every one is flagged mandatory, so this is a mandatory market rather than a single election.[7] Separately, Mid-Tennessee Community ACO, LLC — ACO ID A5543, registered at Maury Regional Medical Center's own address — began its first agreement period on 1 January 2025 on BASIC Track Level B, high revenue, prospective assignment. Its four participants are three Maury Regional entities and one independent physician.[8]

The readmission evidence points at the same window. All five reported excess readmission ratios exceed 1.0 — hip and knee replacement at 1.1263, COPD at 1.0895, heart attack at 1.0784, heart failure at 1.0140 and pneumonia at 1.0103.[9] Excess days in acute care after a heart-failure discharge run 8.8 days per 100 discharges above the national average, a measure that counts readmissions, emergency returns and observation stays together.[10] Hospital safety, meanwhile, holds: the PSI-90 composite is 0.92 and every component measure reads no different than national,[11] corroborated by a Leapfrog “A” Hospital Safety Grade in spring 2026 and a CareChex first-in-Tennessee ranking for patient safety in cardiac care.[12]

None of this starts from zero. Maury Regional put the Abbott CardioMEMS heart-failure system into service in May 2025: an implanted pressure sensor, daily transmissions from the patient's home, remote review by the care team.[13] The model is proven here on the most advanced heart-failure patients. The question is the rest of the panel, where no implant is required.

The forecast in one view

	Year 1	Year 2	24 months
Net reimbursement to Maury Regional	$3,503,737	$6,146,718	$9,650,455
CoachCare fees	$2,054,823	$3,518,842	$5,573,665
Retained by Maury Regional	$1,448,914	$2,627,876	$4,076,790
Retained margin	41.35%	42.75%	42.24%
Hospitalizations avoided	133	213	346
Unique patients in active remote care	3,452 at month 12	held	3,452 at month 24
Active program enrollments	—	—	5,294 at month 24
Care-team hours delivered by CoachCare	—	—	86,405 (41.5 FTE-equivalent)

[7] CMS Transforming Episode Accountability Model participant list, cms.gov/team-model-participant-list, rendition as of 15 April 2026, retrieved 7 August 2026: 720 participant rows, 710 mandatory, 189 distinct CBSAs. Row for CCN 440073 MAURY REGIONAL HOSPITAL, CBSA 34980 Nashville-Davidson–Murfreesboro–Franklin TN, Mandatory, 01/01/2026 to 12/31/2030. 19 rows carry CBSA 34980 and all are flagged Mandatory.

[8] CMS Medicare Shared Savings Program PY2026 participant file, dataset 9767cb68-8ea9-4f0b-8179-9431abc89f11, retrieved 7 August 2026: ACO A5543 MID-TENNESSEE COMMUNITY ACO LLC, BASIC Track Level B, High Revenue, Prospective Assignment, agreement period 1, initial start date 01/01/2025, registered at 1224 Trotwood Avenue, Columbia TN 38401. Four participants.

[9] CMS Hospital Readmissions Reduction Program, provider-data dataset 9n3s-kdb3, CCN 440073, measurement period 07/01/2021 to 06/30/2024. The sixth measure in the program is reported as Not Available, footnote 5, for low volume.

[10] CMS Care Compare Unplanned Hospital Visits, provider-data dataset 632h-zaca, CCN 440073: 30-day readmission rates and denominators, and EDAC_30_HF at +8.8 excess days per 100 discharges, flagged More Days Than Average against a denominator of 600.

[11] CMS Complications and Deaths, provider-data dataset ynj2-r877, CCN 440073, measurement period 07/01/2021 to 06/30/2024: PSI_90 composite 0.92, No Different Than the National Value, with each individual PSI component measure returning No Different Than the National Rate.

[12] Maury Regional Health published awards and accreditations: The Joint Commission Gold Seal of Approval for Heart Failure Certification; American College of Cardiology Chest Pain Center Accreditation with Primary PCI, May 2026, accredited chest pain center since 2008; Leapfrog Group Hospital Safety Grade "A", spring 2026; CareChex #1 in Tennessee for patient safety in cardiac care, 2026.

[13] Maury Regional Health news release, June 2025, "Maury Regional Health introduces heart failure monitoring technology" — Abbott CardioMEMS HF System, in use since May 2025.

1. The Organization and the Panel

1.1 Structure: a county system, an employed group, and their own ACO

Maury Regional Hospital, trading as Maury Regional Health, is a government hospital. It was created in 1953 by Chapter 373 of the Private Acts of Tennessee and is carried as a proprietary enterprise fund of Maury County. Nine trustees are appointed by the Maury County Commission to three-year terms. Maury Regional Medical Group and the Maury Regional Health Care Foundation are the system's 501(c)(3) entities.[14] Three consequences follow for a service-line decision. Contracting runs through a publicly appointed board rather than a system parent or an outside capital committee. Budget authority sits with the chief financial officer and the trustees. And a program that pays for itself in-year, without new headcount, is a materially easier proposal than one that asks for capital first and returns later.

The system also owns its accountable care organization. Mid-Tennessee Community ACO, LLC is registered at Maury Regional Medical Center's own address, its participant list is three Maury Regional tax identification numbers plus one independent physician, and its published participant types are federally qualified health center, rural health clinic, independent practice and hospital-employed providers. The ACO has affirmatively elected the Shared Savings Program telehealth payment waiver under 42 CFR §425.612(f) and §425.613.[15] That election matters operationally: the originating-site and geographic restrictions that otherwise limit remote clinical contact do not bind the ACO's assigned population.

