Samaritan Healthcare

Grant County Public Hospital District No. 1 · Moses Lake, Washington

COACHCARE | SERVICE LINE STRATEGY

A public hospital district that anchors care across the Columbia Basin: a 50-bed sole community hospital in a new campus opened March 2026, two Medicare-certified rural health clinics, and an Epic record shared across all three

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the district's Medicare patients across a rural service area: remote physiologic monitoring, chronic care management and advanced primary care management, billed as individual codes at national amounts on top of the clinic's encounter rate since January 2026, staffed by CoachCare, and run inside the Epic record the district already uses.

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Samaritan Healthcare. It brings together the district's public record, the Medicare structure of Grant County, the billing rules a rural health clinic works under since January 2026, a 24-month Value Analysis for a remote care service line on the Medicare panel, the clinical governance that would run it, the Epic integration it lives in, the Enhanced-track accountable-care footprint beside it, and the operational design a Columbia-Basin program has to get right.

The argument is short. Distance is the adherence problem in a rural service area, and remote care is the way a clinic keeps a daily touch on chronic disease without asking the patient to drive. Since January the district can bill that month of care as its own codes, at national amounts, on top of every visit. The revenue lands as margin in the same year it starts, it needs no capital, and the people to run it are ours.

Table of Contents

Executive Summary

Samaritan Healthcare is Grant County Public Hospital District No. 1, a Washington public hospital district governed by an elected board of commissioners and organized in 1947. It anchors care for the Columbia Basin from Moses Lake: a 50-bed sole community hospital, whose $225 million replacement campus opened in March 2026, and two Medicare-certified rural health clinics, all on one Epic record live since 2021.[1] The district is a participant in an Enhanced-track Medicare Shared Savings Program accountable care organization whose first performance year is 2026.[2]

What the record does not yet show is a between-visit chronic-care revenue line. The district's public materials describe video-visit telehealth and an Epic patient portal, and no remote physiologic monitoring or chronic-care-management program at meaningful scale was evident; there is no CMS claims signal of one either.[3] Chronic-disease patients across a rural service area are seen a few times a year, and the distance between visits is the adherence problem the district cannot staff its way around.

Grant County's Medicare population is 33.6% Medicare Advantage, so two-thirds of Medicare here is still Original Medicare, and that traditional fee-for-service base is the billable population for remote care.[4] Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

The observation this report is built on

Distance is the barrier, and remote care is the answer to it. Since January a rural health clinic bills the month of care between visits as its own codes, at national amounts, on top of every encounter. The revenue lands as margin in the same year it starts and it needs no capital, right after a $225 million capital cycle closed. The panel is large enough to matter and it saturates inside the first year. The people to run it are ours.

G0511, the bundled code rural clinics used for care management, was retired on September 30, 2025. From January 1, 2026 a rural health clinic bills chronic care management, remote physiologic monitoring and advanced primary care management as individual codes at national non-facility Physician Fee Schedule amounts, in addition to the clinic's all-inclusive encounter rate.[5] The short-window remote-monitoring codes new for 2026 (99445, 99470) bill the partial months a hospital discharge creates.

What the Value Analysis returns

The forecast prices a service line for the district's own Medicare panel, modeled at 3,000 traditional fee-for-service patients across the rural health clinics, Original Medicare and Medicare Advantage together, referred by the district's primary-care and internal-medicine staff and delivered by CoachCare under the district's clinical direction, priced at the national amounts a rural clinic is paid for these codes.[6]

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[1] The district's public record and regional reporting, retrieved September 2026: Grant County Public Hospital District No. 1, founded 1947, governed by an elected board of commissioners; Samaritan Hospital, a 50-bed acute-care hospital whose $225 million replacement campus opened March 2026; two rural health clinics; Epic live across the district since 2021 with the MyChart patient portal.

[2] CMS Medicare Shared Savings Program participant file, PY2026, matched on the district's legal business name: an Enhanced-track (two-sided-risk), high-revenue, prospectively-assigned accountable care organization with a first performance year of 2026.

[3] The district's public materials, September 2026: video-visit telehealth across departments and the Epic patient portal. No remote physiologic monitoring or chronic-care-management program at meaningful scale was evident in the public record, and no CMS claims signal of one appears under the district's facilities. Rural-clinic care management bills institutionally and is not visible in the physician claims files, so current state is to be confirmed with the district.

[4] CMS Medicare Advantage county penetration and Medicare Monthly Enrollment, CY2024, Grant County: 17,859 beneficiaries, 11,854 (66.4%) in Original Medicare, Medicare Advantage penetration 33.6%.

[5] CY2025 Physician Fee Schedule Final Rule: rural health clinics and Federally Qualified Health Centers report the individual CPT and HCPCS codes for care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the all-inclusive encounter rate; G0511 retired September 30, 2025 after a transition period; advanced primary care management adopted on the same basis. CY2026 Final Rule for 2026 dates of service, including 99445 and 99470.

[6] CoachCare Value Analysis for Samaritan Healthcare, 2026. Basis: CY2026 national non-facility Physician Fee Schedule amounts; 3,000 Medicare patients in scope; 24 referring clinicians; RPM, CCM and APCM.

	Year 1	Year 2	24 months
Net reimbursement	**$869,817**	**$1,486,565**	**$2,356,382**
CoachCare fees	$506,205	$849,033	$1,355,239
Net to the district	**$363,612**	**$637,532**	**$1,001,143**
Margin to the district	41.80%	42.89%	**42.49%**

CoachCare Value Analysis. CY2026 national non-facility Physician Fee Schedule amounts, the rail a rural clinic bills care-management codes on. 3,000 Medicare patients in scope; RPM + CCM + APCM. Margin is net to the district divided by net reimbursement.

