COACHCARE · REMOTE CARE SERVICE LINE

North Caddo Medical Center

Remote Care Service Line — Performance & Optimization

2026 Strategy Report

A CoachCare Remote Care Service Line — RPM, CCM and APCM — as the operating spine, and the CY2026 billing change that makes care management separately payable at all six Rural Health Clinics, **on top of** the all-inclusive rate.

North Caddo Hospital Service District · Critical Access Hospital, CCN 191304 · Six provider-based Rural Health Clinics · Vivian, Louisiana

Purpose of this report

This report reads North Caddo Medical Center's starting position and makes a single, disciplined case: a managed remote care service line — remote physiologic monitoring, chronic care management and advanced primary care management, staffed by CoachCare — is the highest-return operational move available to the organization in 2026. It is net-positive on its own economics from month two, with no sustained negative period. It is additive to the Rural Health Clinic all-inclusive rate rather than carved out of it. And it is one of the few genuinely incremental margin lines available to a cost-based provider.

Economics shown are illustrative and modeled from a CoachCare Value Analysis; every figure should be verified against the organization's own patient, payer and utilization data during discovery. Public organizational facts are sourced and date-stamped, and items that could not be verified from public records are flagged as such rather than asserted.

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Date: July 2026 · Confidential — prepared for North Caddo Medical Center leadership

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Executive Summary

North Caddo Medical Center is a 25-bed Critical Access Hospital in Vivian, Louisiana, operating as North Caddo Hospital Service District — a public hospital service district and a component unit of Caddo Parish, governed by nine commissioners appointed by the Caddo Parish Commission. It has served far northwest Louisiana since 1965 from a replacement campus opened in 2017, and holds Critical Access status by state "necessary provider" designation dating to 2001. Around the hospital sits the asset this report is about: **six family-practice clinics — Vivian, Oil City, Plain Dealing, Blanchard, Benton and South Bossier — every one of them a CMS-certified, provider-based Rural Health Clinic of the hospital's own provider number**. Three of the six were added in the last five years, the most recent acquired from the regional system next door. Eighteen clinicians work across the network, which recorded 48,865 clinic visits in the last audited year. The clinics run Veradigm; the hospital runs Cerner CommunityWorks. The same chief executive has led the organization for twenty years.

The starting position — and the CY2026 payment change

The single most consequential fact in North Caddo's near-term environment is a change in how Rural Health Clinics get paid for care management. CMS sunset the bundled G0511 code for RHCs and FQHCs after September 30, 2025. Since January 1, 2026, certified Rural Health Clinics bill the individual chronic care management, remote monitoring and advanced primary care management codes as separate line items **at national non-facility Physician Fee Schedule rates — separately payable in addition to the all-inclusive rate, not carved out of it**. For decades the between-visit work of chasing blood pressures, closing A1c gaps and following up after a discharge was an unfunded cost absorbed into the encounter rate. As of this year it is a billable service line, and North Caddo holds six certified clinics that can bill it.

Why this revenue is different from most of the income statement. Critical Access Hospital and provider-based Rural Health Clinic reimbursement is largely cost-based. For much of what North Caddo does, more volume also enlarges the allowable cost base being paid against — the number grows on both sides of the ledger. Care management billed under the Physician Fee Schedule does not work that way. It is paid at a published rate, separately payable in addition to the all-inclusive rate, on a population the organization already serves. **It is one of the very few places where new revenue is genuinely incremental margin** — which is the structural reason to build it even though the clinics are already busy.

No published remote patient monitoring, chronic care management or advanced primary care management program was found at North Caddo in public sources as of July 2026, and no care-coordination, care-management or population-health role appears in the organization's current open postings. Telehealth exists and is described on the organization's own site as a telephone or FaceTime visit for established patients at three of the six clinics. That is a structural observation about billing and monitoring infrastructure, not a judgment about the care delivered — it simply means the revenue line described in this report is unclaimed rather than contested.

Time-sensitive — Louisiana's sub-grant windows are open now

Louisiana holds a $208.4M Year 1 Rural Health Transformation award, and the Louisiana Department of Health has live application windows as this report is written: **Rural Collaborative Provider Models, August 5, 2026**; **Rural Medicaid Alternative Payment Model, August 7**; **Regional Care Conveners & Navigation Networks and Food is Medicine, August 14**. An EHR Implementation Partners request for information and a Rural Provider VBC/APM Readiness Survey are also live. Section 4 sets out what each is and how a remote care service line maps onto them. Deadlines are as published by the Department, are perishable, and must be confirmed directly with it.

The central argument

A managed remote care service line delivers value two ways at once, and both should be read together.

Standalone. Recurring, subscription-like professional-fee revenue — **$1,768,761** of modeled net reimbursement over 24 months and **$746,264 net to North Caddo** after all CoachCare fees, a 42.2% margin on net reimbursement (Year 1 40.9%, Year 2 43.0%) — additive to the all-inclusive rate rather than a reallocation of it, and net-positive from month two onward with no sustained negative period.

Connective tissue. One shared engine — enrollment, connected devices, monitoring and alert triage, documented escalation, claim generation and analytics — simultaneously produces the professional-fee line, closes the distance between six clinics spread across two parishes, carries the post-discharge and swing-bed handoff, and supplies the chronic-disease outcome evidence Louisiana has committed to CMS. Build it once; every layer draws on it.

	Year 1	Year 2	24 months
Net reimbursement	$682,953	$1,085,808	**$1,768,761**
CoachCare fees, including ancillary	$403,396	$619,101	$1,022,497
Net to North Caddo Medical Center	**$279,557**	**$466,707**	**$746,264**
Margin on net reimbursement	40.9%	43.0%	**42.2%**

Modeled on a 4,000-patient Medicare panel with 3,000 in scope, 14 panel-owning providers, and CY2026 Louisiana locality rates (Novitas Jurisdiction H, locality 99). The CoachCare-funded on-site enrollment specialist is CoachCare's expense and is not subtracted from North Caddo's margin. Confirm current rates and concurrency guidance with the MAC before contracting. Illustrative, modeled — verify against practice data.

The population is measurably sicker than the country it is averaged into

Caddo Parish Medicare beneficiaries cost **26% more** than the national average — $15,831 per capita against $12,553 — are hospitalized **22% more often** (274 inpatient stays per 1,000 against 225) and visit the emergency department **13% more often** (664 per 1,000 against 591), with an acute readmission rate of 18.84% (CMS Medicare geographic variation, CY2024). CDC PLACES estimates 44.0% of Caddo adults carry high blood pressure and 17.2% carry diabetes (2024 release). Caddo ranks 48th of 64 Louisiana parishes for health outcomes, and Louisiana ranks 50th of 50 nationally. This is the utilization curve that continuous monitoring plus monthly care management is designed to bend.

One demographic fact turns directly into revenue. 28.2% of Caddo Parish Medicare beneficiaries are dual-eligible and 18.1% are Qualified Medicare Beneficiaries, against roughly 12–13% nationally (CMS Medicare monthly enrollment, CY2024). G0558 — the top advanced primary care management tier — is scoped to exactly that population: QMB patients carrying two or more chronic conditions, at $110.46 per

patient per month at Louisiana rates. The parish's dual-eligible density is why APCM is the largest single revenue line in this model.

The panel, stated honestly

The model runs on a 4,000-patient Medicare panel across the six clinic sites, with 3,000 in scope — an estimated 75% carrying at least one qualifying chronic condition. Neither number is a chart count. The 4,000 figure is client-directed and cannot be verified from public data for a structural reason worth stating plainly: provider-based Rural Health Clinic encounters are billed institutionally under the clinic's own CCN, so they are largely invisible in the CMS physician utilization files that would otherwise confirm a panel. It does land inside three independent estimation bands built from the audited visit count, the audited payer mix and provider supply — those are set out in Section 5. The 75% qualifying-condition share is an estimate on the same footing. Both are the first items to validate in discovery, and the entire forecast is built to be re-run the moment they land.

Workforce relief is the delivery model, not a side benefit

North Caddo staffs six clinics with roughly one physician and one advanced practice provider apiece, in a state where the Louisiana Department of Health reports 73% of residents live in a primary care shortage area. The Vivian clinic carries its own facility-level HRSA shortage designation, scored 19 in primary care, mental health and dental and flagged rural, designated November 2025. Against that, a program that requires the organization to hire care managers in order to operate it solves the wrong problem. CoachCare supplies the enrollment and engagement labor: **9,904 staff-hours over 24 months, roughly a 4.8 FTE-equivalent of CoachCare-performed work, with no new North Caddo headcount**. North Caddo's clinicians retain protocol governance and every clinical decision.

2026–2027 priority recommendations

1. **Answer Louisiana's open windows in the next two weeks.** The Rural Provider VBC/APM Readiness Survey is a zero-cost, high-signal entry point, and “Regional Care Conveners & Navigation Networks” is close to a verbatim description of a rural care-management and remote-monitoring service. Treat this as a co-application conversation rather than a procurement one. Section 4.
2. **Charter the remote care service line now, with one named owner.** A service line with a P&L, a monthly scorecard and a single accountable executive — not three programs distributed across six clinics. Chartered in 30 days; billing by day 90. It is a natural home for the Health Initiative Program the chief executive reported working on to the board in May 2026.
3. **Launch on the dual-eligible cohort, starting at Vivian and Blanchard.** APCM requires no device and imposes no minute-tracking on a shortage-area staff, and Caddo's 18.1% QMB share means the richest tier is unusually well populated. Vivian and Blanchard together carry 64% of all clinic visits, so that is where a pilot proves capture rate fastest.
4. **Confirm the three numbers that move everything.** The Medicare panel count by clinic, the share carrying a qualifying chronic condition, and the dual-eligible and QMB counts. They set the denominator, the APCM tier mix and therefore the whole forecast. The RHC cost-report visit counts by clinic CCN and the Veradigm panel report are the authoritative sources.
5. **Settle the national-rate question in the first finance conversation.** All six clinics are certified provider-based RHCs, and RHCs bill these codes at national non-facility rates. The forecast in this report is deliberately built on lower Louisiana locality rates. Section 3 sets out what that conservatism is worth and why essentially all of it would fall to North Caddo.