1.2 The clinical footprint and the market around it

Facility or site type	Location	CMS designation	Scale
Maury Regional Medical Center	Columbia (Maury County)	Acute care hospital, CCN 440073	255 beds
Marshall Medical Center	Lewisburg (Marshall County)	Critical access hospital, CCN 441309	25 inpatient beds
Wayne Medical Center	Waynesboro (Wayne County)	Rural emergency hospital, CCN 440780	24-hour emergency, observation and outpatient
Federally qualified health center sites	Columbia ×4, Collinwood, Mt Pleasant, Waynesboro, Hohenwald, Spring Hill, Ethridge, Lewisburg	FQHC clinic NPIs	10 sites
Rural health clinics	Columbia, Mt Pleasant, Spring Hill	RHC clinic NPIs	7 sites
Post-acute assets	System-owned	Home health agency and skilled nursing facility	Both enumerated under the hospital

Facility type is not a detail here. It decides which CMS programs reach which building. The critical access hospital and the rural emergency hospital are both non-IPPS, which places them categorically outside the episode model; the acute care hospital in Columbia carries that exposure alone.[16] The health center and rural clinic sites matter for a different reason: they bill institutionally rather than on the Part B carrier file, so a large part of the system's outpatient primary care is invisible in physician-level Medicare data and prices care management on a different rail.[17]

[14] See note 1.
[15] Maury Regional Health, Accountable Care Organization public reporting page, mauryregional.com: participant types and the election of the Shared Savings Program telehealth payment waiver under 42 CFR §425.612(f) and §425.613.
[16] See note 2.
[17] See note 3.

The market is eight counties — Maury, Marshall, Wayne, Lewis, Giles, Hickman, Lawrence and Perry — holding 67,350 Medicare beneficiaries, of whom 32,546 are in Original fee-for-service Medicare and 33,604 are in Medicare Advantage or other plans. Weighted Medicare Advantage penetration across the eight is 49.9%, and five of the eight counties sit above 50%: Hickman at 56.9%, Perry at 53.7%, Marshall at 53.4%, Lewis at 50.8% and Wayne at 50.7%.[18] Fee-for-service lives are the population the fee schedule and the ACO both run on. Medicare Advantage lives are reached through the plan contract instead, which is why the treatment of the care-management code families in those contracts is worth settling early.

1.3 The panel: 60% sicker than national

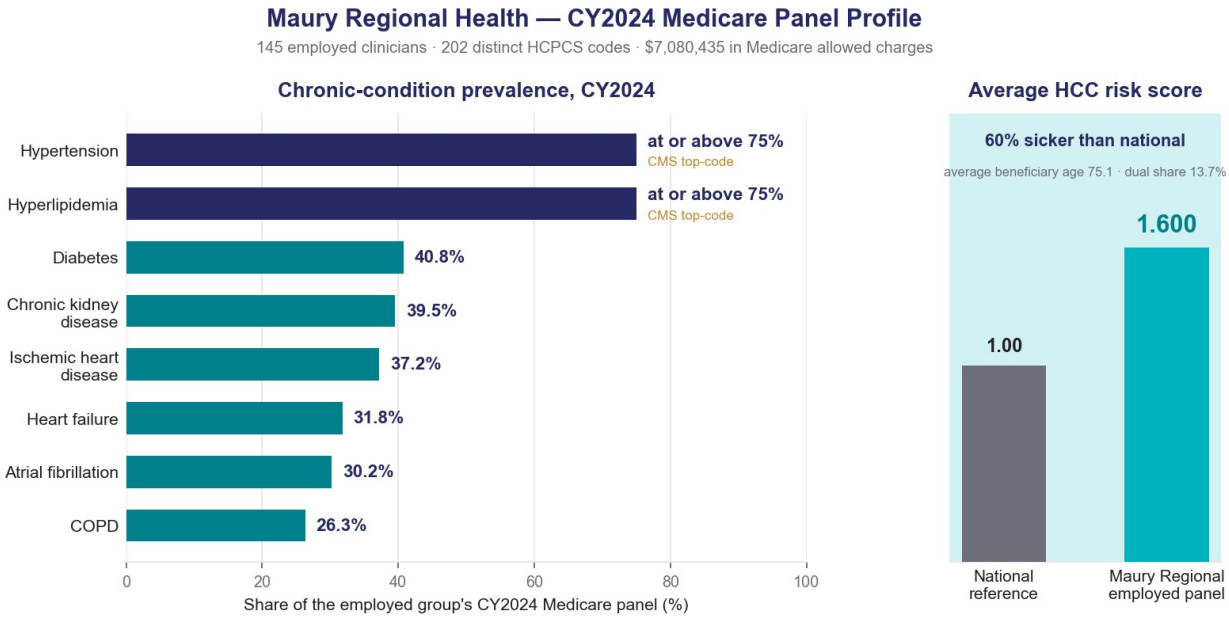

Figure 1 — CY2024 Medicare panel profile for the 145 employed clinician NPIs. CMS publishes chronic-condition prevalence with a 75.0% top-code, so hypertension and hyperlipidemia are shown at or above 75% rather than at a measured value.

The employed group's CY2024 Medicare book is 772 provider-by-code lines across 202 distinct HCPCS codes and $7,080,435 of allowed charges, with 110 of the 145 clinicians appearing in the file. The beneficiary-weighted acuity of that book is the first thing worth reading.[19]

Panel characteristic	CY2024
Average HCC risk score	1.600 against a national reference of 1.00
Average beneficiary age	75.1
Dual-eligible share	13.7%
Hypertension[20]	at or above 75%
Hyperlipidemia	at or above 75%
Diabetes	40.8%

[18] CMS Medicare Monthly Enrollment, dataset d7fabe1e-d19b-4333-9eff-e80e0643f2fd, April 2026 rendition, retrieved 7 August 2026, for Maury, Marshall, Wayne, Lewis, Giles, Hickman, Lawrence and Perry counties: 67,350 total Medicare beneficiaries, 32,546 Original fee-for-service, 33,604 Medicare Advantage and other.

[19] See note 5.

[20] CMS publishes chronic-condition prevalence in the Medicare Physician & Other Practitioners — by Provider file with a 75.0% top-code. Hypertension and hyperlipidemia both sit at that ceiling for this panel and are reported here as at or above 75%, which is the highest value the published file can express.