1. **This is a $1.0 million two-year net line, and it clears $1,000,000 net to the district with the panel modeled conservatively.** Over 24 months the service line produces $2,356,382 in net reimbursement, $1,355,239 in CoachCare fees, and $1,001,143 net to the district, a 42.49% margin, 41.80% in Year 1 and 42.89% in Year 2. It carries no capital cost.
2. **The program funds itself from the second month.** Month 1 nets −$4,428 to the district, because implementation and the Epic integration land before enrollment revenue does. The first positive month is M2, at $6,035, and from month 14 the service line holds at $123,816 in monthly net reimbursement and $53,095 net to the district.
3. **The revenue diversifies the payer base and it lands in-year.** About two in five of the district's patients rely on Apple Health, and remote-care revenue comes from Medicare fee-for-service. It is recurring, it starts in the first quarter, and it needs no new building, no bond and no requisition.
4. **The binding constraint is the size of the Medicare panel, not enrollment pace.** Every program reaches its ceiling inside the first year: APCM in M5, CCM in M8, RPM in M13. At M24 the program holds 1,357 active program enrollments across 885 unique patients. Because the panel saturates, the case for extending the same infrastructure to adjacent service lines follows directly from the forecast.
5. **Nobody is hired.** CoachCare delivers about 15,970 hours of care-team work over 24 months, roughly 7.7 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense, in a rural labor market where clinical hiring is slow and expensive. No capital outlay and no new requisition.
6. **The clinical return is concrete, and it feeds the accountable-care footprint.** The forecast projects roughly 80 avoided hospitalizations over 24 months, about $1.2 million at $15,000 per admission. A consented, monthly-managed panel with continuous readings holds beneficiary attribution and strengthens total-cost-of-care performance for the district's Enhanced-track accountable care organization; that upside is a separate layer this fee-for-service forecast does not model.
7. **The panel is the number to confirm first.** The 3,000-patient figure is a research estimate, not a chart count, and it moves the forecast nearly one-for-one. Pulling the Medicare panel by clinic from the district's own practice-management system is discovery item one.

1. The District Today

1.1 A public hospital district across the Columbia Basin

Samaritan Healthcare is the operating name of Grant County Public Hospital District No. 1, founded in 1947 and governed by an elected board of commissioners. Public-district status shapes the account:

bond and levy funding, open-meeting governance, and a statutory community-access mission across a rural Columbia-Basin service area for which the district is the anchor provider.[7]

The footprint is one hospital and two clinics on one record. Samaritan Hospital is a 50-bed acute-care hospital with a 24-hour emergency department, surgery, obstetrics and an intensive-care unit; its $225 million replacement campus opened in March 2026, which means the district's capital cycle has just closed. It is classified as a sole community hospital, a payment status that itself certifies the distance from other hospitals that defines the market. The district's two rural health clinics carry the primary-care panel this service line runs on.[8]

Facility (CMS certification number)	What it is	What it means for the service line
Samaritan Hospital (500033)	50-bed acute-care hospital; sole community hospital; new campus opened March 2026	A certified hospital discharge is a real inpatient or observation discharge, so transitional care management is legitimate here (Section 3.3)
Samaritan Clinic on Pioneer (508536)	Medicare-certified rural health clinic	Primary-care panel; the RPM, CCM and APCM codes bill at national amounts on top of the clinic's encounter rate
Samaritan Clinic on Patton (508592)	Medicare-certified rural health clinic	Second clinic site; the same billing rail and the same shared infrastructure

CMS Rural Health Clinic and Hospital Enrollments, pulled September 2026; all three facilities are owned by the same public hospital district.

The record is on Epic, live across the hospital and both clinics since 2021, with the Epic patient portal on the district's site. That single record is what makes a shared monitoring service line practical: device readings, enrollment status and documentation land in the chart the clinicians already use, not in a system beside it.[9]

1.2 The gap: the month between visits

Between-visit chronic care has no dedicated revenue line here yet, and that is a structural observation rather than a criticism. The district's public materials describe video-visit telehealth across departments and the Epic patient portal; no remote physiologic monitoring, device clinic or chronic-care-management program at meaningful scale was evident in the public record, and there is no CMS claims signal of one under the district's facilities.[10] Rural health clinic encounters bill institutionally under the clinic's all-inclusive rate rather than under individual clinicians, so a clinic's care-management billing does not appear in the physician claims files at all; the precise finding is that no program at meaningful scale was evident, to be confirmed with the district on the first call.

What the record does show is a district that keeps care local across distance. A rural chronic-disease patient with hypertension, diabetes or heart failure is seen in clinic a few times a year, and the miles between those visits are where control is lost. A monthly documented touch, on continuous readings, in the patient's own language, reaches that patient where an office schedule cannot. That is the layer this service line builds.

[7] The district's public record: Grant County Public Hospital District No. 1, founded 1947, an elected board of commissioners, bond and levy funding, and a community-access mission across a rural Columbia-Basin service area.

[8] CMS Hospital Enrollments, September 2026: certification number 500033, a 50-bed government acute-care hospital, classified a sole community hospital in Washington state filings. Regional reporting: the $225 million replacement hospital opened March 2026.

[9] The EHR as stated by the district (Epic, live across the hospital and both clinics since 2021), with the MyChart patient portal on the district's site.

[10] The district's public materials, September 2026, and the CMS claims record: no remote monitoring, chronic-care-management, advanced-primary-care or care-management program at meaningful scale was evident. Rural health clinic encounters and care management bill under the clinic's all-inclusive rate and do not appear in the physician claims files.

2. What Changed: A Rural Clinic Now Bills the Month Between Visits

2.1 G0511 is gone; the individual codes pay on top of the clinic's encounter rate

Rural health clinics are paid an all-inclusive rate per qualifying encounter. For years, everything a clinic did for chronic patients between those encounters was compressed into one bundled monthly code, G0511, a single flat payment regardless of how many services, minutes or programs a patient carried. That code was retired on September 30, 2025. From January 1, 2026 a rural health clinic reports the individual CPT and HCPCS codes, the chronic care management, remote monitoring and advanced primary care management families among them, and Medicare pays each at the **national non-facility Physician Fee Schedule amount, in addition to the all-inclusive encounter rate**.[11]

CY2026 also added two codes that matter for a district with its own hospital: 99445 pays the device-supply month when a patient transmits 2 to 15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time where 20 minutes is not reached. A patient discharged mid-month used to produce an unbillable partial month; now it bills. The structural consequence is the point: between-visit care stops being a flat bundled payment and becomes a per-service revenue line that scales with enrollment and delivered work, on a panel the district already sees.