6. **Scope the Veradigm integration early, and the hospital record separately.** Care-management billing lives on the clinic side, which runs Veradigm's cloud EHR — a configured CoachCare integration rather than a custom build. The Cerner CommunityWorks hospital record is a separate, later conversation about acute and swing-bed data flow, not a prerequisite to launch.

1. Footprint & Operating Model

North Caddo Medical Center operates as the health-care anchor of far northwest Louisiana. The hospital at 815 South Pine Street in Vivian is a 25-bed Critical Access Hospital with a 24-hour emergency department, two operating rooms, two labor and delivery suites, imaging including CT and MRI, a CLIA-certified laboratory, and an active swing-bed program covering wound care, post-surgical recovery, stroke rehabilitation, and cardiac and pulmonary rehabilitation. It is one of 27 Critical Access Hospitals in Louisiana and the only one in the Shreveport–Bossier City core-based statistical area. Around it the organization runs outpatient physical, occupational and speech therapy, three Community RX retail pharmacies with free next-day mail delivery of maintenance medications, a dental practice, a fitness center, three ambulances, and — as the anchor site of the LSU Health Shreveport Family Medicine Rural Residency — a physician pipeline that has produced six of its seven family medicine physicians.

The six clinics are the commercially decisive fact. Vivian Medical & Surgical, Oil City Medical, Plain Dealing Medical, Blanchard Medical, Benton Medical and South Bossier Medical are each certified by CMS as a Rural Health Clinic and each is provider-based to the hospital's own provider number — verified against the CMS Provider of Services file, Q2 2026. Nothing in the published clinic footprint is uncertified and nothing is missing: the six sites on the organization's website map one to one onto six active RHC provider numbers. Three of the six were added since 2021, the most recent, Oil City, acquired from Willis-Knighton Health effective January 2025 and certified that December. This is an organization that has been acquiring clinic sites in a consolidating rural market, not shedding them.

The shape of the business

Audited FY2024 activity	Volume
Clinic visits across the six Rural Health Clinics	**48,865**
— Vivian Medical & Surgical	20,504 (42%)
— Blanchard Medical	10,730 (22%)
— Benton Medical / Plain Dealing Medical	6,647 / 6,635
— South Bossier Medical (opened mid-2024)	1,346
Emergency department visits	5,490
Acute admissions · average length of stay	328 · 4.16 days
Swing-bed admissions · days · average length of stay	76 · 1,154 · 15.18 days

Louisiana Legislative Auditor, audited financial statements for the year ended June 30, 2024 — the most recent posted. Vintage: FY2024.

Two things follow from that table. First, **this is overwhelmingly an ambulatory organization** — 48,865 clinic visits against 328 acute admissions, and roughly 85% of charges outpatient. Second, the visit base is concentrated: Vivian and Blanchard together carry 64% of it, which is where any pilot should start. The

swing-bed program is genuinely in use, at a 15-day average stay, which makes the post-acute handoff described in Section 6 a real workflow rather than a theoretical one.

On the financial shape, one observation, stated neutrally. The most recent audited statements show operating results moving from a modest surplus in FY2022 to an operating loss in FY2024, with the positive change in net position driven by a one-time Employee Retention Credit that the chief financial officer reported to the board in May 2026 was still pending with the Internal Revenue Service. Property and sales tax together contribute roughly $2.4M. None of that is unusual for a Louisiana critical access hospital, and none of it is the point here. The point is the **shape** of revenue this income statement is short of: recurring, outpatient, margin-positive, and requiring no capital, no construction and no new hires to produce. That is precisely the shape of a care-management service line.

Design principles for the service line

Principle	What it means at North Caddo
Longitudinal by default	The Medicare patient is managed between visits, every month — not re-encountered episodically when something breaks.
Additive, never substitutive	Every care-management code is billed on top of the Rural Health Clinic all-inclusive rate. Nothing in this design reallocates encounter revenue or changes how a visit is billed.
One service line, one scorecard	RPM, CCM and APCM run as a single named service line with one owner, one P&L and one scorecard across all six clinics — not three programs in six places.
Staffed, not licensed	CoachCare supplies the enrollment and engagement labor. In a shortage-designated rural market, a program that requires new hires to operate is a program that does not launch.
Clinical governance stays inside	Protocols, escalation preferences and every clinical decision remain North Caddo's. CoachCare executes to documented standard operating procedures and documents every touch.
Built where the work already happens	Enrollment, orders, vitals, escalation tasks and claims live inside Veradigm, so clinicians and billers do not learn a second system.

What public sources do not answer

Public records name David Jones as chief executive, Dakota Robinson as chief financial officer, Brent Leonard as controller, Stacy Alexander as chief nursing officer and privacy officer, Ross Hansen as chief information officer, and Dr. John Woods as chief of staff. They do not name a chief medical officer, a quality director, a compliance officer or a revenue cycle manager — the latter two roles are confirmed to exist but are never named — so those owners are identified in discovery rather than assumed here.

Provider counts differ across three public sources — the organization's own roster, its About page, and the CMS Provider of Services file — and are treated as approximate. The model uses 14 panel-owning providers, deliberately excluding emergency-only physicians, the surgeon and the visiting cardiologist, none of whom carries a longitudinal chronic-care panel.

The FY2025 audit is not yet posted; FY2024 is the most recent available and is the source of every audited figure in this report.

2. The Remote Care Service Line — The Spine

This is the centerpiece. The remote care service line is not a point solution bolted onto the clinics; it is the operating spine that carries recurring, all-inclusive-rate-additive revenue, closes the distance a six-site rural footprint creates, and supplies the chronic-disease evidence the organization will be asked for — on one shared engine.

2.1 What It Is: The Care-Management Stack

North Caddo owns a longitudinal primary-care panel across six certified Rural Health Clinics, which is what makes the full stack billable here. Three programs run together, each with a distinct job.

Layer	Codes	Role in the Rural Health Clinic stack
APCM	G0556 / G0557 / G0558	Advanced Primary Care Management — non-time-based monthly management of the longitudinal panel. G0558 covers QMB dual-eligible patients with two or more chronic conditions. Richest per patient touched, no minute-tracking, and the largest single revenue line in this model.
CCM	99490 / 99439 (complex 99487 / 99489)	Chronic Care Management for Medicare patients with two or more chronic conditions who are not on the APCM arm — the longitudinal wrapper for hypertension, diabetes, heart failure and COPD in one family-practice panel.
RPM	99453 / 99454 / 99457 / 99458 (short-window 99445 / 99470)	Remote Physiologic Monitoring — blood pressure, weight and glucose. The continuous early-warning layer that makes chronic control measurable rather than episodic, and the depth program on the sickest slice of the panel.

The one coordination rule — and why the care-management pool is a split, not a stack

APCM bundles. It is not billed in the same month as CCM for the same patient — those services overlap with APCM by definition. RPM may be billed alongside either. Because each patient therefore sits on one management rail or the other, the CCM and APCM cohorts are distinct populations rather than layers on the same population: at month 24 the model carries 300 CCM and 600 APCM patients, and all 270 RPM patients sit inside those cohorts. That is why 1,170 active program enrollments resolve to **900 unique patients**, and why the forecast never counts the same patient on two care-management rails.

North Caddo sets one written attribution policy and the model follows it: QMB and dual-eligible multi-chronic patients run APCM plus RPM; the remaining multi-chronic Medicare patients run CCM plus RPM. Clean rules like this keep the model reimbursement-accurate and audit-ready. Confirm current concurrency guidance with the MAC before go-live.

Enrolled Patients versus Enrolled Services

A patient enrolled in APCM and RPM counts once as a patient and twice as a service. Program enrollments are never labeled “patients” anywhere in this report or in the companion workbook. At month 24 the model carries 1,170 active program enrollments across 900 unique patients.

2.2 Standalone Value: Four Value Layers

Before any grant dollar or any avoided-cost argument, the service line pays for itself through four layers of value. The first is the one that should be read first, because it is not simply new revenue — it is new revenue of a kind a cost-based provider almost never gets. Section 3 sets out why.

1. **Care-management revenue additive to the all-inclusive rate.** Recurring monthly APCM, CCM and RPM billing, each separately payable on top of the RHC encounter, at a published fee-schedule rate rather than a cost-based one. A subscription-like revenue line the organization owns, on a population it already serves, across six certified clinics. Detailed in this section and in Section 3.
2. **Remote care as the answer to geography.** Six clinics spread across two parishes, and a patient population for whom distance is the adherence barrier. Monitoring replaces windshield time — the reading travels instead of the patient, and one centrally staffed team covers all six panels. Detailed in Section 6.
3. **Post-acute follow-through for a Critical Access Hospital.** Discharges from North Caddo's own beds, its swing-bed program — 76 admissions and 1,154 days in the last audited year — and returns from tertiary care in Shreveport all land in a monitored program with a documented follow-up cadence rather than into a 35-minute gap. Detailed in Section 6.
4. **A recruiting-proof staffing model.** 9,904 staff-hours of monitoring, outreach and documentation over 24 months — roughly a 4.8 FTE-equivalent — performed by CoachCare, not hired by North Caddo and not added to existing staff. Detailed in Section 7.