Panel characteristic	CY2024
Chronic kidney disease	39.5%
Ischemic heart disease	37.2%
Heart failure	31.8%
Atrial fibrillation	30.2%
Depression	29.6%
COPD	26.3%

A risk score of 1.600 means the panel is 60% more costly than the national average beneficiary after risk adjustment. Four conditions above 30% prevalence — chronic kidney disease, ischemic heart disease, heart failure and atrial fibrillation — are all conditions whose deterioration shows up in home physiologic data days before it shows up in a clinic. Hypertension and hyperlipidemia are reported at or above 75% because that is where CMS stops publishing a higher number, not because the panel measures there.

1.4 The discharge that is not followed

Every one of the 145 employed clinician NPIs was queried against the CY2024 Medicare Physician and Other Practitioners file by code family. The result is a clean, single-sentence finding.[21]

Code family	Codes	CY2024 result
Hospital discharge day management	99238 · 99239	3,914 services across 3,784 beneficiaries and 27 clinicians
Transitional care management	99495 · 99496	None at reportable volume
Remote physiologic monitoring	99453 · 99454 · 99457 · 99458	None at reportable volume
Remote monitoring, CY2026 short-window codes	99445 · 99470	Did not exist in CY2024
Chronic care management	99490 · 99439 · 99487 · 99489 · 99491 · 99437	None at reportable volume
Remote therapeutic monitoring	98975–98981	None at reportable volume
Physiologic data collection and interpretation	99091	None at reportable volume
Behavioral health integration and collaborative care	99484 · 99492–99494 · G2214	None at reportable volume

What the null result does and does not say

Read plainly: there was no remote-care or care-management program at meaningful scale across Maury Regional's employed clinicians in CY2024. CMS suppresses any provider-and-code line below eleven beneficiaries, so the honest claim is about scale.

Two boundaries are worth naming because they sharpen rather than soften the finding. The file is Part B carrier claims only, so the ten health center and seven rural clinic sites — which bill institutionally — are outside it entirely. And it covers employed clinicians, so cardiology at Maury Regional, which is staffed by the two Nashville systems, bills elsewhere. The finding is precise: the employed group does the discharges and does not bill the follow-through.

The shape of the employed bench explains how that happened. The 44 clinicians with an internal medicine primary specialty carry 222 established outpatient evaluation-and-management beneficiaries

[21] See note 6.

between them, against 4,779 on subsequent hospital care and 3,039 on discharge day management. That bench is a hospitalist service, and hospitalists do not own a longitudinal panel. Outpatient primary care at Maury Regional runs through nurse practitioners, who carry 3,902 established evaluation-and-management beneficiaries, and through the health center and rural clinic sites.[22] A discharge handled by a hospitalist and a follow-up owned by a nurse practitioner at a different site is exactly the seam a transitional care and remote monitoring program is built to close.

1.5 Not greenfield: what the heart-failure sensor program already proved

Maury Regional introduced the Abbott CardioMEMS heart-failure system in May 2025. A sensor is implanted in the pulmonary artery during an outpatient catheterization procedure; the patient takes a daily reading at home on a transmitting pillow; the care team reviews the data remotely and adjusts therapy before symptoms escalate.[23] The organization runs a monthly heart failure support group alongside it, and holds The Joint Commission Gold Seal of Approval for Heart Failure Certification, which already commits it to a documented heart-failure disease-management program with follow-up and self-care education requirements.

The position of strength

The clinical model is already proven inside this organization. Daily physiologic data from a patient's home, reviewed by a care team, acted on before an admission — that is the CardioMEMS workflow, and Maury Regional has been running it since May 2025.

CardioMEMS is implant-gated, billed under a separate code family, and reaches only advanced heart failure. It does not touch the 244 heart-failure discharges with major complications, the COPD cohort, the renal cohort or the ACO's assigned primary-care panel. The service line described here extends the same logic to the rest of the panel, with a blood pressure cuff, a scale and a pulse oximeter instead of an implant.

[22] See note 6.
[23] See note 13.

2. Two Verified Payment Exposures

2.1 TEAM: mandatory, live, and measured on the thirty days

Maury Regional Hospital appears on the CMS Transforming Episode Accountability Model participant list as a mandatory participant, CCN 440073, CBSA 34980, for the performance period 1 January 2026 through 31 December 2030. The list rendition current as of 15 April 2026 carries 720 hospitals — 710 mandatory and 10 voluntary — across 189 distinct CBSAs.[24] Nineteen of those hospitals are in CBSA 34980 and all nineteen are mandatory, which settles the question of whether this is a market-wide requirement or an individual election.

The model reconciles all Medicare Part A and Part B spending for the thirty days following a qualifying discharge. What determines episode cost is not what happens in the operating room; it is readmissions, emergency department returns and post-acute utilization in the month after the patient leaves. Maury Regional's largest reported exposure in that window is orthopedic: major hip and knee joint replacement at 51 Medicare discharges, hip replacement with a principal diagnosis of hip fracture at 45, and hip and femur procedures other than major joint at 40 in CY2024.[25] Its hip and knee excess readmission ratio is 1.1263, the highest of the five reported measures. The two exposures land on the same patients.

Which facilities are in, and which are out

Maury Regional Medical Center, CCN 440073, is in — mandatory, from 1 January 2026.

Marshall Medical Center, CCN 441309, is a critical access hospital and Wayne Medical Center, CCN 440780, is a rural emergency hospital. Both are non-IPPS and both are categorically outside the model. The accountability sits with Columbia.

2.2 Mid-Tennessee Community ACO: second year, prospective assignment

The Shared Savings Program record for ACO A5543 reads: BASIC Track Level B, high revenue, prospective assignment, first agreement period, initial start date 1 January 2025.[26] Four attributes of that record change how an enrollment program should be built.