2.2 What the codes pay a rural clinic

The Value Analysis is priced at the national amounts a rural clinic is paid for these codes: the CY2026 non-facility Physician Fee Schedule at the national conversion factor with no geographic adjustment. That is the rail a rural clinic bills care-management codes on, and it is the only basis on any page of this report.[12]

Code	What it pays for	Cadence	CY2026 national amount
99453	RPM setup and patient education	One-time	$21.71
99454	Device supply, 16–30 days of readings	Monthly	$52.11
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	$52.11
99457	RPM management, first 20 minutes	Monthly	$51.77
99470	RPM management, first 10 minutes (new 2026)	Monthly	$26.05
99458	RPM management, each additional 20 minutes	Monthly	$41.42
99490	CCM, first 20 minutes of clinical staff time	Monthly	$66.13
99439	CCM, each additional 20 minutes	Monthly	$50.44
G0556	APCM, level 1: one chronic condition	Monthly	$16.37
G0557	APCM, level 2: two or more chronic conditions	Monthly	$53.78
G0558	APCM, level 3: Qualified Medicare Beneficiary	Monthly	$117.24
99495	Transitional care management, moderate complexity	Per discharge	$220.11 (available here, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	$298.60 (available here, not in the forecast)

[11] CY2025 Physician Fee Schedule Final Rule (see note 5): G0511 retired with a transition period; from 2026 dates of service the individual codes are the standing requirement for rural health clinics, paid at national non-facility amounts in addition to the all-inclusive encounter rate.

[12] CY2026 Physician Fee Schedule national non-facility amounts: total non-facility relative value units times the national conversion factor, with every geographic practice cost index at 1.000. Rural clinics bill the care-management codes at the national amount regardless of the locality their ZIP code falls in.

CY2026 national non-facility Physician Fee Schedule amounts, the Value Analysis basis. Advanced primary care management is a bundled monthly payment with no minute tracking; the tier blend in the forecast yields $57.57 of net reimbursement per patient-month.

These are Original Medicare amounts. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families. With two-thirds of the county's Medicare still in Original Medicare, that contract check is a discovery item, not a load-bearing assumption. Principal care management, the single-condition specialist code family, is off: a primary-care panel bills chronic care management or advanced primary care management, not the specialist wrapper.

2.3 The work the change creates, and who carries it

Individual-code billing pays more and asks more. Each code carries its own eligibility test, consent, time capture and documentation standard, and the claim volume is real: this forecast generates about 36,989 claims over 24 months. In the operating model of Section 11, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside Epic. The district's own billing team files the clinic claims with the care-management codes, and the clinicians keep the clinical decisions.

One note on the Medicaid rail, because the deal design has to respect it. Washington Medicaid covers roughly two in five of the district's patients, and its remote-care reimbursement is a separate line with its own rules, sized against the district's own registries in a later session rather than folded into this Medicare forecast. The forecast on these pages does not include a Medicaid dollar.

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

3.1 The clinical and billing stack

Three programs, one infrastructure. Remote physiologic monitoring supplies the daily signal; chronic care management and advanced primary care management supply the monthly coordination wrapper. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare engine for all three, inside Epic.

Program	Who qualifies (modeled)	What it is	Billing
RPM	1,950 of the 3,000 Medicare patients (65%): hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, glucose meter, scale, pulse oximeter); readings monitored against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management
CCM	1,200 (40%): two or more chronic conditions expected to last twelve months or more	Monthly non-face-to-face coordination: comprehensive care plan, medication reconciliation, referrals, outreach	99490 + 99439
APCM	1,050 (35%): ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of thirteen practice-capability elements; no minute tracking	G0556 / G0557 / G0558
TCM	Any inpatient or observation discharge home from Samaritan Hospital	Contact within two business days, medication reconciliation, a face-to-face visit within 7 or 14 days	99495 / 99496, available here and not in the forecast

Eligible-pool counts from the Value Analysis eligibility model at a 3,000-patient in-scope panel; pools overlap, billing does not (see the coordination rule below).

One coordination rule, set at enrollment

Advanced primary care management and chronic care management never bill for the same patient in the same month; a patient carries one care-management wrapper, not two. Remote monitoring stacks with either. A transitional care episode runs for 30 days after a discharge and does not overlap the monthly wrapper for that patient in that month. The enrollment workflow assigns each patient a wrapper plus remote monitoring where clinically indicated, so the code families never collide on a claim.

The service line pays the district three ways. First, additive revenue: every care-management dollar lands on top of the encounter rate, not inside it. Second, avoided admissions: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not admitted three weeks later; that is where the forecast's roughly 80 avoided hospitalizations come from. Third, attribution: a documented monthly touch on the primary-care service codes holds beneficiary assignment for the district's Enhanced-track accountable care organization, the subject of Section 5.

3.2 The Medicare panel it runs on

The forecast is built on **3,000 traditional fee-for-service Medicare patients** across the rural health clinics, Original Medicare and Medicare Advantage together. Rural clinic panels do not appear in the physician claims files, so the figure is a research estimate, anchored on Grant County's 11,854 Original Medicare beneficiaries and the district's share of the area's primary-care Medicare panel, with a credible range of 1,800 to 4,500.[13] From that panel the eligibility model carves the program pools: 1,950 patients RPM-eligible (65%), 1,200 CCM-eligible (40%), 1,050 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.

The panel is the single largest lever in this report, and it is the district's own number to confirm. Section 4.3 shows the forecast moving nearly one-for-one with it, and the first implementation step in Section 11 pulls the Medicare panel by clinic from the district's practice-management system. Because the county is 33.6% Medicare Advantage, two-thirds of its Medicare is traditional fee-for-service, which is the billable base for these codes.

3.3 Transitional care at the hospital discharge, available here and not in the forecast

Most rural clinics have no hospital of their own to discharge from. This district does. A discharge home from Samaritan Hospital, a certified acute-care hospital, is a real inpatient or observation discharge, so it opens a legitimate transitional care management episode: an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days (99495, $220.11) or 7 days (99496, $298.60).[14] Transitional care is on the recommended stack for that reason, and it carries no dollars anywhere in this forecast: the district's discharge volume, the share of discharges that come home to a clinic patient, and visit-scheduling capacity are all discovery items. What it does in the forecast is clinical. A discharge is the highest-yield moment to enroll a patient in monitoring, and the three-touch post-discharge cadence in Section 7.5 runs on the same contact the transitional-care code requires. It is the discharge-to-monitoring loop, and it is upside beyond the modeled revenue.