The CY2026 billing stack — Louisiana locality rates

Service / code	Type	Rate	Notes
APCM G0556	Monthly bundle	$15.49	Level 1 — zero or one chronic condition
APCM G0557	Monthly bundle	$50.67	Level 2 — two or more chronic conditions
APCM G0558	Monthly bundle	$110.46	Level 3 — QMB dual-eligible with two or more chronic conditions
CCM 99490 / 99439	Monthly	$62.54 / $47.45	Two or more chronic conditions; complex CCM 99487 / 99489 where applicable
RPM 99453	One-time setup	$19.26	Requires at least two days of transmitted data
RPM 99454 / 99445	Monthly	$46.14	99454 = 16–30 days; 99445 = new CY2026 2–15 day short window
RPM 99457 / 99470	Monthly	$48.26 / $24.30	First 20 minutes / new CY2026 first-10-minute code
RPM 99458	Monthly	$39.09	Each additional 20 minutes

Rates resolve to North Caddo's Louisiana locality (Novitas Jurisdiction H, locality 99) from the CY2026 Physician Fee Schedule and are the magnitudes used in the Value Analysis model — illustrative, not quotes. Actual payment is locality-adjusted and set by the regional MAC; verify the current-year schedule before contracting. Every rate is user-editable in the model. The short-window RPM codes 99445 and 99470 are not included in the modeled figures — they are upside, and a natural fit for the 2–15 day window after an emergency visit or a discharge. Illustrative, modeled — verify against practice data.

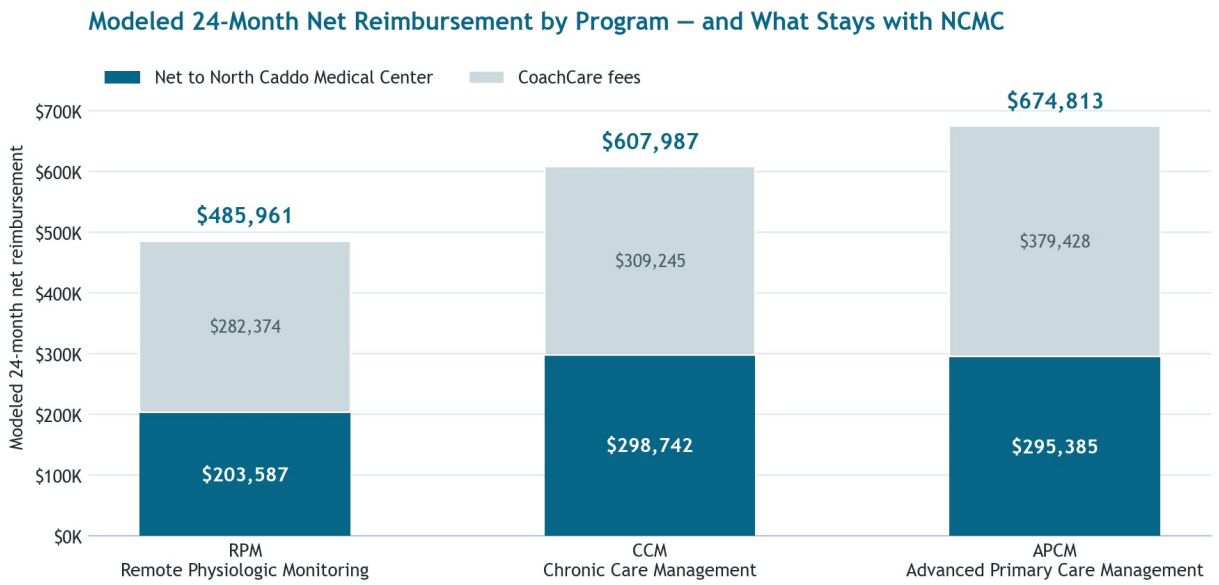

Figure 1. Modeled 24-month net professional-fee reimbursement by program, and the share that stays with North Caddo after all CoachCare fees. APCM leads — the signature of a rural primary-care panel with high dual-eligible density. A further $51,450 of ancillary cost over 24 months (one-time implementation, EMR integration setup and monthly integration, and telephonic enrollment support) sits outside these three bars and is included in every total elsewhere in this report. Illustrative, modeled — verify against practice data.

How the recurring-revenue math works

Each enrolled patient generates a predictable monthly professional fee for as long as they remain clinically appropriate and engaged. Scale that across the in-scope population and the line compounds: the model reaches 270 RPM, 300 CCM and 600 APCM active program enrollments — 1,170 in total across 900 unique patients — and holds there. Blended net reimbursement per active patient-month, after modeled denials and coinsurance bad debt, is approximately $89.56 for RPM, $104.48 for CCM and $58.66 for APCM. At steady state the line delivers roughly **$38,892 per month net to North Caddo** after every CoachCare fee.

The APCM tier mix is what makes the third of those numbers larger than it looks. At the modeled distribution — 15% at Level 1, 55% at Level 2 and 30% at Level 3 — the blended rate is $63.33 per patient per month before denials, weighted deliberately toward the top tier because Caddo Parish's QMB share runs roughly half again above the national figure. That mix is a modeled distribution, not a count from North Caddo's records, and it moves this section more than any other assumption in the report.

Modeling assumptions — read before quoting any number

The forecast assumes a 4,000-patient Medicare panel with 3,000 in scope, 14 panel-owning providers across the six clinics, one CoachCare-funded on-site enrollment specialist plus telephonic outreach, enrollment beginning in month 1, and roughly 1.5% monthly attrition. Program eligibility within the in-scope population and enrollment acceptance produce active ceilings of 270 RPM, 300 CCM and 600 APCM. CCM and APCM are mutually exclusive per patient per month, so those cohorts are distinct populations; the eligible pools behind them are not additive and are never presented as such.

Not included anywhere in the financial figures: the short-window RPM codes 99445 and 99470, transitional care management, principal care management, the CY2026 behavioral health integration add-on codes, Louisiana Medicaid care-management or remote-monitoring coverage, any Rural Health Transformation Program sub-grant, the national-rate basis described in Section 3, and the value of avoided hospitalizations. All are upside on top. **All financial figures are illustrative, modeled — verify against practice data.**

2.3 Connective Tissue: One Engine, Every Layer

The reason to build this as a service line rather than a series of disconnected point programs is that one shared engine carries every layer the organization cares about. Enroll a patient once, ship one device, run one monitoring and escalation protocol, capture one billing workflow — and the same activity shows up in the professional-fee line, in the access story across six sites, in the post-discharge record, and in the chronic-disease outcome evidence the state is measuring.

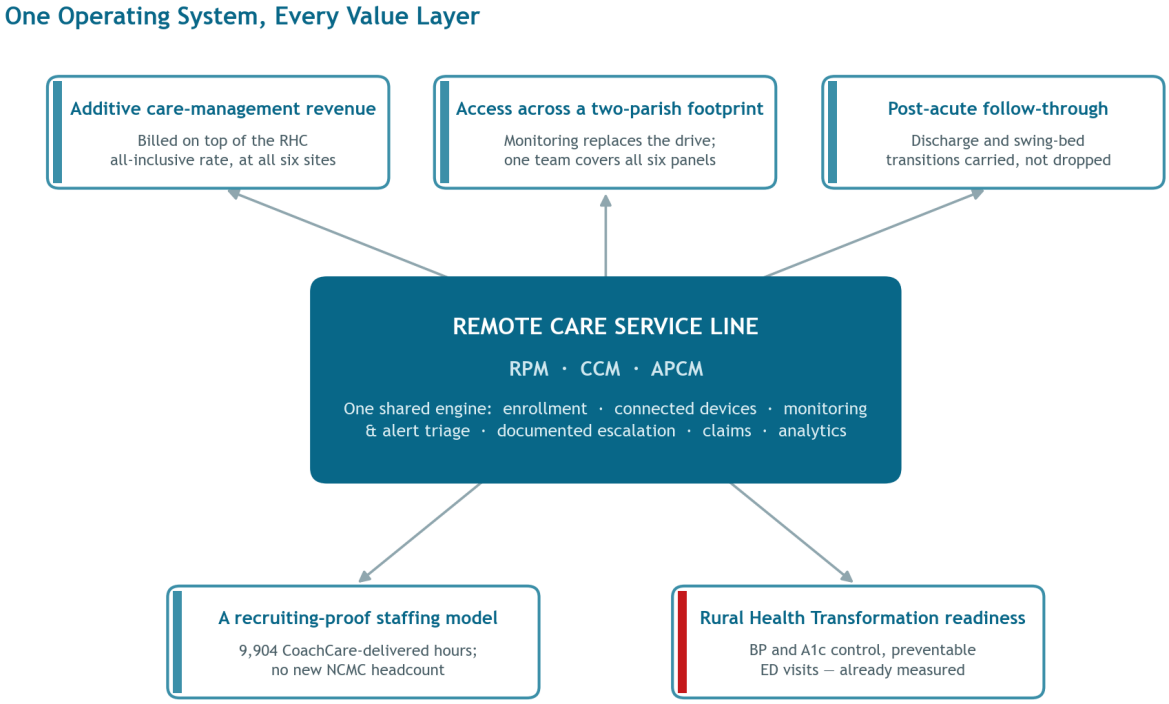

Figure 2. One service line, every value layer. Modeled figures are illustrative — verify against practice data. No Rural Health Transformation Program funding, Medicaid revenue or avoided-cost dollars are included in any modeled financial figure in this report.