ACO attribute	What it means operationally
First agreement period, started 1 January 2025	PY2026 is the second performance year. The care-management infrastructure decision is still in front of this ACO rather than behind it.
Prospective assignment	The assigned beneficiary list is known on 1 January. There is no attribution guesswork, which is the single best operating condition an enrollment campaign can have — the outreach list for the year exists on day one.
BASIC Track Level B	Limited downside and a 40% maximum shared-savings rate. The program should be pitched on quality performance and avoided admissions rather than on catastrophic-risk mitigation.
High revenue	The hospital's Part A spending sits inside the ACO benchmark. A reduction in readmissions lands on the ACO's own shared-savings arithmetic and on the episode model at the same time.

The ACO's own public reporting names its participant types as federally qualified health center, rural health clinic, independent practice and hospital-employed providers, and records its election of the

[24] See note 7.

[25] CMS Medicare Inpatient Hospitals — by Provider and Service, CY2024, dataset 690ddc6c-2767-4618-b277-420ffb2bf27c, CCN 440073: 75 published DRG lines summing to 2,510 Medicare discharges. CMS suppresses any provider-and-DRG cell under 11 discharges, so every count is a floor.

[26] See note 8.

telehealth payment waiver.[27] An ACO that has already elected the waiver has already decided that remote clinical contact is part of how it manages its population. The service line supplies the staffing, the devices and the documented monthly contact that decision implies.

[27] See note 15.

3. The Readmission and Excess-Days Record

3.1 Five of five reported ratios above 1.0

An excess readmission ratio above 1.0 means CMS observed more thirty-day readmissions than it expected after risk adjustment. At CCN 440073, every reported measure is above 1.0. The sixth measure is suppressed for low volume.[28]

Condition	Excess readmission ratio	Readmission rate	Denominator
Hip and knee replacement	1.1263	5.4%	99
COPD	1.0895	20.0%	164
Heart attack	1.0784	14.5%	172
Heart failure	1.0140	20.0%	600
Pneumonia	1.0103	16.2%	576
Hospital-wide readmission	not applicable	15.7%	2,435

3.2 Excess days after a heart-failure discharge

Excess Days in Acute Care is the measure worth dwelling on, because it counts what a readmission rate misses. It adds emergency department visits and observation stays to inpatient readmissions across the thirty days after discharge, so a patient who returns twice to the emergency department and is held overnight is captured rather than filtered out. Maury Regional runs 8.8 excess days per 100 heart-failure discharges above the national average across a denominator of 600, which CMS flags as more days than average. Heart attack at 10.8 and pneumonia at 6.5 both read average.[29]

Why this measure and this cohort

Excess days after a heart-failure discharge is the single cleanest quality signal in Maury Regional's published file, and it is precisely the event set a post-discharge program prevents: a weight gain caught on day four, a diuretic adjusted on day five, an emergency department visit that never happens on day nine.

Heart failure is also the second-largest Medicare DRG in the hospital at 244 discharges with major complications, the third-highest chronic condition on the employed panel at 31.8%, and the condition the organization already holds a Joint Commission certification for. Every arrow points at the same cohort.

3.3 The contrast that defines the opportunity

Hospital safety at Maury Regional is genuinely strong. The PSI-90 patient safety composite is 0.92, and every individual component measure returns no different than the national rate.[30] Leapfrog awarded the hospital an “A” Hospital Safety Grade in spring 2026, CareChex ranked it first in Tennessee for patient safety in cardiac care in 2026, and the cardiology program holds ACC Chest Pain Center Accreditation with Primary PCI, awarded in May 2026.[31]

Set that against five of five reported excess readmission ratios above 1.0 and heart-failure excess days above average, and the diagnosis writes itself. Care inside the building measures at or above national. Care in the thirty days after the patient leaves is not staffed, not documented and not billed. That is a coverage-of-time problem, and it has a code set.

[28] See note 9.
[29] See note 10.
[30] See note 11.
[31] See note 12.

4. The Remote Care Service Line — The Operating Spine

4.1 What it is: transitional care, remote monitoring, chronic care management

The service line is one clinical spine that starts at a discharge and continues into longitudinal management. Transitional care management is the on-ramp. Remote physiologic monitoring supplies the objective signal through the weeks that follow. Chronic care management supplies the documented monthly contact once the patient is stable. For a post-discharge patient the three run in sequence; for a stable chronic patient, monitoring and care management run together.

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

How the layers coordinate

Transitional care management covers the thirty days that begin at discharge. Chronic care management picks the patient up from the month after that and continues indefinitely. Remote monitoring runs through both, because it is billed alongside care management rather than instead of it, provided the clinical time counted toward each is distinct.

The forecast in Section 7 is built on remote monitoring and chronic care management. Transitional care is described here because it is the clinical entry point and the reason the discharge volume matters — and every transitional care claim it generates sits outside the forecast.

4.2 Where it deploys

Bundle the same engine once and point it at four populations. This is a health system, and the case for building once rather than four times is the enterprise argument.

Population	Scale	Why this cohort
Post-discharge chronic cohorts	843 Medicare discharges in CY2024 — 409 cardiovascular, 209 respiratory, 225 renal, out of 2,510 published in total	Thirty-four percent of the hospital's published Medicare discharge volume sits in three condition groups whose readmissions the episode model and the ACO both price. Heart failure with major complications alone is 244 discharges.
The employed primary-care network	101 primary-care-capable clinicians of 145 employed; 111 referring clinicians in the model	Where chronic care management actually lives. The outpatient panel runs through nurse practitioners and the clinic sites, both of which carry longitudinal relationships the hospitalist bench does not.
Health center and rural clinic sites	10 federally qualified health center sites and 7 rural health clinics	These sites price the unbundled care-management codes on the national non-facility fee schedule rather than the Tennessee locality, and CoachCare's per-patient fee does not move with the rate — so the difference falls to Maury Regional.

Population	Scale	Why this cohort
The ACO's assigned population	Prospectively assigned each 1 January	A known list on day one. Enrollment outreach can be built as a campaign against a fixed roster rather than a rolling attribution estimate.