[13] CoachCare panel basis: Grant County's 11,854 Original Medicare beneficiaries (CMS Medicare Monthly Enrollment, CY2024) and the district's share of the area's primary-care Medicare panel; modeled in scope at 3,000, credible range 1,800–4,500. Rural-clinic panels do not appear in the physician claims files; the chart count is discovery item one. Eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

[14] CPT 99495 and 99496 requirements (interactive contact within two business days of discharge; face-to-face visit within 14 or 7 days; moderate or high medical decision-making); CY2026 national non-facility amounts $220.11 and $298.60. A discharge from certification number 500033, a certified acute-care hospital, is a qualifying inpatient or observation discharge. Transitional care is carried at zero dollars in every figure in this report.

3.4 Built for a workforce-short region: nobody is hired

CoachCare delivers about 15,970 hours of care-team work across the 24 months, roughly **7.7 full-time-equivalent years**, without the district hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. In a rural labor market where clinical recruitment is slow and expensive, the service line adds the working capacity of several hires and zero requisitions, and it adds it in the languages the panel speaks. The district's clinicians contribute the two things only they can: the referral flag that starts each enrollment, and clinical judgment at the escalation points.

4. Value Analysis: The 24-Month Forecast

4.1 Headline economics

Over 24 months the service line produces **$2,356,382 in net reimbursement** to Samaritan Healthcare. CoachCare's fees total $1,355,239, including $58,840 of ancillary items: implementation, the Epic integration and telephonic outreach. Net to the district is **$1,001,143, a 42.49% margin** on the program, 41.80% in Year 1 and 42.89% in Year 2.[15]

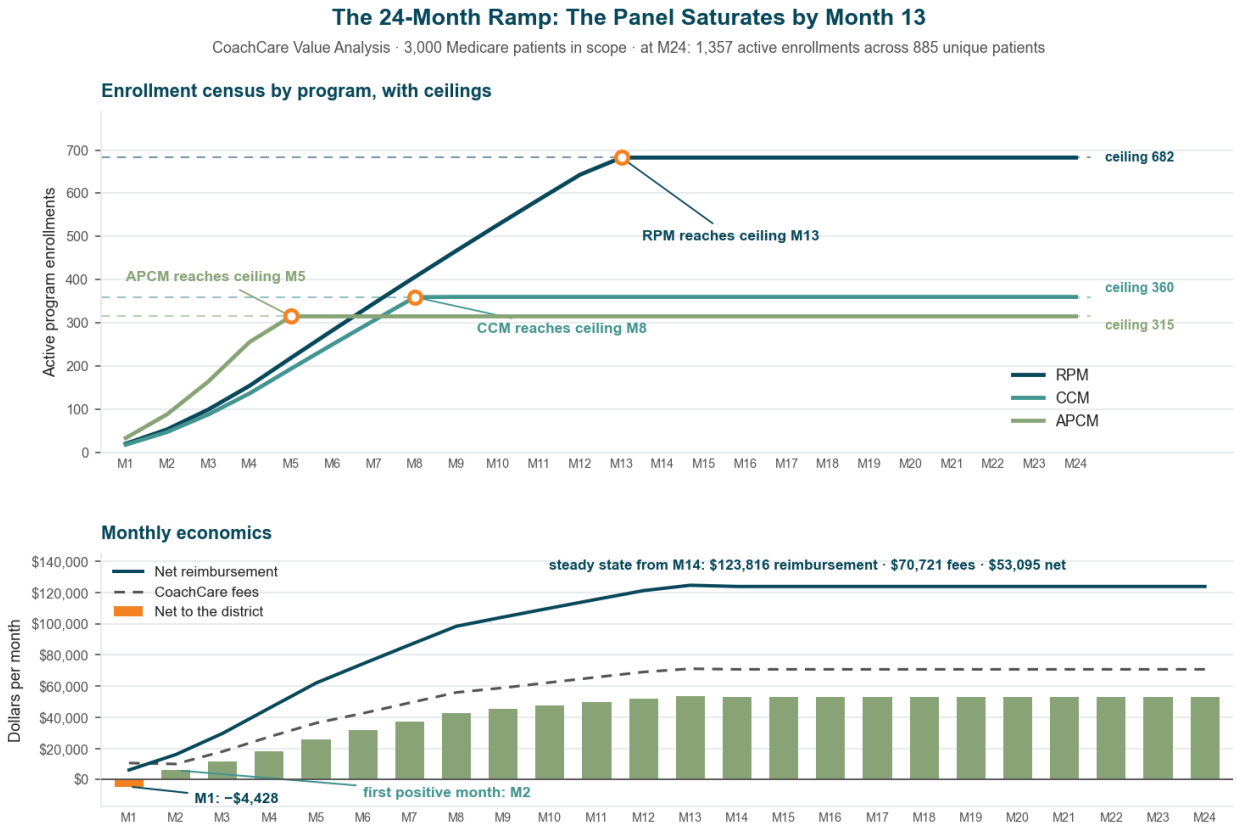

Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the district (below). Month 1 nets −$4,428; the first positive month is M2; from M14 the line holds at $53,095 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, −$4,428, because implementation and the Epic integration land before the first full billing months do. Month 2 turns positive at $6,035, month 3 nets $11,607, and the line climbs as the three programs fill. From month 14 the line settles at

[15] CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-district series; Year 1 margin 41.80%, Year 2 margin 42.89%, 24-month margin 42.49%, each defined as net to the district divided by net reimbursement. Ancillary fees of $58,840 over 24 months: implementation, the Epic integration, and telephonic outreach.

$123,816 of net reimbursement, $70,721 of fees and $53,095 net a month, once setup codes fall away and the census holds at ceiling.

4.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the district
RPM	$379,264	$790,497	$1,169,762	$671,429	$498,332
CCM	$314,276	$478,435	$792,711	$403,983	$388,728
APCM	$176,276	$217,633	$393,909	$220,987	$172,923
Ancillary (implementation, integration, outreach)	—	—	—	$58,840	−$58,840
All programs	**$869,817**	**$1,486,565**	**$2,356,382**	**$1,355,239**	**$1,001,143**

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation, the Epic integration, and telephonic outreach.