How the same infrastructure carries each layer

Value layer	What the shared engine contributes
Additive care-management revenue	Enrollment at scale across six clinic panels, monthly documentation that satisfies the code requirements, and automated claim generation inside Veradigm — the difference between a program and a result.
Access across the footprint	Device-based home readings and monthly structured contact reach patients in Oil City, Plain Dealing and Vivian on the same cadence as patients in Bossier City, from one central team rather than six local ones.
Post-acute follow-through	Any admission, swing-bed stay or emergency visit in the previous 60 days triggers a fixed three-touch cadence with medication reconciliation and a confirmed follow-up appointment — documented, not remembered.
Staffing leverage	9,904 hours of monitoring, outreach and documentation delivered by CoachCare over 24 months, including a CoachCare-funded on-site enrollment specialist, at CoachCare's expense.
Chronic-disease outcome evidence	Blood-pressure and A1c control and preventable emergency visits are measured continuously in the enrolled cohort — the same measures Louisiana committed to CMS under its Rural Health Transformation award (Section 4).

3. The CY2026 Payment Change — and Why This Revenue Is Different

Start with the structural point

Critical Access Hospital and provider-based Rural Health Clinic reimbursement is largely cost-based. That is the design of the programs and it is what protects a rural provider: payment follows allowable cost rather than a fee schedule set for a national average. But it has a consequence that every rural chief financial officer already knows. **For much of what North Caddo does, growing volume also grows the cost base it is paid against** — the number gets larger on both sides of the ledger, and the margin does not scale the way it would in a fee-schedule world.

Care management billed under the Physician Fee Schedule is different in kind. It is paid at a published rate per patient per month, it is separately payable in addition to the all-inclusive rate, and — under the delivery model in this report — its enrollment, monitoring and documentation labor is performed by CoachCare rather than added to North Caddo's cost base. **It is one of the very few lines available to this organization where new revenue is genuinely incremental margin rather than a bigger number on both sides**. That is the structural reason to build this even though the clinics are already busy — and it is why the case does not depend on finding new patients, new visits or new square footage.

What changed, and when

When	What changed	Why it matters at North Caddo
October 1, 2025	**The bundle sunset**	G0511 — the bundled RHC and FQHC general care-management code that aggregated roughly two dozen distinct care-management services into one payment — was last billable September 30, 2025.

When	What changed	Why it matters at North Caddo
January 1, 2026	**Individual codes, national rates**	Certified Rural Health Clinics bill the individual codes as separate line items at national non-facility Physician Fee Schedule rates: CCM (99490 / 99439, complex 99487 / 99489), RPM (99453 / 99454 / 99457 / 99458), PCM, BHI and APCM (G0556 / G0557 / G0558).
Ongoing	**Additive, not substitutive**	These are not carve-outs of the encounter. They are separately payable Medicare lines that sit on top of the clinic's all-inclusive rate — turning between-visit care management from an unfunded cost centre into a revenue line at all six sites.

Time-sensitive — verify before contracting

The G0511 sunset and the January 2026 move to individual-code billing at national non-facility rates are stated from public CY2026 final-rule summaries for rural health clinics as of July 2026. Confirm the exact CY2026 rates, the current concurrency guidance, and any Louisiana-specific billing instruction with North Caddo's Medicare Administrative Contractor — Novitas Solutions, Jurisdiction H — before any contract language. Confirm with the MAC and the organization's cost-report preparer how these separately payable services interact with the all-inclusive rate calculation before relying on the treatment described above.

APCM: the code family built for this panel

Advanced Primary Care Management began January 1, 2025 under the CY2025 Physician Fee Schedule final rule, and Rural Health Clinics may furnish and bill it. Three properties make it the right first wave at North Caddo. It is not time-based — there are no minute thresholds to track, which matters a great deal when the clinical staff at a site is one physician and one advanced practice provider. It requires no device, so enrollment is not gated on logistics. And its top tier is aimed squarely at the population Caddo Parish has in unusual volume.

Tier	Code	Who qualifies	Monthly rate	Modeled share
Level 1	**G0556**	Zero or one chronic condition	$15.49	15%
Level 2	**G0557**	Two or more chronic conditions	$50.67	55%
Level 3	**G0558**	QMB dual-eligible, two or more chronic conditions	$110.46	30%
Blended		Across the modeled 600-patient APCM cohort	**$63.33**	**100%**

CY2026 Physician Fee Schedule rates resolved to North Caddo's Louisiana locality. The tier mix is a modeled distribution across the 600-patient APCM cohort, not a count from North Caddo's records — the actual QMB and dual-eligible count is the single most important number still missing, and it moves this section more than any other assumption in the report. Illustrative, modeled — verify against practice data.

The conservatism in this model, stated plainly

The forecast in this report is built on Louisiana locality rates. Certified Rural Health Clinics bill these codes at **national** non-facility rates. Across this specific code set, Louisiana locality rates run roughly 7–13% below national. Rebuilding the same census on a national-rate basis lifts 24-month net reimbursement by approximately **8%, on the order of $150,000**. Because CoachCare's fees are fixed per active patient-month and do not scale with the reimbursement rate, essentially all of that difference would fall to North Caddo.

Read this as conservatism, not as a promise

Every headline figure in this report uses the lower Louisiana locality basis. The national-rate difference is presented as a disclosure about how the model was built and as upside that is deliberately not counted — not as a committed number, and not as part of any total shown anywhere in this document. Confirm the applicable rate basis for provider-based Rural Health Clinic care-management claims with Novitas Jurisdiction H before it informs any decision. It belongs in the first finance conversation precisely because it can only move in one direction.

Two Louisiana policy changes worth tracking alongside this

Act 859 of 2026, signed June 8, 2026, directs the Louisiana Department of Health to equalize Medicaid reimbursement between independent and provider-based Rural Health Clinics by October 1, 2026. All six North Caddo clinics are provider-based, so the change bears directly on their Medicaid economics. The direction and magnitude of that effect for a provider-based operator are for the organization's finance team and the Department to determine; it is flagged here because it lands in the same quarter as the decisions in this report, not because anything in the model depends on it.

Separately, Louisiana Medicaid work requirements take effect January 1, 2027, with renewal packets mailing in November 2026, and Medicaid is roughly 30% of North Caddo's gross patient revenue. Neither Medicaid revenue nor any Medicaid care-management coverage is included in any figure in this report — the revenue thesis here is deliberately a Medicare and dual-eligible one. Louisiana Medicaid coverage of remote monitoring and care management should be treated as unmodeled upside and confirmed against the current state provider handbook.

One further note on the code set. The CY2026 final rule adds behavioral health integration add-on codes billable alongside APCM by the same practitioner in the same month. North Caddo employs a psychiatric-mental health nurse practitioner at Benton Medical, and Caddo Parish carries a mental health shortage designation with a population-to-provider ratio of 156,408 to 1 — the most extreme access statistic in the public record for this market. That pathway is open. No behavioral health integration revenue is included in any figure in this report.

4. Louisiana's Rural Health Transformation Program

There is a timing argument here that has nothing to do with CoachCare's calendar and everything to do with Louisiana's.

On December 29, 2025, CMS awarded Louisiana **$208.4 million** in Year 1 Rural Health Transformation Program funding — among the largest awards nationally, with an estimated $1.4 billion over five years. The Louisiana Department of Health's funded plan names rural health clinics and critical access hospitals as target recipients. Its technology strategy explicitly funds **remote-monitoring devices** and care-coordination technology; its care-delivery strategy explicitly funds “innovative care models not traditionally billable”; and its care-integration strategy funds regional care conveners and navigation networks. The Governor created a standing Office of Rural Health Transformation and Sustainability by executive order in April 2026.

The windows are open now

Louisiana Department of Health instrument	Deadline	Relevance to this service line
Rural Collaborative Provider Models	**August 5, 2026**	A collaborative delivery model across a rural network is close to what a six-clinic care-management line already is.
Rural Medicaid Alternative Payment Model	**August 7, 2026**	Care-management infrastructure is the operational prerequisite for any alternative payment arrangement — it is what produces the data such an arrangement is scored on.
Regional Care Conveners & Navigation Networks	**August 14, 2026**	Close to a verbatim description of a rural remote-monitoring and care-navigation service covering multiple clinic panels from one team.
Food is Medicine	**August 14, 2026**	Adjacent rather than core; a monthly care-management touch is the delivery channel such a programme needs.
EHR Implementation Partners — request for information	Live	Directly relevant to the Veradigm and Cerner CommunityWorks estate described in Section 8.
Rural Provider VBC/APM Readiness Survey	Live	A zero-cost, high-signal entry point. North Caddo participates in no accountable care or alternative payment arrangement today, so the readiness gap this survey exists to surface is exactly the gap a care-management service line closes.

Deadlines are as published by the Louisiana Department of Health and retrieved in late July 2026. They are perishable. Confirm every date, eligibility condition and submission requirement directly with the Department before relying on it.

What Louisiana told CMS it would measure

This is the part that should shape the conversation. The outcome metrics the Department committed to CMS are chronic-care metrics, not construction metrics.