One structural fact shapes the specialty side of this. Maury Regional employs no cardiologists and no nephrologists; the twenty-one cardiologists practising in Columbia reassign their Medicare billing to the two Nashville systems that staff the heart program here.[32] The hospital owns the two catheterization labs, primary PCI, the chest pain accreditation and the heart failure certification. The right design follows from that: a hospital-owned, hospital-billed post-discharge program. Episode performance and shared savings accrue to Maury Regional either way, and the program works alongside the cardiology partners rather than requiring anything from them.[33]

4.3 Connective tissue: one infrastructure, every lever

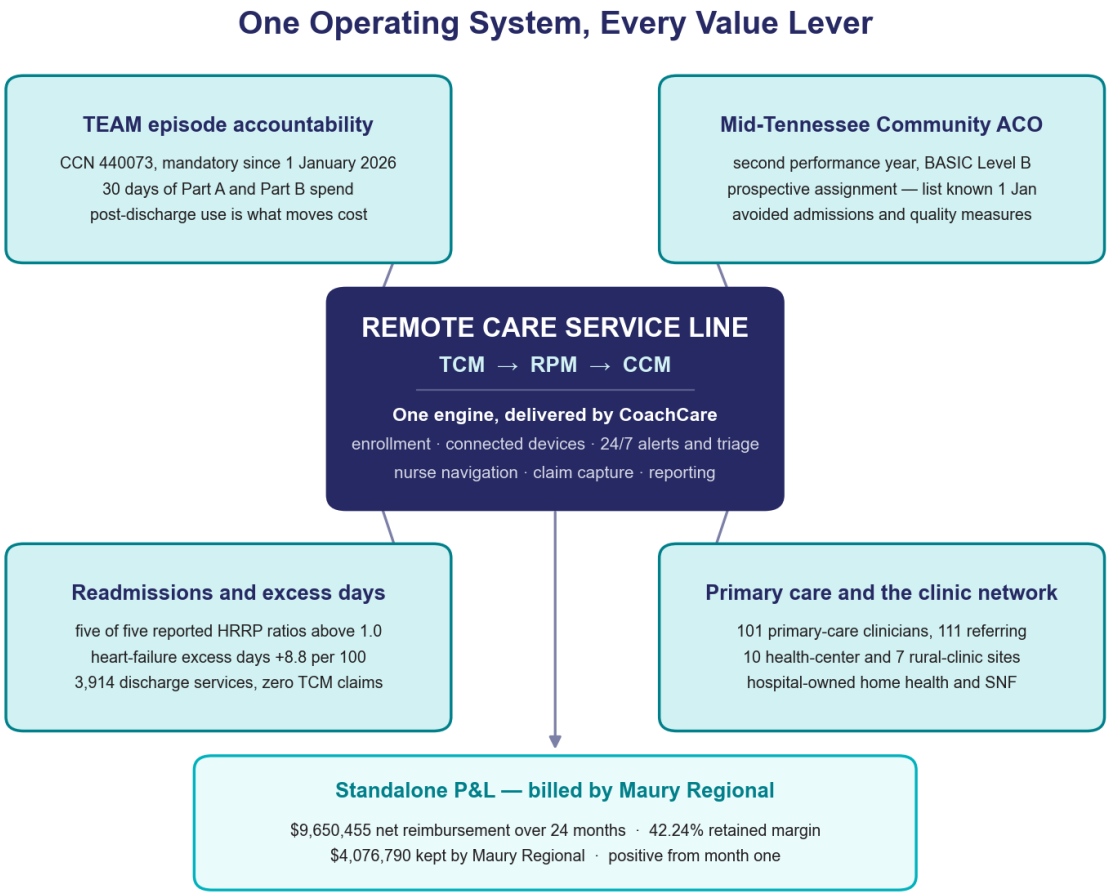

Figure 2 — The same enrolled patient, the same daily reading and the same documented escalation serve the fee-for-service P&L, the episode model, the ACO and the readmission measures at once.

[32] CMS Doctors and Clinicians National Downloadable File, provider-data dataset mj5m-pzi6, filtered to practice ZIP 38401: 21 clinicians with a cardiology primary specialty, none of whom reassign to Maury Regional Medical Group or Maury Regional Hospital. Corroborated by Maury Regional Health's own cardiology service page.

[33] See notes 7 and 8 for the model and ACO participant records; see note 25 for the CY2024 discharge counts in the table above.

Accountability	What it measures	What the service line contributes
Fee-for-service	Nothing — it pays per service	$9,650,455 of net reimbursement over 24 months at a 42.24% retained margin. This layer stands alone and does not depend on any of the others.
TEAM	All Part A and Part B spending for thirty days after a qualifying discharge	The post-discharge cadence is the only intervention operating inside the reconciliation window. Readmissions, emergency returns and post-acute use are what move episode cost.
Mid-Tennessee Community ACO	Total cost of care for a prospectively assigned population, plus the quality score that gates the savings rate	346 avoided hospitalizations over 24 months in the forecast, and documented monthly contact against the quality measures that determine the shared-savings rate.
Readmission and excess-days measures	Thirty-day readmissions, emergency visits and observation stays	Five reported ratios above 1.0 and heart-failure excess days above average, all measured in the window the program covers.

The forecast in Section 7 is fee-for-service. It does not model episode reconciliation, and it does not model shared-savings settlement. For a high-revenue ACO the avoided-admission line is the number to carry into the benchmark conversation, because care-management billing adds Part B spending inside total cost of care while the admissions it prevents subtract from it. The two arguments are separate and both are real, and they belong in different conversations.