Program	Year 1 fees	Year 1 net	Year 2 fees	Year 2 net
RPM	$212,840	$166,424	$458,589	$331,908
CCM	$160,162	$154,114	$243,821	$234,614
APCM	$98,893	$77,384	$122,094	$95,539

Per-program fees and net to the district by contract year, before ancillary items.

RPM is the volume engine at 11,991 patient-months and $1,169,762 of net reimbursement. CCM is the yield engine at $110.75 of net reimbursement per patient-month across 7,158 patient-months, against $97.55 for RPM and $57.57 for APCM over its 6,842. APCM earns its place a different way: a bundled monthly payment with no minute tracking, and the level-3 tier (G0558, $117.24) on a safety-net panel where the dual-eligible share runs above the county's 18.8%. Year 2 outruns Year 1 because Year 1 carries the ramp and Year 2 runs all three programs at ceiling from its first month.

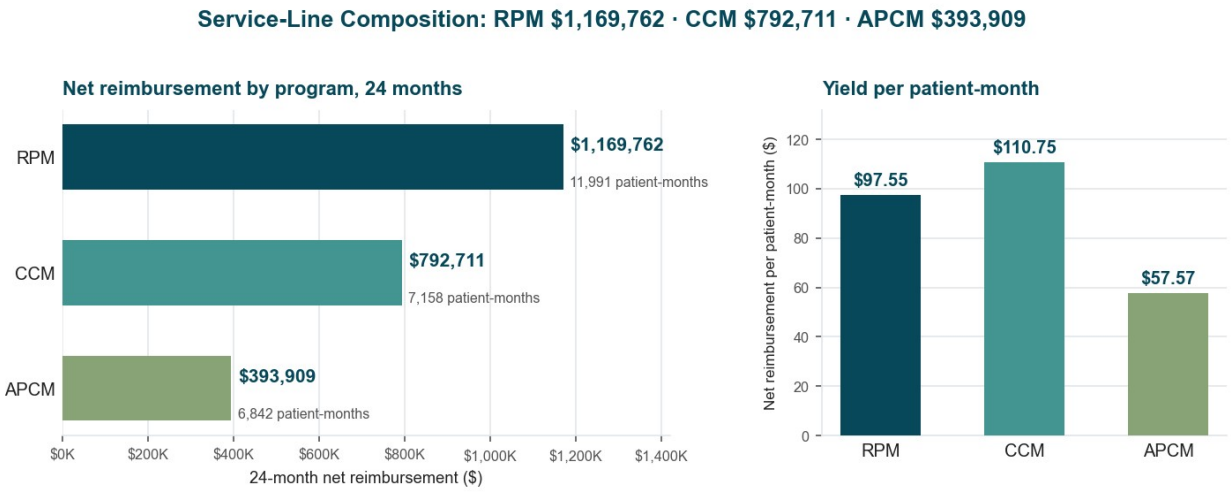

Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: the panel saturates inside the first year

This account is ceiling-limited in all three programs inside the first year. APCM reaches its ceiling of 315 enrollments in month 5, CCM its 360 in month 8, and RPM its 682 in month 13. From there the forecast is flat because there is no one left to add.[16] The first 90 days move fast: 71 new enrollments across the three programs in month 1, 118 in month 2, 166 in month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	1,950	682	Month 13	682
CCM	1,200	360	Month 8	360
APCM	1,050	315	Month 5	315
All programs		**1,357**		**1,357 enrollments · 885 unique patients**

Enrollment counts are program enrollments, not unique patients; the 1,357 enrollments at M24 belong to 885 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

Say the constraint out loud: what binds this program is the size of the Medicare panel, not enrollment capacity, and not clinician count. That cuts two ways. It de-risks the forecast, because the model asks the clinicians for no heroic enrollment performance, only a panel that exists. And because the panel saturates inside the first year, the next increment of value comes from extending the same enrollment, device, monitoring and billing infrastructure to the district's adjacent chronic-disease populations, and from the Washington Medicaid rail in Section 10, rather than from working the Medicare panel harder. The on-site enrollment specialist cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 12 prices what that is worth.

4.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	36,989
Device readings monitored	125,907
Care-management tasks completed	73,977
Chart updates written to Epic	18,494
Patient conversations held	11,097 (616 hours of call time)
Care-team hours delivered	15,970 (≈ 7.7 FTE-years)
Hospitalizations avoided	**≈ 80 · ≈ $1.2 million at $15,000 per admission**

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. Roughly 80 avoided hospitalizations over 24 months is about $1.2 million of cost that never lands on anyone: not on Medicare, not on the plans that cover a third of the county, and not on a bed in the district's own hospital.[17] It is also the entry requirement for accountable-care performance: a consented, documented, monthly-managed panel with continuous readings, which this service line builds under fee-for-service first.

[16] CoachCare Value Analysis enrollment model: program ceilings 682 (RPM), 360 (CCM), 315 (APCM); ceilings reached in months 13, 8 and 5; 1,357 active enrollments across 885 unique patients at month 24. Acceptance: RPM 35%, CCM and APCM 30% of the eligible pool.

[17] CoachCare Value Analysis clinical-outcomes module: approximately 80 avoided hospitalizations over 24 months, valued at $15,000 per avoided admission (≈ $1.2 million).

5. The Enhanced-Track ACO: Care Management Holds Attribution

The district is a participant in an Enhanced-track Medicare Shared Savings Program accountable care organization, its first performance year 2026. Enhanced is the two-sided-risk track: the organization shares in savings and is accountable for losses against a total-cost-of-care benchmark, on prospective beneficiary assignment.[18] That structure makes a monthly care-management program more than a revenue line.

Why a monthly documented touch matters under two-sided risk

Attribution. Beneficiary assignment runs on primary-care service codes. A documented monthly care-management or advanced-primary-care touch is exactly that kind of service, so the program helps hold assigned lives inside the organization rather than losing them to another provider's claims.

Total cost of care. The roughly 80 avoided hospitalizations in the forecast are avoided admissions against the benchmark. Under two-sided risk, an avoided admission is both a clinical outcome and a shared-savings and downside-protection outcome.