What Louisiana committed to measure	What a remote care service line produces
Improvement in blood-pressure control among target populations	Device-based home blood-pressure readings between visits, with protocolized outreach on out-of-range trends and titration support rather than waiting for the next appointment.
Improvement in A1c control among target populations	Monthly APCM or CCM contact closes testing gaps and surfaces medication and adherence barriers; glucose monitoring makes control continuous rather than quarterly.
Reduction in potentially preventable emergency department visits	Early detection of decompensation plus a live clinical phone line converts avoidable emergency trips into a same-week clinic touch — against a Caddo Parish baseline 13% above the national emergency-visit rate.
Rural providers using data exchange for care coordination	A structured, chart-attached record of monitoring, escalation and care-plan activity inside Veradigm, exportable as evidence rather than reconstructed from notes.

Louisiana Department of Health Rural Health Transformation plan materials and the CMS-published Louisiana application abstract, retrieved July 2026. Award announced December 29, 2025.

This is a co-application conversation, not a software purchase

North Caddo is a critical access hospital operating six certified rural health clinics in a parish ranked 48th of 64 in Louisiana for health outcomes, in a state that ranks 50th of 50 nationally. It is close to a canonical intended recipient of this program. And the practical asymmetry is straightforward: **a service line already running, with a documented enrollment engine and measurable blood-pressure and A1c results in an enrolled cohort, is a materially stronger application than a service line proposed**. The right first move is not a procurement decision. It is a joint working session on which instrument fits, what the state is actually asking for, and what evidence North Caddo can put in front of it.

The organization has done this before. Public federal award records show USDA Rural Development financing behind the replacement hospital, two USDA community facilities awards in 2022, and a HRSA award received specifically in its capacity as a Rural Health Clinic. The grant-administration muscle exists. Those same records also show a 2021 USDA Distance Learning and Telemedicine award to the district with no funds obligated against it and a period of performance that closed in 2023. Read neutrally, that is evidence the organization has wanted this capability for years, and that what has been missing is a funded delivery path rather than intent.

What this section is and is not

No Rural Health Transformation Program funding is included in any financial figure in this report. Sub-grant eligibility, terms, timing and award decisions are set by the Louisiana Department of Health and by CMS, not by CoachCare, and nothing here should be read as a representation about them. The point is narrower and firmer: the state has published what it intends to fund and what it has agreed to be measured on, and both descriptions fit this service line closely.

5. The Population and the Panel

Being precise about the denominator is the difference between a forecast a chief financial officer can defend and a number that falls apart in the first finance meeting. This section states the market and the panel honestly, including what could not be verified and why.

The need, quantified in CMS and CDC data

Measure	Caddo Parish	National	Difference
Total standardized Medicare payment per capita	$15,831	$12,553	**+26%**
Inpatient covered stays per 1,000 beneficiaries	274	225	**+22%**
Emergency visits per 1,000 beneficiaries	664	591	**+13%**
Acute hospital readmission rate	18.84%	18.07%	+0.8 pts
Adults with high blood pressure	44.0%	—	CDC PLACES, 2024 release

Measure	Caddo Parish	National	Difference
Adults with diagnosed diabetes	17.2%	—	CDC PLACES, 2024 release
Medicare beneficiaries who are dual-eligible	28.2%	~12–13% QMB nationally	**18.1% QMB in Caddo**

Sources and vintages: CMS Medicare geographic variation by county, CY2024 (per-capita payment, stays, emergency visits, readmission); CDC PLACES county estimates, 2024 release (crude prevalence, adults 18 and over); CMS Medicare monthly enrollment, CY2024 (dual-eligible and QMB shares). Caddo Parish ranks 48th of 64 Louisiana parishes for health outcomes; Louisiana ranks 50th of 50 nationally.

Two conclusions follow, and they point in the same direction. Clinically, this is a population whose chronic disease is under-controlled and whose acute utilization is well above the national curve — exactly the profile on which continuous monitoring and monthly structured contact have the most room to work. Commercially, the dual-eligible and QMB density means the top APCM tier is unusually well populated: **18.1% of Caddo Parish Medicare beneficiaries are QMB against roughly 12–13% nationally**. G0558 pays $110.46 per patient per month at Louisiana rates. That single demographic fact is why APCM, not RPM, is the largest revenue line in this model — the inverse of what the same model produces in a suburban commercial market.

From the panel to the enrolled census

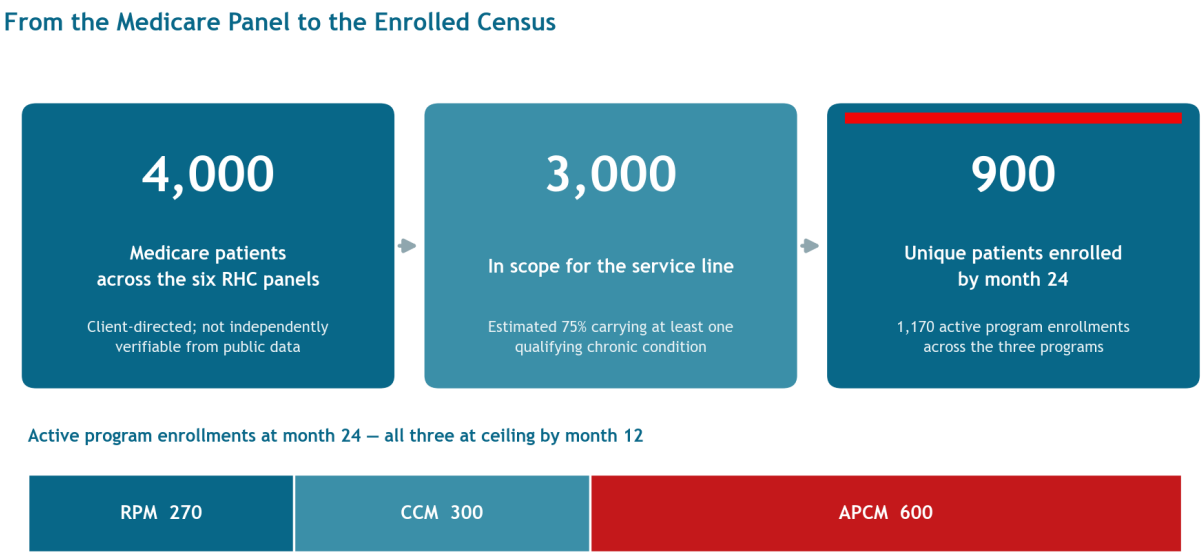

Figure 3. From the Medicare panel to the modeled billable core and the enrolled census at month 24. The 4,000 panel is client-directed and the 75% in-scope share is an estimate; neither is a chart count. Illustrative, modeled — verify against practice data.

The model runs on 4,000 Medicare patients across the six Rural Health Clinic panels, of whom 3,000 are treated as in scope — an estimated 75% carrying at least one remote-care-eligible chronic condition. By month 24 the model carries 900 unique enrolled patients and 1,170 active program enrollments: 270 on RPM, 300 on CCM and 600 on APCM. All 270 RPM patients sit inside the two care-management cohorts, which is the correct shape — remote monitoring is depth on the sickest slice of the panel, not additional breadth.

Why 4,000 is a credible working figure — and still a discovery item

The 4,000-patient panel is client-directed and cannot be confirmed from any public dataset, for a structural reason rather than a gap in the research. Provider-based Rural Health Clinic encounters are billed institutionally under the clinic's own CCN at the all-inclusive rate, not under the Physician Fee Schedule by individual clinician, so they are largely invisible in the CMS physician utilization files. What can be done is to triangulate it from three independent directions, all of which land in the same band.

Estimation route	Basis	Implied Medicare panel
Audited visit volume	48,865 clinic visits in FY2024 at a conventional three to four primary-care visits per patient per year implies roughly 12,000–16,000 unique clinic patients; the audited payer mix puts Medicare-lineage revenue at about 48% of gross patient revenue	**~3,600–4,800**
Provider supply	Roughly ten primary-care clinician FTEs across the six clinics at conventional rural panel sizes and a 25–35% Medicare mix	**~3,700–4,500**
Market share	Caddo and Bossier parishes together hold 75,451 Medicare beneficiaries (CY2024); a 4,000 panel is 5.3% of that market for the only critical access hospital and six-clinic primary-care network in the northern half of it	**Proportionate**

Audited figures from the Louisiana Legislative Auditor FY2024 statements; Medicare enrollment from CMS, CY2024. The bands above are estimation arithmetic, not counts.

Discovery item #1 — the panel count, the condition share, and the QMB count

Three numbers set the denominator, the APCM tier mix and therefore the entire forecast: the Medicare panel count by clinic, the share of it carrying a qualifying chronic condition (modeled at 75%), and the dual-eligible and QMB counts (the APCM tier mix is modeled at 15 / 55 / 30). None is taken from North Caddo's records in this report.

The authoritative sources are the organization's own Rural Health Clinic cost-report visit counts by clinic CCN and its Veradigm practice-management panel report. The model is built to be re-run against them in an afternoon, and it should be, before any of these figures is used in a budget.

The honest constraint — and why it is good news

All three programs reach their eligible-population ceilings by month 12 and hold flat through month 24. That is not an enrollment-pace problem. Fourteen panel-owning providers and one CoachCare-funded on-site enrollment specialist saturate a 3,000-patient in-scope panel inside a year. The forecast is therefore constrained by **the size of the confirmed in-scope population**, not by how fast patients can be enrolled — which means the leverage runs one way. A larger confirmed population, or a higher confirmed chronic-condition share, scales this entire forecast close to proportionally. Adding a second on-site enrollment specialist would not move the number; the ceiling binds first. That is a useful thing for a chief financial officer to know before, rather than after, a contract.