5. The CY2026 Billing Stack at the Tennessee Locality

Every rate below is the CY2026 Medicare Physician Fee Schedule non-facility amount for MAC locality 10312-35, Palmetto GBA, Tennessee statewide, resolved from the hospital's ZIP code.[34]

Code	Service	CY2026 rate	Cadence
99453	Remote monitoring setup and patient education	$19.49	Once per episode
99454	Device supply, 16 or more days of readings	$47.24	Monthly
99445	Device supply, 2–15 days of readings (new for 2026)	$47.24	Monthly
99457	Treatment management, first 20 minutes	$48.42	Monthly
99458	Treatment management, each additional 20 minutes	$39.01	Monthly
99470	Treatment management, 10–19 minutes (new for 2026)	$24.38	Monthly
99490	Chronic care management, first 20 minutes	$62.29	Monthly
99439	Chronic care management, each additional 20 minutes	$47.35	Monthly

Two of these codes are new for CY2026 and they change the arithmetic of a post-discharge program. Until this year, a patient who transmitted readings for fewer than sixteen days in a month produced no device-supply payment at all, and clinical time under twenty minutes produced no management payment. 99445 pays device supply from two days of readings, and 99470 pays treatment management from ten minutes. Post-discharge patients are exactly the population that used to fall through both gaps — enrolled mid-month, monitored intensively for three weeks, then stepped down.

Blended across the modeled enrollment mix, remote monitoring produces $90.34 of net reimbursement per active patient-month and chronic care management produces $104.15. Those two figures, multiplied across the census in Section 7, are the entire revenue model.

[34] CMS Medicare Physician Fee Schedule, CY2026, non-facility amounts for MAC locality 10312-35, Palmetto GBA, Tennessee statewide, resolved from ZIP 38401.

6. Clinical Governance and Escalation

Remote monitoring generates data continuously and clinical risk episodically. The governance question is not who watches the numbers; it is who acts, how fast, and under whose authority. Maury Regional's clinicians retain clinical authority over their own patients throughout. CoachCare's care team operates under parameters the organization sets and documents everything back into the patient record.

Tier	Trigger	Response	Owner
Routine	Readings inside the patient's set range	Logged, trended, and rolled into the monthly management note. No interruption to the practice.	CoachCare care team
Adherence	Missed transmissions across consecutive days	Outreach to the patient, device troubleshooting, re-education. Protects both the clinical signal and the billing threshold.	CoachCare care team
Clinical alert	A reading outside range — weight gain against a heart-failure baseline, blood pressure or oxygen saturation outside the set band	Same-day nurse assessment against protocol, documented, with a recommendation prepared for the responsible clinician.	CoachCare nurse, escalating to the practice
Urgent	A pattern consistent with decompensation, or a patient reporting acute symptoms	Immediate notification of the responsible clinician or the on-call service, with the trend data attached. Disposition is the clinician's decision.	Maury Regional clinician

What the organization sets, and what CoachCare runs

Maury Regional sets: the alert thresholds by cohort, the escalation pathway and on-call routing, the enrollment criteria, and the clinical protocols the care team works to. The responsible clinician makes every clinical decision.

CoachCare runs: enrollment and consent, device fulfillment and logistics, twenty-four-hour monitoring and triage, the documented monthly clinical contact, the documentation that supports each claim, and the reporting back to the practice.

Every escalation, every minute of clinical time and every care-plan update lands in the patient's record. That documentation is what makes the claim defensible and what makes the quality performance measurable.

7. The Value Analysis

7.1 Model inputs

The forecast is built on remote physiologic monitoring and chronic care management across the employed primary-care network and the post-discharge chronic cohorts, billed by Maury Regional at the Tennessee locality. Transitional care management is the clinical entry point and sits outside the financial model.

Input	Value	Basis
Medicare panel	18,000	Triangulated three ways: the Part B established-visit floor of 10,487 beneficiaries grossed for Medicare Advantage, a 26.7% share of the 67,350 Medicare beneficiaries in the eight core counties, and the ACO's assigned population grossed the same way.
In-scope chronic population	11,700	65% of the panel carrying a qualifying chronic condition, supported by the panel's own prevalence profile in Section 1.3.
Referring clinicians	111	101 primary-care-capable clinicians: 44 internal medicine, 44 nurse practitioners, 7 physician assistants and 6 family practice, plus 5 pulmonology and 5 critical care.[35]
Program eligibility	Remote monitoring 65% · chronic care management 75%	Applied to the in-scope population, not the whole panel.
Acceptance	Remote monitoring 35% · chronic care management 30%	Of eligible patients.
Overlap between programs	70%	The share of chronic care management patients also enrolled in remote monitoring, which is what separates unique patients from program enrollments.
Monthly attrition	1.5%	Applied to the active census every month.
Enrollment support	One CoachCare-funded on-site enrollment specialist	Staffed and paid by CoachCare.
Program ceilings	Remote monitoring 2,662 · chronic care management 2,633	The maximum enrolled census each program can reach against this panel.
Locality	Tennessee, MAC locality 10312-35	Palmetto GBA, Tennessee statewide.

[35] See note 4.

7.2 The twenty-four-month forecast

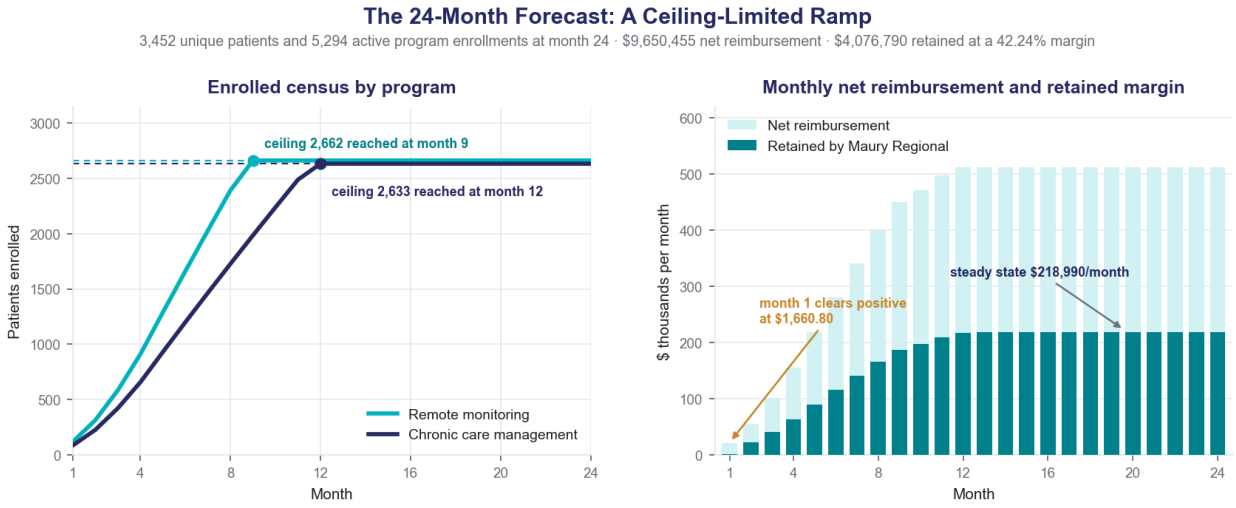

Figure 3 — Enrolled census against program ceilings, and monthly net reimbursement against the share Maury Regional retains. Month 1 clears positive at $1,660.80; steady state is $218,990 per month from month 13.