Two things are stated plainly. This forecast is fee-for-service: it prices the care-management codes at the national rail and nothing else. Accountable-care economics, shared-savings distributions and benchmark performance are a separate, additive layer that this report does not model; the avoided-admission figure is presented as a clinical output, not as modeled savings. And the care-management codes here bill per claim in the ordinary way; the organization's arrangement does not change how they are paid. The point of this section is direction, not a number: the same infrastructure that produces the fee-for-service margin in Section 4 also feeds the district's accountable-care position.

6. Epic Integration: The Program Lives in the Record

The district runs on Epic across the hospital and both clinics, live since 2021, with MyChart as the patient portal. CoachCare's Epic integration puts the program inside that record rather than beside it, so clinicians and billing staff learn no new system.[19]

- **Integrated enrollment.** Enrollment flags and trigger orders live inside the Epic workflow; CoachCare enrolls qualified Medicare patients on the district's behalf, and enrollment status is visible in Epic in real time. Patients begin receiving services in under five days from the flag.
- **Discrete vitals, not PDFs.** Device readings land in the chart as discrete, integrated vitals, so a clinician reads a blood-pressure trend in the record the way they read an in-office reading, and health history exchanges bi-directionally at intake.
- **Compliance documentation.** The integrated care summary and audit-ready care-management documentation attach to the record each month, which is what makes individual-code billing defensible at roughly 36,989 claims over 24 months.
- **Automated claim generation.** The CoachCare billing engine creates the monthly claim lines automatically; CoachCare is the only care-management platform integrated with Epic that generates claims automatically, which removes the manual per-patient, per-month claim step. The district's billing team files the clinic claims with the care-management codes.
- **The discharge feed.** Discharges from Samaritan Hospital reach the program from the record, which arms the post-discharge cadence in Section 7.5 without anyone relaying a message.

[18] CMS Medicare Shared Savings Program participant file, PY2026 (see note 2): Enhanced-track, two-sided risk, high-revenue, prospective assignment, first performance year 2026. Beneficiary assignment in the program runs on primary-care service codes.

[19] CoachCare Epic integration overview: integrated enrollment and trigger ordering, enrollment status visible in the clinical workflow, bi-directional exchange of health history, integrated discrete vitals, compliance documentation and the integrated care summary, and automated claim generation through the CoachCare billing engine; patients begin services in under five days from the flag.

7. Clinical Governance and Escalation

7.1 A monitoring program is a clinical operation first

A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the district inherits on the first day of the program: CoachCare's Care Management Programs standard operating procedures, rendered as process maps covering qualification, monitoring, escalation and discharge.[20] The purpose is keeping a patient with heart failure or uncontrolled diabetes at home in the Columbia Basin, managed in the language the family speaks, rather than in a hospital bed or a transfer to a tertiary center hours away.

7.2 One shared escalation engine

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

7.3 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any site-specific escalation preference and any quiet window in Section 8: whichever clinic the patient belongs to, whichever day of the week it is, the emergent floor does not move.

7.4 Qualification, device assignment and routing

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

7.5 The post-discharge cadence

A hospitalization within the last 60 days fires a fixed three-touch follow-up sequence: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. Each touch is documented, and any clinical alert surfaced during a touch escalates under the same shared logic; the post-discharge window gets more contact, not a different rulebook. For a discharge from Samaritan Hospital the first touch is also the interactive contact a transitional care episode requires, and the day-12-to-14 touch lands inside the 14-day visit window. One workflow serves both, and it is where most of the roughly 80 avoided hospitalizations in Section 4.4 are won.

7.6 Discharge governance and continuity

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

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

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

8. Built for the Columbia Basin: Distance, Language and Operational Design

A rural safety-net program has to be built for its geography and its people rather than adapted afterward. Grant County spans a wide agricultural service area, and roughly 45% of its residents are Hispanic or Latino, a large Spanish-speaking community.[21] Five design decisions follow.

- **Cellular devices, not app-dependent.** A cellular cuff or glucose meter transmits the moment it is used: nothing to pair, no smartphone, no app, no home broadband. Across a rural service area with uneven connectivity, that is the difference between a reading and a device in a drawer.
- **Bilingual care management, Spanish and English.** In a county that is roughly 45% Hispanic, bilingual staffing is a readiness requirement, not a nice-to-have. Enrollment scripts, device instructions and outreach calls are prepared in Spanish and English and matched to the patient's language of record. This is a design principle for reaching the panel, not a criticism of current staffing.
- **Monitoring replaces windshield time.** The program's premise is that a daily reading and a monthly call substitute for the drive a rural patient will not make four times a month. The service area's distances are the reason remote care works here, not an obstacle to it.
- **The hospital discharge is the front door.** The district's own hospital gives the program a discharge feed most rural clinics lack: enroll at the first post-discharge contact, run the three-touch cadence, and keep the highest-risk patients monitored from the day they most need it.
- **Enrollment lists pulled by condition, with payer attached.** Enrollment lists come from the hypertension, diabetes, heart-failure and COPD registries, screened by diagnosis, with payer attached so the Medicare and Medicaid rails stay distinct from the first list.

9. Market Context: Grant County Medicare

Grant County had 17,859 Medicare beneficiaries in CY2024, 11,854 of them in Original Medicare and 3,355 (18.8%) dually eligible.[22] Medicare Advantage penetration is 33.6%, which leaves two-thirds of the county's Medicare in Original Medicare, the base that bills these codes. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.

Grant County, Washington	Value
County population (approximate)	≈ 100,000; Moses Lake ≈ 27,000
Medicare beneficiaries, CY2024	17,859
Original (fee-for-service) Medicare, CY2024	**11,854** (66.4%)
Medicare Advantage penetration, CY2024	**33.6%**
Dual-eligible share of beneficiaries, CY2024	**18.8%** (3,355)
Hispanic or Latino share of county residents	**≈ 45%**
Apple Health (Medicaid) share of county residents	≈ 40%

[21] U.S. Census Bureau demographic estimates, Grant County: Hispanic or Latino residents approximately 45% of the county; a wide rural agricultural service area anchored on Moses Lake.

[22] CMS Medicare Monthly Enrollment, CY2024, Grant County: 17,859 beneficiaries; Original Medicare 11,854 (66.4%); dual-eligible 3,355 (18.8%). CMS Medicare Advantage county penetration, CY2024: 33.6%.