6. Geography, Access and the Post-Acute Handoff

North Caddo runs six family-practice sites from the hospital campus on South Pine Street in Vivian out to South Bossier — roughly 35 miles end to end across two parishes and both sides of the Red River. Oil City and Vivian sit in the far north of Caddo Parish, near the Texas and Arkansas lines; Plain Dealing sits at the top of Bossier Parish; Benton is central Bossier; Blanchard is on the north Shreveport edge; South Bossier is at the metro's southern end. Vivian is about 32 miles and 35 minutes from the nearest tertiary care in Shreveport.

That footprint is the organization's greatest strength and the exact reason chronic disease is hard to hold steady between visits. A hypertensive patient in Oil City is seen a few times a year. In between, nobody sees a blood pressure. The clinic learns what happened at the next appointment, or at the emergency department. Remote care closes that gap without asking the patient to drive: the reading travels instead of the patient, a care manager works it, and travel is requested only when travel is actually the answer.

Where the current posture leaves a gap

North Caddo's published telehealth offering is a telephone or FaceTime conversation for established patients, available at three of the six clinics. It is a real service and it solves a real problem — a visit without a drive. What it does not do is produce a continuous physiologic record, a monthly documented care-management touch, or a billable recurring line. Those are different capabilities from a video visit, and they are the ones the CY2026 code set now pays a Rural Health Clinic to deliver. Stated structurally: the organization has the panel, the certification and the clinical relationships, and does not yet have the monitoring and billing rail underneath them.

A centrally staffed team covers all six panels

A six-site, two-parish footprint is precisely the geometry that makes centralized monitoring worth more than it is worth in a single-site practice. One monitoring and care-management team covers every clinic panel from one place; a CoachCare-funded on-site enrollment specialist rotates where enrollment volume is; devices are shipped, provisioned and supported directly to the patient. The devices are cellular-connected — no home Wi-Fi, no router credentials, no Bluetooth pairing for the patient to manage. In a rural parish with 22.5% poverty and a Medicare population averaging 73 years of age, that is not a convenience feature; it is the difference between a device that transmits and a device in a drawer.

There is a ready-made adherence loop attached to it. North Caddo operates three Community RX pharmacies with free next-day mail delivery of maintenance medications. A monthly care-management contact that surfaces a refill lapse has somewhere to send it the same day. No pharmacy effect is included in any modeled figure in this report.

The post-acute handoff — a Critical Access Hospital advantage

North Caddo is unusual among the organizations this analysis is normally run for, because it owns both ends of the transition. It operates a 24-hour emergency department that saw 5,490 visits in the last audited year, 25 certified beds carrying 328 acute admissions, and an active swing-bed program — 76 admissions and 1,154 days at a 15-day average stay — covering wound care, post-surgical recovery, stroke rehabilitation, and cardiac and pulmonary rehabilitation. It also owns the primary-care panel those patients return to.

Today the handoff between those two ends depends on the next scheduled appointment. Under a remote care service line it becomes a protocol: any admission, swing-bed stay or emergency visit in the previous

60 days triggers a fixed three-touch cadence — medication reconciliation and a confirmed follow-up appointment in days 1–2, adherence and trigger review in days 5–8, medication and risk re-assessment in days 12–14 — with the patient already on monitoring when they get home. A 15-day swing-bed stay is an unusually good enrollment moment: the patient is present, the diagnosis is fresh and the care team already has their attention.

The same logic runs upstream. Caddo Parish beneficiaries are admitted 22% more often and visit the emergency department 13% more often than the national average. A share of that volume is decompensation that was visible days earlier in a blood pressure or a weight trend. Detecting it early converts some of those episodes into a clinic touch or a locally managed stay rather than an unplanned transfer out of the parish — which matters clinically for a patient 35 minutes from tertiary care, and matters organizationally for a hospital that has inpatient and swing-bed capacity available.

Scope discipline on the avoided-hospitalization figure

The model projects **36 avoided hospitalizations over 24 months**, roughly $542,600 of avoided acute cost at $15,000 per admission. That figure is excluded from every revenue number in this report and is not counted as North Caddo revenue anywhere.

It is worth naming the nuance directly, because a chief financial officer will: North Caddo owns inpatient beds, so an avoided admission is not automatically a financial gain to the hospital. It is presented here as a clinical and utilization argument — the point of the exercise, and the evidence base for the outcome measures in Section 4 — not as a financial one.

7. Staffing Leverage — A Recruiting-Proof Model

The reimbursement is the reason the service line survives a budget review. This is the reason it is worth running: the clinical work performed, and the labor a rural organization in a shortage-designated market does not have to hire.

Modeled 24-month output	Figure	What it means
Staff-hours delivered by CoachCare	**9,904**	Roughly a 4.8 FTE-equivalent of enrollment, monitoring, outreach and documentation performed by CoachCare — not headcount North Caddo hires, and not hours added to existing clinic staff.
Reimbursable claims	**22,054**	Recurring professional-fee volume generated automatically inside the Veradigm workflow rather than assembled by hand each month.
Physiologic readings	**56,973**	A continuous picture of blood pressure, weight and glucose between visits — the raw material for chronic control and for any outcome measure the organization is asked to report.
Hospitalizations avoided	**36**	Approximately $542,600 of avoided acute cost at roughly $15,000 per admission. A system-level clinical benefit — not North Caddo revenue, and not counted as such anywhere in this report.

Illustrative, modeled — verify against practice data.

Why the staffing model is the argument, not a footnote

North Caddo staffs its six clinics with roughly one physician and one advanced practice provider apiece. The Louisiana Department of Health reports that 73% of the state's residents live in a primary care health professional shortage area, and among rural Louisiana adults it reports diabetes prevalence 42% above the urban figure and heart disease prevalence 32% above it. The shortage is not abstract here: the Vivian clinic carries its own facility-level HRSA automatic shortage designation — scored 19 in primary care, in mental health and in dental, flagged rural, designated November 2025 — and every clinic sits in a parish carrying an active primary care shortage designation. It is also the reason all six sites can hold Rural Health Clinic certification at all, since certification requires a current shortage or underserved designation no more than four years old.

Against that, the binding constraint on any new care-management program is people, not intent. A vendor that ships software and asks the organization to hire two care managers has handed it the hardest part of the problem. CoachCare supplies the enrollment and engagement labor — telephonic outreach, a CoachCare-funded on-site enrollment specialist, device logistics, monitoring and alert triage, and the documentation each code requires. **The on-site enrollment specialist is CoachCare's expense. It is embedded in the delivery model and is not subtracted from North Caddo's margin anywhere in this analysis.**

There is a second-order benefit worth naming. North Caddo is the anchor site of the LSU Health Shreveport Family Medicine Rural Residency, and six of its seven family medicine physicians came through that program. A structured, protocol-driven chronic-care service line is a teachable asset — residents who learn population management on a real enrolled cohort are more likely to stay and practise it. Recruiting is the hardest problem a rural hospital has; this is one of the few programs that helps with it rather than adding to it.

Who does what

Function	CoachCare	North Caddo
Enrollment	Telephonic outreach and a funded on-site enrollment specialist; consent, eligibility screening and program education	Provider endorsement at the point of care; the attribution policy
Devices and logistics	Cellular-connected cuffs, scales and glucometers; shipping, provisioning, replacement and patient support	Nothing to procure, configure or warehouse
Monitoring and triage	Daily physiologic review, protocolized outreach, alert triage and escalation to the named clinic contact	Escalation preferences, the named recipient, and the response
Documentation and claims	Evidence of care, vitals and care plans into the chart; automated claim creation each month	Claim submission and revenue-cycle ownership
Clinical decisions	Executes to North Caddo's documented protocols; never makes a clinical decision	**Every clinical decision, protocol and standing order**

8. Veradigm Integration

North Caddo runs a split stack, and the distinction matters operationally. The six Rural Health Clinics run **Veradigm's cloud EHR**, with FollowMyHealth as the clinic patient portal — which is exactly where care-

management enrollment, documentation and billing live. The hospital runs **Cerner CommunityWorks**, Oracle Health's build for critical access and community hospitals, with its own separate patient portal. Both are identifiable from the organization's own published links. The volume tells you where a care-management program belongs: 48,865 clinic visits a year against 328 acute admissions. This report targets the Veradigm side. The hospital record is an integration conversation about acute and swing-bed data flow, not a prerequisite to launching the service line. There is no Epic exposure on either side.

Veradigm is one of CoachCare's integrated EHRs, so this is a configured integration rather than a custom build, and the program lives inside the chart and the billing workqueues North Caddo's staff already use. Clinicians and billers stay in Veradigm; enrollment flags, discrete vitals, evidence of care, care plans and claims move between the two systems automatically. In a typical deployment, patients begin services in under five days.

Capability	What it does	Operational effect
Integrated enrollment	Ordering and enrollment prompted inside Veradigm, with enrollment flags and real-time status in the existing workflow	Care teams enroll qualified Medicare patients at the point of care instead of working a separate list in a separate system.
Enrollment by services and devices	Enrollment specified by program and by device at the point of order	The right patient goes onto the right rail — APCM, CCM, RPM or a combination — under the written attribution policy rather than by memory.
Exchange of health history	Problem list, medications and history flow to the monitoring team	The monitoring team works from the same record the clinic sees, rather than a parallel chart that drifts.
Integrated vital reports	Home blood pressure, weight and glucose returned to the chart	Readings land as trendable clinical data attached to the patient record, not as documents someone has to open.
Compliance documentation and integrated care summary	Evidence of care, vitals and care plans attached to the chart monthly	The documentation each code requires is produced as a by-product of the work, which is what makes the record audit-ready rather than merely visible.
Claims generation to Practice Management	Claims created automatically by the CoachCare billing engine	Eliminates the manual claim-creation step for each patient every month — the single most common failure mode in care-management programs.