Modeled result	Year 1	Year 2	24 months
Net reimbursement to Maury Regional	$3,503,737	$6,146,718	$9,650,455
CoachCare fees	$2,054,823	$3,518,842	$5,573,665
Retained by Maury Regional	$1,448,914	$2,627,876	$4,076,790
Retained margin	41.35%	42.75%	42.24%
Unique patients in active remote care	3,452 at month 12	held at 3,452	3,452 at month 24
Active program enrollments	—	—	5,294 at month 24
Hospitalizations avoided	133	213	346
Claims generated	—	—	194,371
Device readings received	—	—	544,825
Care-team hours delivered	—	—	86,405

The margin, and how it is defined

Retained margin is 24-month practice profit divided by 24-month net reimbursement: $4,076,790 ÷ $9,650,455 = 42.24%. Year 1 runs at 41.35% because implementation and integration fees post in the first month; Year 2 runs at 42.75%.

Month 1 clears positive at $1,660.80 after those fees. There is no negative month anywhere in the forecast, and no quarter in which the program is a net cost. From month 13 the practice keeps $218,990 a month.

The on-site enrollment specialist is recruited, employed and paid by CoachCare. That cost sits on CoachCare's side of the model. It is embedded value in every figure above, never a deduction from the margin shown.

Program	24-month net reimbursement	CoachCare fees	Retained	Per patient-month
Remote physiologic monitoring	$4,687,825	$2,802,864	$1,884,961	$90.34

Program	24-month net reimbursement	CoachCare fees	Retained	Per patient-month
Chronic care management	$4,962,630	$2,594,349	$2,368,281	$104.15
Total	$9,650,455	$5,573,665	$4,076,790	—

7.3 The ramp, the ceiling, and what moves them

This forecast is ceiling-limited rather than pace-limited, and the distinction changes which levers matter. Remote monitoring reaches its ceiling of 2,662 enrolled patients at month 9 and chronic care management reaches 2,633 at month 12. From month 12 the terminal census of 3,452 unique patients is held flat through month 24, which is why the month-12 and month-24 unique patient counts are identical and why monthly net reimbursement flattens at $512,226.

Because both programs saturate inside the first year, enrollment throughput is not the binding constraint. The panel definition is. A second enrollment specialist reaches the same ceiling sooner rather than raising it, and the figure that actually scales the model is the in-scope count of 11,700. Settling that number against Maury Regional's own chart data is the highest-value input to revisit, and it is the first recommendation in Section 9.

Panel penetration at terminal census is 3,452 of 18,000, or 19.2%. That sits level with the book average across CoachCare's modeled accounts and below what the standard eligibility assumptions on their own would imply.

7.4 Clinical and operational output

Output over 24 months	Volume	What it represents
Hospitalizations avoided	346 — 133 in Year 1, 213 in Year 2	Admissions prevented across the enrolled cohort. This is the line that carries into the episode model and the ACO benchmark.
Device readings received and reviewed	544,825	Roughly 158 readings for every unique patient enrolled, each one a chance to intervene before an admission.
Claims generated	194,371	Produced, documented and submitted by CoachCare against the practice's own billing identifiers.
Care-team hours delivered	86,405 — 41.5 FTE-equivalent	Clinical labour delivered rather than recruited. At the standard 165-patient caseload, the steady-state program is staffed entirely by CoachCare.
Active program enrollments	5,294 at month 24	Across 3,452 unique patients, because a patient enrolled in both programs counts once as a person and twice as an enrollment.

The 86,405 hours is the figure worth dwelling on in a market this size. It is 41.5 full-time equivalents of clinical work delivered into an eight-county footprint without a single requisition.

8. Implementation

8.1 Staffing: nobody has to be hired

The service line is delivered, not licensed. CoachCare recruits, employs and manages the care team, places an enrollment specialist on site, ships and supports the devices, runs twenty-four-hour monitoring and triage, produces the documentation and generates the claims. Maury Regional supplies clinical authority, the referring clinicians, the protocols and the billing identifiers under which the claims go out.

Function	Delivered by	Demand on Maury Regional
Patient identification and enrollment	CoachCare enrollment specialist, on site	Approve the eligibility criteria and the outreach list.
Consent, device fulfillment, logistics	CoachCare	None.
Daily monitoring, triage, escalation	CoachCare clinical team, 24/7	Set thresholds and on-call routing; receive escalations.
Monthly clinical contact and care-plan maintenance	CoachCare care managers	Review and co-sign under the responsible clinician.
Documentation and claim generation	CoachCare	Claims submit under Maury Regional's billing identifiers.
Clinical decisions	Maury Regional clinicians	Unchanged from today.

8.2 Clinical workflow

Step	Timing	What happens
Identify	Continuous	Two entry paths run in parallel: a discharge from Maury Regional Medical Center in a cardiovascular, respiratory or renal cohort, and a chronic-condition match on the employed primary-care panel or the ACO's assigned list.
Enroll	Within 2 business days of discharge, or at a scheduled visit	Consent, device selection, baseline readings established against the discharge summary.
Stabilize	Days 1–30	Daily transmissions against the baseline, structured outreach on days 1–2, 5–8 and 12–14, medication reconciliation, and the face-to-face visit that closes the transitional care window.
Manage	Month 2 onward	Monitoring continues; the documented monthly clinical contact begins; the care plan is maintained and revised.
Escalate	As triggered	Per the tiers in Section 6, with the trend data attached to every notification.
Report	Monthly	Enrollment, adherence, escalation volume and disposition, billing yield per enrolled patient, and readmission rates on the enrolled cohort against its own pre-enrollment baseline.