CMS Medicare Monthly Enrollment and Medicare Advantage penetration, CY2024; U.S. Census Bureau population and demographic estimates, Grant County.

Two market facts shape the program. The first is the fee-for-service base: with only a third of the county's Medicare in Medicare Advantage, the billable Original-Medicare population is large for a rural county, which is a selling point rather than a caveat. The second is language: a county that is roughly 45% Hispanic is one where a monthly documented touch in the patient's own language does the work an office schedule cannot.

10. A State-Administered Budget Line: The Rural Health Transformation Program

There is a near-term, state-administered budget line that maps directly onto this tooling. Under the federal Rural Health Transformation Program, CMS awarded Washington roughly $181 million for its first year, and Washington's approved plan funds a provider technology fund for telehealth, remote patient monitoring and population-health analytics, naming rural health clinics among the eligible organizations. First funds are scheduled to distribute October 1, 2026.[23]

How to read this in the plan

This is presented as context and opportunity, not as a secured award. Whether and how the district draws on the program is the district's decision and the state's process. The point for planning is timing: a state budget line written for exactly this kind of remote-care technology opens in the same window this service line would stand up, and the district's rural health clinics are named as eligible.

It pairs with the capital picture. The $225 million replacement hospital opened in March 2026, so the capital cycle is closed. This service line asks for no capital: it is an operating program that generates margin in-year, and its technology may be partly underwritten by a program built for it.

11. Implementation and the First 90 Days

11.1 Who runs what

CoachCare delivers	Samaritan Healthcare keeps
Telephonic and on-site enrollment in Spanish and English; the enrollment specialist is CoachCare's expense	Referral flags in Epic; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences
Monitoring, documentation and the escalation protocol of Section 7	Responses to clinic-routed escalations; the discharge feed from the hospital
Automated claim creation inside Epic	Filing the clinic claims with the care-management codes; billing review; the revenue
Monthly operating reports against the dashboard in 11.3	Program governance; the accountable-care relationship

[23] CMS award announcement, December 2025 (Washington's approximately $181 million first-year Rural Health Transformation Program award), and the Washington Health Care Authority's approved plan: a provider technology fund for telehealth, remote patient monitoring and population-health analytics, with rural health clinics among the eligible organizations; first funds distributing October 1, 2026. Presented as context and opportunity, not as a secured award.

11.2 Model inputs

Input	Value
Medicare panel in scope	3,000 traditional fee-for-service patients (research estimate; credible range 1,800–4,500); confirmed against the district's practice-management panel in the first 30 days
Referring clinicians	24, the district's primary-care and internal-medicine staff who flag chronic-disease patients (an estimate; confirmed on the first call)
Programs	RPM + CCM + APCM; transitional care available and not in the forecast; principal care management off
Program-eligible pools	RPM 1,950 · CCM 1,200 · APCM 1,050
Enrollment ceilings	RPM 682 (M13) · CCM 360 (M8) · APCM 315 (M5)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	referral flags plus one CoachCare-funded on-site enrollment specialist and telephonic outreach
Rate basis	CY2026 national non-facility Physician Fee Schedule amounts, the rail a rural clinic bills care-management codes on
APCM tier blend	level 1 / level 2 / level 3 = 20% / 55% / 25%; $57.57 of net reimbursement per patient-month
Medicare Advantage	33.6% of Grant County's Medicare. Medicare Advantage plans pay at least the Medicare amount, a floor; individual contracts set their own terms for the care-management code families.
EMR	Epic, live since 2021 across the hospital and both clinics

11.3 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the Epic integration workplan. The Medicare panel pulled by clinic from the district's practice-management system, and the hypertension and diabetes registries by payer, the two inputs that move the model most. Diagnosis screening of the Medicare panel per the qualification map, device logistics staged, escalation routing set, materials and scripts finalized in Spanish and English, and clinician orientation to the general-supervision workflow.

Days 31–60: enrollment live. Telephonic and in-clinic enrollment running; first devices in homes; first billable service months. Month 1 nets −$4,428 as implementation lands; month 2 turns positive. The forecast carries 71 new enrollments in month 1 and 118 in month 2.

Days 61–90: scale and file. 166 new enrollments in month 3, APCM at its ceiling, CCM two months from its own. First monthly operating report against the dashboard. Second working session on the Washington Medicaid remote-monitoring rail, with the registries counted by payer.

The operating dashboard from month one:

- Enrollment census by program against ceiling (682 / 360 / 315)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Discharges captured: hospital discharges that entered the three-touch cadence
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, clinic-routed, documented
- Claims generated against expected claims, and claims filed on the clinic claim
- Blood-pressure and glucose control among enrolled patients against baseline
- Net to the district per month against the $53,095 steady-state line

12. Recommendations

1. **Stand up the Medicare service line now, as an operating line that needs no capital.** The individual-code rail has been live since January 2026. This is a $1,001,143 two-year net line at a 42.49% margin that generates margin in-year, right after the capital cycle closed; each month of delay pushes it one month further out, and nothing about it waits on a hire or a build.
2. **Confirm the Medicare panel by clinic in the first 30 days.** The 3,000-patient figure is a research estimate and it drives every ceiling in the forecast. Pulling the true count by clinic from the practice-management system is the single largest lever in this report, and the table below prices the range.
3. **Lead with the dual-eligible tier on advanced primary care management.** G0558 at $117.24 a month is the best-paying monthly code on the page, and a safety-net panel skews toward the dual-eligible patients it applies to. Set the wrapper rule at enrollment so those patients with two or more conditions land on the level-3 tier.
4. **Use the hospital discharge as the front door.** Wire the discharge feed from Samaritan Hospital, enroll at the first post-discharge contact, and bill transitional care on every discharge home to a clinic patient. Transitional care is in the forecast at zero dollars; every episode billed is upside, and every episode enrolled is a monitoring patient from the day they most need it.
5. **Run the program bilingually and by cellular device.** Spanish-and-English materials and staffing, cellular devices that need no smartphone or broadband, and enrollment lists pulled by condition. None of these is a retrofit in a county that is roughly 45% Hispanic across a rural service area.
6. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner and is worth about $251,992 of 24-month net reimbursement against the no-specialist case in the table below.
7. **Position the service line inside the accountable-care and rural-funding picture.** The same monthly touch that produces the fee-for-service margin holds attribution and strengthens total-cost-of-care performance for the Enhanced-track accountable care organization, and the Washington Rural Health Transformation Program is a near-term budget line written for exactly this technology.