The differentiator worth naming specifically

CoachCare is the only care-management application integrated with Veradigm Practice Management that creates claims automatically through its own billing engine, eliminating the manual claim-creation step for each patient every month.

For a service line whose entire economics depend on monthly capture across 1,170 active enrollments and roughly 22,054 claims over 24 months, that is the difference between a model and a result. Monthly capture rate — billable months divided by eligible enrolled months — is the single operational variable that determines whether a care-management forecast is realized, and automating it removes the most common way these programs quietly underperform.

Confirm in discovery — and again at contracting

The Veradigm clinic environment and the Cerner CommunityWorks hospital environment are both identifiable from public sources, but the specific Veradigm edition and Practice Management footprint should be confirmed with Ross Hansen, the chief information officer, since they determine the exact integration path and timing. Whether the two systems are integrated today, and which system the Rural Health Clinic claims are generated from, are open items. Integration scope — which interfaces are in scope, what configuration is required, and the implementation timeline — is a contracting confirmation, not an assumption of this report.

9. Implementation Playbook

Goals and scope

Stand up a managed remote care service line that is self-funding on its own economics across all six Rural Health Clinics within the first year. Scope: APCM plus CCM plus RPM, billed by North Caddo, on the Medicare panel, delivered full-service by CoachCare with no new North Caddo headcount. Chartered in 30 days; billing by day 90.

Target populations, in launch order

- **QMB and dual-eligible patients with two or more chronic conditions — launch first.** Where the economics and the clinical need converge. No devices, no minute-tracking, first billable month inside the quarter, and the cleanest possible early proof of capture rate and revenue per patient-month.
- **The hypertension and diabetes cohorts.** Layered onto RPM second, because that is where device data actually changes management — and where Caddo Parish's 44.0% hypertension and 17.2% diabetes prevalence concentrate the opportunity.
- **Multi-chronic Medicare patients outside the APCM arm.** Carried on CCM plus RPM under the written attribution policy.
- **Post-discharge, post-swing-bed and post-emergency patients.** Any admission, swing-bed stay or emergency visit in the previous 60 days triggers the three-touch cadence — the concrete loop behind the avoided-hospitalization figure.

Staffing, technology and billing architecture

- **CoachCare-delivered labor.** Telephonic enrollment, a CoachCare-funded on-site enrollment specialist rotating across the six sites, health coaches, monitoring and alert triage, and documentation — 9,904 staff-hours over 24 months, roughly a 4.8 FTE-equivalent, at CoachCare's expense. North Caddo adds no headcount to launch.
- **Devices that work in a rural panel.** Cellular-connected blood-pressure cuffs, scales and glucometers, shipped, provisioned and supported directly to the patient — no home Wi-Fi, no router credentials, no Bluetooth pairing for the patient to manage.
- **Native Veradigm integration from launch.** Enrollment, orders, discrete vitals, evidence of care, care plans and claims run inside Veradigm per Section 8, subject to the scope confirmations noted there.

- **Billing architecture built for capture.** Automated claim generation for every eligible patient every month, with the APCM-versus-CCM attribution policy enforced in the workflow rather than remembered by a biller.

Clinical workflow and escalation governance

Steady state: enroll at a clinic visit, on provider referral, or through telephonic outreach → ship and activate connected devices where the program calls for them → daily physiologic data and monthly structured contact into a monitoring and triage layer → protocolized outreach on out-of-range trends → documentation and claim generation inside Veradigm → monthly scorecard to service-line governance. Every RPM, CCM and APCM finding runs through a documented protocol rather than ad hoc triage.

Routing	Trigger	What happens
Emergent	An active emergent symptom reported live during outreach — chest pain, new shortness of breath, stroke signs, syncope, worst-ever headache, sudden swelling	The care team calls 911 with the patient still on the line. If the patient refuses, CoachCare loops in the clinic; if the clinic is unavailable, CoachCare activates 911 itself. The urgent and emergent policy supersedes any local escalation preference — the response never waits on a callback.
Critical value	A critical reading, regardless of symptoms	Escalates regardless of symptoms. An out-of-range value first gets a retake plus a symptom check; a trend is defined objectively — three consecutive out-of-range readings at least an hour apart — rather than by a single stray number.
Non-critical clinical change	A confirmed trend or clinically meaningful change that is not emergent	Routed to a defined member of North Caddo's care team for review and follow-up — the right person at the right clinic, not a broadcast page across a six-site network.
Stable or resolved	A reading that normalizes, or a resolved finding	Documented in the record for continuity, without interrupting anyone.
Post-acute	Any hospitalization, swing-bed stay or emergency visit in the previous 60 days	A fixed three-touch sequence: days 1–2 stabilize, reconcile medications and confirm a 7–14 day follow-up; days 5–8 verify adherence, re-evaluate triggers and confirm the appointment happened; days 12–14 review medications and risk and re-assess symptoms.

Every escalation documents the vital, the findings, the method of contact, who was reached, the outcome and the follow-up. A patient who cannot be reached is escalated to the clinic and re-escalated on a fixed cadence, and no change to a patient's monitoring status happens without the clinic informed. In a rural panel where patients move, change phone numbers and miss appointments, that record is what converts a hard-to-reach patient into a documented longitudinal touch — which is simultaneously the clinical goal, the billing requirement and the outcome evidence.

Service-line scorecard

Clinical	Operational	Financial
Share of enrolled hypertensive patients at goal	Enrolled patients and enrolled services by program and by clinic	Monthly capture rate — billable months divided by eligible enrolled months
A1c testing and poor-control rates in the enrolled cohort	Time to first billable enrollment	Net revenue per patient per month, by program
Readings per patient per month	Successful-contact rate and attrition	Net to North Caddo after all fees
Admissions, emergency visits and 30-day readmissions in the enrolled cohort	Escalations by category and time to resolution	Claims generated and denial rate by code
	Device provisioning and activation lead time	Revenue per clinic site

Expected impact and 12-month roadmap

Modeled 24-month impact, illustrative and to be verified against practice data: **$1,768,761** of net professional-fee reimbursement, **$746,264 net to North Caddo** after all CoachCare fees, 22,054 reimbursable claims, 56,973 physiologic readings, roughly 36 avoided hospitalizations, and 9,904 staff-hours delivered by CoachCare. 900 enrolled patients and 1,170 enrolled services under active management at month 24. 24-month margin: 42.2% of net reimbursement (Year 1 40.9%, Year 2 43.0%). Month 1 nets −$3,545; the line is positive from month two onward with no sustained negative period, and reaches a steady state near $38,892 per month.

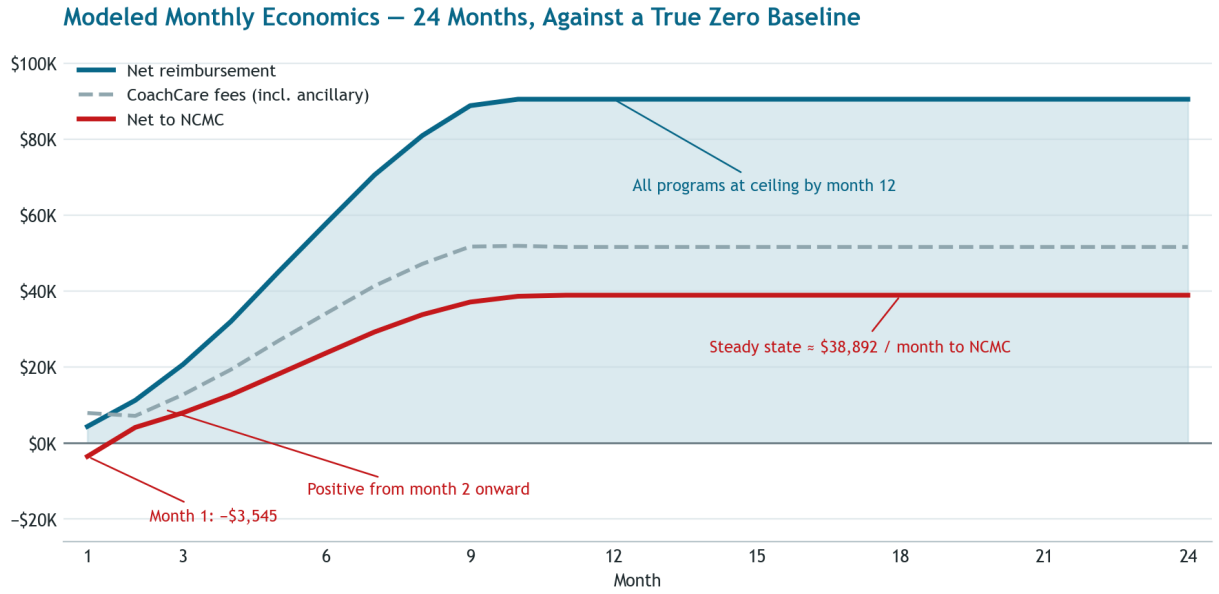

Figure 4. Modeled monthly economics — net reimbursement, total CoachCare fees, and net to North Caddo, drawn against a true zero baseline so the month-1 position is visible rather than hidden. Fees include one-time implementation, EMR integration and telephonic enrollment. Illustrative, modeled — verify against practice data.