8.3 Twelve-month roadmap

Phase	Months	Milestones
Design	Months 0–1	Confirm the in-scope population and the referring clinician list. Set cohort thresholds and the escalation pathway. Agree the billing identifiers and the claim-review cadence. Confirm the EHR platform and the integration route.
Launch	Months 1–3	Enrollment specialist on site. Start with the heart-failure post-discharge cohort and one primary-care site, then extend. First claims out in month 1.

Phase	Months	Milestones
Extend	Months 3–6	Add the COPD and renal post-discharge cohorts. Bring the health center and rural clinic sites into scope. Run the January ACO assignment list as a dedicated outreach campaign.
Scale	Months 6–12	Remote monitoring reaches its ceiling at month 9 and chronic care management at month 12. Reporting shifts from enrollment volume to readmission and excess-day performance on the enrolled cohort.

Two dates in that sequence matter more than the rest. Claims go out in month 1, so the service line contributes revenue inside the same budget year it starts in. And by month 12 the reporting has moved from enrollment counts to what the enrolled cohort's readmissions and excess days look like against its own pre-enrollment baseline, which is the measure the episode model and the ACO are both scored on.

9. Priority Recommendations

#	Recommendation	Why now
1	Count the in-scope chronic population across the employed practices, the health center sites and the rural clinics.	The forecast models 11,700 in-scope patients from a panel of 18,000. Because both programs saturate inside the first year, this is the input the whole model scales on, and the only one that cannot be settled from public data.
2	Stand up transitional care management on the discharge volume that is already there.	3,914 discharge day-management services were billed in CY2024 and no transitional care claims followed them. The code family exists, the discharges exist, and the thirty days they open are the window the episode model reconciles.
3	Build the post-discharge cadence around heart failure first.	244 discharges with major complications, 31.8% prevalence on the employed panel, excess days 8.8 above average, and a Joint Commission Heart Failure Certification that already requires a documented disease-management program with follow-up and self-care education.
4	Run the ACO's prospectively assigned list as a dated enrollment campaign each January.	Prospective assignment hands the organization a fixed roster on 1 January. Every month that list sits unworked is a month of care-management revenue and quality performance left on the table.
5	Bill 99453 at every enrollment, and adopt 99445 and 99470 from day one.	Setup revenue is routinely lost at launch, and the two short-window codes are new for CY2026. They pay for exactly the intermittent, mid-month, step-down pattern a post-discharge cohort produces.
6	Establish the share of the primary-care panel delivered at the health center and rural clinic sites.	Those sites price the unbundled care-management codes on the national non-facility fee schedule rather than the Tennessee locality. CoachCare's per-patient fee does not move with the rate, so the difference falls to Maury Regional.
7	Settle how the Medicare Advantage contracts treat the care-management code families before budgeting.	Weighted Medicare Advantage penetration across the eight core counties is 49.9%, and five of the eight sit above 50%.[36]

[36] See note 18.

10. Open Items for the First Call

Seven questions would sharpen the design. Each is a working-session item rather than something public data can settle.

Question	Why it matters
What EHR platform is in production today across the hospitals and the ambulatory sites, and who owns the interface work?	CoachCare integrates with the major certified platforms. Confirming the current platform and version sets the integration route and the data flow for claim documentation.
What share of the primary-care panel is delivered at the ten health center sites and the seven rural clinics?	Those sites price care management on the national fee-schedule rail. The share sets how much of the panel prices above the Tennessee locality.
How do the Medicare Advantage contracts treat remote monitoring and chronic care management?	Half the Medicare population in the eight core counties is in a plan. Plans pay at least the Medicare rate; the code-family treatment is a contracting question.
What do the Post-Acute Care Network, Home Services and Hospital-to-Home Transitional Rehabilitation programs already do in the thirty-day window?	Three named programs already touch this window. The service line should extend them rather than run beside them.
Is remote cardiac device follow-up billed by the hospital or by the cardiology groups?	It sets whether device follow-up is inside or outside the hospital's own book, and which workflows the program can attach to.
Which clinic sites carry health professional shortage area designations, and what are the scores?	It shapes the enrollment approach and the copay conversation across the rural counties.
Does the system carry any exposure through ACO REACH or a TennCare managed-care arrangement?	Both would add a scoring surface the same enrolled population already serves.

References & Data Sources

Every figure in this report traces to a CMS published file or to a document published by Maury Regional Health. The numbered footnotes give the specific file, query and vintage for each. A companion Disclosures and Assumptions document records the modeling assumptions, estimate methods and source vintages behind the forecast in Section 7.

Source	Vintage
CMS Medicare Physician & Other Practitioners (by Provider; by Provider and Service)	CY2024, released 21 May 2026
CMS Medicare Inpatient Hospitals — by Provider and Service	CY2024
CMS Care Compare — hospital general information, complications and deaths, unplanned hospital visits	Current rendition, August 2026
CMS Hospital Readmissions Reduction Program	Measurement period 07/2021–06/2024
CMS Transforming Episode Accountability Model participant list	As of 15 April 2026
CMS Medicare Shared Savings Program participant file	PY2026
CMS Doctors and Clinicians National Downloadable File	Retrieved August 2026
CMS Medicare Monthly Enrollment	April 2026
CMS Medicare Physician Fee Schedule, MAC locality 10312-35	CY2026
NPPES National Plan and Provider Enumeration System	Retrieved August 2026
Maury County, Tennessee Annual Financial Report; Maury Regional Hospital Annual Financial Report	FY2025; FY2023
Maury Regional Health published service pages, news releases and ACO public reporting	2025–2026