What moves the number

Scenario	24-month net reimbursement	What it changes
Base: 3,000 panel · 24 clinicians · 1 enrollment specialist	**$2,356,382**	**42.49% margin; ceilings M13 / M8 / M5**
Panel 1,800 (low end of the credible range)	$1,544,155	42.21% margin
Panel 4,500 (high end of the credible range)	$3,125,875	42.67% margin
No on-site enrollment specialist	$2,104,390	RPM fills at M18, not M13
Second on-site enrollment specialist	$2,486,618	RPM fills at M10
12 referring clinicians	$2,072,210	slower ramp to the same ceilings
40 referring clinicians	$2,526,880	faster ramp to the same ceilings

CoachCare Value Analysis recalculations at the same pricing. Margin holds between 42.2% and 42.7% across the range. The binding constraint is the size of the Medicare panel, not enrollment capacity or clinician count; the enrollment specialist changes when each ceiling is reached, not where it sits.

Read the table from the top. The panel rows are the only rows that move the ceilings, and the panel is the district's own number to confirm. The specialist rows move the timing, not the ceilings. The clinician-count rows barely move the result, because every program fills inside the first year.[24]

13. The Ask: A Working Session

CoachCare asks for one working session with the district's executive team, clinical leadership and billing lead. The forecast stands on the figures in Section 4; the session is about the four inputs that would move it, in the order they matter.

1. **The Medicare panel by clinic.** The count of traditional fee-for-service Medicare patients across the two rural health clinics, with the dual-eligible share. This one number sets every ceiling, and it replaces the 1,800-to-4,500 estimate.
2. **The hypertension and diabetes registries by payer.** The Medicare slice sizes the remote-monitoring cohort in this forecast; the Medicaid slice sizes the second rail.
3. **The current care-team roster and the Epic product line.** Who on the current staff carries nursing and care-coordination work, and which Epic modules and interfaces are in place, so the integration workplan can be written.
4. **The accountable-care and rural-funding posture.** The organization's assigned-beneficiary count and shared-savings position, and the district's intent for the Washington Rural Health Transformation Program, so the service line is positioned inside both.

Everything else in this report is a workplan item that follows the session rather than a condition of it.

About CoachCare

CoachCare runs remote care programs for rural districts, health centers, specialty practices and health systems: the enrollment, the devices, the clinical monitoring, the documentation and the claims, inside the EHR the organization already uses.[25]

Measure	CoachCare, 2026
Patients managed	over 400 managed conditions for 500,000+ patients
Clinicians on the platform	10,000+ providers running remote care programs day to day
Implementations	1,000+ programs stood up and running in market
Claims generated	care-plan coding and billing behind more than 5 million claims
Vitals recorded	over 100 million vitals recorded; 4 million+ care actions enabled

References and Data Sources

- **The district's public record,** retrieved September 2026: the organization's site (governance as a public hospital district, service lines, locations, telehealth and the Epic patient portal) and regional reporting on the $225 million replacement hospital opened March 2026 and the district's sole-community-hospital status.
- **CMS Rural Health Clinic Enrollments and Hospital Enrollments,** pulled September 2026: Samaritan Hospital (certification number 500033, 50-bed acute-care government hospital) and the

[24] CoachCare Value Analysis recalculations at the same pricing: panel 1,800 $1,544,155 (42.21%); panel 4,500 $3,125,875 (42.67%); no on-site enrollment specialist $2,104,390; second specialist $2,486,618; 12 referring clinicians $2,072,210; 40 referring clinicians $2,526,880. The first enrollment specialist is worth about $251,992 of 24-month net reimbursement against the no-specialist case.

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

two Medicare-certified rural health clinics (508536 and 508592), all under the same public hospital district.

- **CMS Medicare Shared Savings Program participant file, PY2026,** matched on the district's legal business name: participation in an Enhanced-track (two-sided-risk), high-revenue, prospectively-assigned accountable care organization with a first performance year of 2026.
- **CMS Medicare Monthly Enrollment, CY2024, and Medicare Advantage county penetration, CY2024,** Grant County: 17,859 beneficiaries, 11,854 in Original Medicare, 3,355 dual-eligible (18.8%), Medicare Advantage penetration 33.6%.
- **The CY2025 Physician Fee Schedule Final Rule and CY2026 Final Rule:** retirement of G0511 on September 30, 2025; individual-code reporting for rural-clinic care management at national non-facility amounts in addition to the all-inclusive encounter rate; advanced primary care management adopted on the same basis; the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule national rate files:** national non-facility amounts for the eleven forecast codes and the two transitional care codes, at the national conversion factor with no geographic adjustment.
- **CMS and Washington Health Care Authority materials on the Rural Health Transformation Program:** the December 2025 award announcement (Washington's approximately $181 million first-year award) and Washington's approved plan, which funds a provider technology fund for telehealth, remote patient monitoring and population-health analytics and names rural health clinics among eligible organizations, with first funds distributing October 1, 2026.
- **U.S. Census Bureau population and demographic estimates,** Grant County and Moses Lake: population, age structure and the Hispanic or Latino share of residents; Washington Apple Health context for the county.
- **CoachCare Epic integration overview:** integrated enrollment and trigger ordering in the clinical workflow, bi-directional exchange of health history, integrated discrete vitals, compliance documentation and the integrated care summary, and automated claim generation through the CoachCare billing engine.
- **CoachCare Care Management Programs standard operating procedures** and the derived process maps: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 7.
- **CoachCare Value Analysis for Samaritan Healthcare, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 2, 4, 11 and 12, built on 3,000 Medicare patients in scope, 24 referring clinicians, one on-site enrollment specialist, and CY2026 national non-facility amounts for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 1,357 active program enrollments belonging to 885 unique patients, because a patient may carry a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

The panel figure is a research estimate. Rural health clinic visits bill on the clinic claim rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount a clinic panel. The 3,000-patient figure is a research estimate anchored on county Medicare enrollment and the district's share, and the first implementation step confirms it against the district's own practice-management panel by clinic.

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