- **Days 0–30 — charter the service line, and answer Louisiana.** Named owner, P&L and scorecard; Veradigm integration and billing configuration; the APCM-versus-CCM attribution policy;

protocol sign-off for hypertension, diabetes, heart failure and COPD with the cardiology clinic consulted; confirm the Medicare panel count by clinic, the qualifying-condition share and the dual-eligible and QMB counts. In parallel, complete the Rural Provider VBC/APM Readiness Survey and decide which Rural Health Transformation window to answer.

- **Days 31–90 — launch APCM on the dual-eligible cohort at Vivian and Blanchard.** Start where the economics and the clinical need converge, at the two sites carrying 64% of clinic visits. No devices, no minute-tracking, first billable month inside the quarter, and the cleanest early proof of capture rate and revenue per patient-month.
- **Days 91–180 — layer RPM and scale CCM across all six clinics.** Extend device-based monitoring across the hypertension and diabetes cohorts; activate CCM for multi-chronic Medicare patients outside the APCM arm; stand up the post-acute three-touch cadence off the emergency department and swing-bed census; monthly scorecard to service-line governance.
- **Days 181–365 — prove the outcomes and put them to work.** Report blood-pressure and A1c control and emergency-visit rates in the enrolled cohort against the cohort's own baseline; take that evidence into the Rural Health Transformation conversation; settle the national-rate basis with the MAC; and re-run the forecast against the now-confirmed panel.

References & Data Sources

- CMS Provider of Services File — Quality Improvement and Evaluation System, Hospital and Other Facilities, Q2 2026. Source of the Critical Access Hospital certification and subtype, 25 certified beds, swing-bed approval, dedicated emergency department, 2001 original participation and state “necessary provider” designation, and the certification, provider-based status and parent provider number of all six Rural Health Clinics. Vintage: Q2 2026.
- CMS Hospital General Information and CMS Hospital Enrollments (file dated July 17, 2026) — facility identification, hospital type, government hospital district ownership, emergency services. Retrieved July 2026.
- Louisiana Legislative Auditor — North Caddo Hospital Service District audited financial statements for the years ended June 30, 2024 and 2023 (auditor Eide Bailly LLP), the most recent posted. Source of operating results and the three-year trend, the one-time Employee Retention Credit and its pending status, property and sales tax revenue, the audited payer mix, and the FY2024 utilization figures: 48,865 clinic visits by site, 5,490 emergency department visits, 328 acute admissions at a 4.16-day average stay, and 76 swing-bed admissions across 1,154 days. Vintage: FY2024. No FY2025 audit was posted as of July 2026.
- CMS Hospital Provider Cost Report, fiscal year ended June 30, 2024 — charge mix, cost structure, bed count, occupancy and FTE employees.
- CMS Medicare Geographic Variation by National, State and County, CY2024 — Caddo Parish standardized Medicare payment per capita, inpatient stays per 1,000, emergency visits per 1,000, acute readmission rate, and the national comparison figures.
- CMS Medicare Monthly Enrollment, CY2024 annual county rows — total Medicare beneficiaries in Caddo and Bossier parishes, dual-eligible share and Qualified Medicare Beneficiary share.
- CDC PLACES County Data, 2024 release — model-based small-area estimates of high blood pressure, diabetes, coronary heart disease, COPD and stroke prevalence among adults 18 and over in Caddo and Bossier parishes.
- U.S. Census Bureau, American Community Survey 2024 5-year estimates — population, population 65 and over, median household income and poverty rate for Caddo and Bossier parishes.
- HRSA shortage-designation data, retrieved July 2026 — the facility-level automatic health professional shortage area designations attached to the Vivian Rural Health Clinic in primary care, mental health and dental (each scored 19, designated November 2025, flagged rural); the active parish-level primary care, mental health and dental designations for Caddo and Bossier, including the Caddo mental health population-to-provider ratio; and the medically underserved area designations covering both parishes.

- CMS CY2026 Physician Fee Schedule — care-management and remote-monitoring codes (APCM G0556 / G0557 / G0558; CCM 99490 / 99439 and complex 99487 / 99489; RPM 99453 / 99454 / 99457 / 99458; short-window codes 99445 / 99470), resolved to North Caddo's Louisiana locality (Novitas Solutions, Jurisdiction H, locality 99). Illustrative magnitudes — verify against the current schedule and the organization's MAC.
- CY2025 and CY2026 Physician Fee Schedule final rules and public summaries for rural health clinics and federally qualified health centers — sunset of the bundled G0511 code effective after September 30, 2025; individual-code billing at national non-facility rates from January 1, 2026, separately payable in addition to the all-inclusive rate; APCM billable by rural health clinics; CY2026 behavioral health integration add-on codes. Stated as of July 2026; confirm with the MAC before contracting.
- Louisiana Department of Health — Rural Health Transformation Program award announcement (December 29, 2025), the Department's Rural Health Transformation Program page carrying the current sub-grant windows and surveys, its 2026 rural health materials, and the CMS-published Louisiana Rural Health Transformation application abstract. Source of the $208.4M Year 1 award and estimated five-year total, the goal and strategy matrix naming remote-monitoring devices, care-coordination technology, care models not traditionally billable and regional care conveners, the naming of rural health clinics and critical access hospitals as target recipients, the published application deadlines, and the committed outcome metrics on blood-pressure control, A1c control and preventable emergency visits. Deadlines retrieved late July 2026 and perishable.
- Louisiana Act 859 of 2026 (House Bill 971), signed June 8, 2026 — equalization of Medicaid reimbursement between independent and provider-based Rural Health Clinics by October 1, 2026. Louisiana Department of Health materials on Medicaid work requirements effective January 1, 2027, with renewal packets mailing November 2026.
- County Health Rankings, Louisiana (Caddo Parish ranked 48th of 64 parishes for health outcomes) and America's Health Rankings 2025 Annual Report (Louisiana ranked 50th of 50). Also cited by the Louisiana Department of Health in its funded CMS application.
- CMS Rural Health Clinic fact sheet and Medicare Benefit Policy Manual Chapter 13 — Rural Health Clinic location eligibility, including the non-urbanized-area requirement and the current shortage or underserved designation requirement.
- USAspending federal award records for North Caddo Hospital Service District, retrieved July 2026 — two 2022 USDA community facilities awards, a 2021 HRSA Rural Health Clinic Vaccine Confidence Program award, and a 2021 USDA Distance Learning and Telemedicine award showing no obligated funds and a period of performance closing in 2023. USDA Rural Development financing of the replacement hospital completed in 2017.
- North Caddo Medical Center public website and board materials — services, six clinic locations, provider roster, administration page, board agendas and minutes from March 2026 forward, telehealth page, Community RX pharmacy, careers portal, and the two published patient portals identifying Veradigm FollowMyHealth on the clinic side and Oracle Health on the hospital side. LSU Health Shreveport Family Medicine Rural Residency materials identifying North Caddo as the anchor site. Reviewed July 2026. The absence of a published remote monitoring or care-management program, and the absence of a care-management role among current open postings, are absence-based findings.
- Caddo Parish Commission — North Caddo Hospital Service District governance, board composition and appointment terms.
- CoachCare / Veradigm integration overview — integrated enrollment, enrollment by services and devices, exchange of health history, integrated vital reports, compliance documentation and integrated care summary, and claims generation to Practice Management.
- CoachCare Care Management standard operating procedures — escalation decision logic, the urgent and emergent policy, and the post-acute three-touch cadence.
- CoachCare Value Analysis (2026) — modeled economics for North Caddo Medical Center on a 4,000-patient Medicare panel with 3,000 in scope at the Louisiana locality; source of all illustrative financial, clinical and operational figures in this report. Companion workbook available.

Verification and validation caveat

All financial figures in this report are illustrative, modeled outputs of a CoachCare Value Analysis under the stated assumptions — verify against practice data — and are not a guarantee of reimbursement or revenue. Verify all rates against the current-year Physician Fee Schedule and the organization's actual MAC locality before contracting.

The modeled panel is a discovery-stage figure, not a chart count. The 4,000-patient Medicare panel is client-directed and cannot be verified from public data, because provider-based Rural Health Clinic encounters are billed institutionally under the clinic CCN rather than under the Physician Fee Schedule by individual clinician; the three estimation bands in Section 5 are arithmetic, not counts. The 75% qualifying-condition share and the APCM tier mix are estimates. Public sources do not name a chief medical officer, quality director, compliance officer or revenue cycle manager; provider counts differ across three public sources and are treated as approximate; and the FY2025 audit was not yet posted at the time of writing. Each is carried as a discovery item rather than asserted.

CY2026 rural health clinic care-management billing rules, including the sunset of G0511 and the move to individual-code billing at national non-facility rates in addition to the all-inclusive rate, are stated from public CMS and industry summaries as of July 2026 and must be confirmed with the organization's MAC and its cost-report preparer. The national-rate sensitivity described in Section 3 is a modeling disclosure and an upside; it is not included in any total in this report. No Rural Health Transformation Program funding is included in any figure, and sub-grant eligibility, terms and deadlines are set by the Louisiana Department of Health and CMS and must be confirmed directly with the Department. Organizational, financial, clinical and market facts are sourced from CMS, CDC, HRSA, the Census Bureau, the Louisiana Legislative Auditor, the Louisiana Department of Health and the organization's own public materials as of July 2026, with data vintages stated, and should be confirmed at the time of decision.

Contact

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