COACHCARE | GRANGER MEDICAL CLINIC

SERVICE LINE STRATEGY · **Connected Care, by CoachCare.**

Granger Medical Clinic

A physician-owned multispecialty group serving the Salt Lake Valley since 1954: more than 160 providers at 24 locations in six Utah counties, on one eClinicalWorks system, with 63 primary care, pulmonary, endocrine and kidney clinicians caring for a Medicare panel of about 15,600

Remote Care Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for Granger Medical Clinic: remote monitoring and chronic care management for the Medicare panel its primary care and pulmonary clinics already know, billed under the group's own NPIs at Utah's CY2026 Medicare rates, staffed by CoachCare and run inside eClinicalWorks

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the leadership and board of Granger Medical Clinic. It is the companion to the group's remote care strategy page and makes the same case at report length: why Medicare's payment rules make this the year, what the group's own Medicare claims show, how the service line runs across its clinics, what it returns over 24 months at Utah's rates, and why CoachCare is the partner to run it.

Granger already completes about 4,000 annual wellness visits a year for traditional-Medicare patients, has its own pulmonary, endocrine and kidney specialists, lab and imaging, and urgent care, and bills inside a two-sided Shared Savings Program ACO. What its claims do not show is daily readings for the hypertension, diabetes and COPD patients, or monthly care management in primary care. This report shows what that program returns, who does the work, and how fast a group this size can responsibly enroll it.

Prepared by CoachCare for discussion with Granger Medical Clinic. © 2026 CoachCare.

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Executive Summary

Granger Medical Clinic opened in 1954 as the first physician practice west of the Jordan River and is still owned by its physicians, one of the largest physician-owned groups in Utah. More than 160 providers practice at 24 locations across Davis, Salt Lake, Summit, Tooele, Utah and Wasatch counties, in family and internal medicine and more than twenty specialties, all on one eClinicalWorks system the group adopted in 2013. Its flagship, a four-story building at Fairbourne Station in West Valley City, houses urgent care, a pharmacy, lab and imaging.[1]

This report covers the part of Granger that carries the Medicare chronic-care panel: 63 clinicians, 44 family and internal medicine physicians, 14 nurse practitioners and physician assistants, and 5 pulmonary, endocrine and kidney specialists. Their CY2024 traditional-Medicare patients averaged 74.1 years old with a weighted risk score of 1.08 against a national 1.00. Hypertension appears in two of three, diabetes in three in ten, chronic kidney disease in 25% and COPD in 11%. The primary care clinicians completed about 4,000 annual wellness visits and billed transitional care for about 40 patients after hospital stays. **No remote monitoring, chronic care management or principal care management appears in Granger's primary care claims at meaningful scale**.[2]

Granger bills inside **an Enhanced-track Medicare Shared Savings Program ACO**, the two-sided track, and every in-scope clinician carries that ACO in CMS's 2026 eligibility record. Every admission avoided among assigned patients is spending that never posts against the ACO's benchmark, and the quality measures the ACO is scored on turn on what happens between visits.[3]

Medicare Advantage is most of this panel. About 58.0% of Salt Lake County's Medicare beneficiaries are in a Medicare Advantage plan. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount, so how each plan Granger contracts with covers these codes is the second thing to confirm, after the chart count.[4]

The observation this report is built on

Turn the panel Granger already manages into a profit-generating service line.

The group has the panel, the conditions, the record system, the wellness-visit rhythm, its own specialists and the accountable-care position. What it lacks is daily readings between visits and monthly billable care management for the thousands of patients with two or more chronic conditions. This service line fills that gap: staffed by CoachCare, governed by Granger's clinicians, billed under its NPIs from inside eClinicalWorks.

What the Value Analysis returns

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	1,374	2,590	2,590
Contribution margin	**$404,102**	**$1,688,008**	**$2,092,109**

[1] grangermedical.com, retrieved October 26, 2026: About (founded 1954; 160+ providers; over 24 locations in six counties; physician-owned), Specialties and Locations pages. eClinicalWorks customer story, 2017 (eClinicalWorks since 2013). Valley Journals, June 15, 2020 (Fairbourne Station: 94,000 square feet, four stories, occupied spring 2020).

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, queried October 26, 2026 for all 233 NPIs enrolled under Granger's two billing organizations. In scope: 31 family medicine and 13 internal medicine physicians, 14 nurse practitioners and physician assistants with a primary care billing pattern, 3 pulmonologists, 1 endocrinologist and 1 nephrologist. Primary care: average age 74.1; HCC risk 1.08; hypertension 65.9%, diabetes 29.5%, CKD 24.5%, COPD 10.6%; annual wellness visits 3,993 beneficiaries; transitional care 41. CMS suppresses lines under 11 beneficiaries.

[3] CMS Shared Savings Program Participants and Organizations files, performance year 2026: Enhanced track, retrospective assignment, not in ACO Primary Care Flex. CMS Quality Payment Program eligibility, 2026: all 63 in-scope NPIs resolve to Granger with the Shared Savings Program APM.

[4] CMS Medicare Monthly Enrollment, July 2026, Salt Lake County: 167,146 beneficiaries, 96,963 in Medicare Advantage and other health plans (58.0%). Granger's in-scope clinicians bill almost entirely from Salt Lake County addresses.

CoachCare Value Analysis: Medicare panel of 15,600, 12,480 in scope, remote monitoring and chronic care management, 63 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 Utah locality 09 amounts. Contribution margin is what Granger keeps from the service line.

Granger can take this two ways, and both are net-positive. CoachCare can run remote monitoring on its own, with care coordination left where it sits today: **$1,078,322 of contribution margin over 24 months**, for 2,028 patients. Or CoachCare can run both programs, the forecast of record above, for 2,590 unique patients.

1. **Enrollment pace sets year one; the panel sets year two.** Referrals from 63 clinicians and an on-site enrollment specialist build to full speed over twelve months, so about 1,400 unique patients are enrolled at month 12. In year two remote monitoring reaches its eligible ceiling in month 19 and chronic care management in month 23, and the census reaches about 2,600 unique patients by month 24.
2. **So confirm the Medicare chart count first.** A smaller panel than modeled lowers the forecast: at 9,500 patients 24-month contribution margin is $1,611,749. A larger one does not raise it inside two years: at 23,400 it is $2,079,067, because new enrollment is held to 1,500 patients a year.
3. **It is also a staffing plan.** CoachCare brings on 8 care managers by month 12 and 16 by month 24, at 165 patients each, and delivers 42,085 care-team hours over 24 months, about 20.2 full-time-equivalent years. None of it is Granger headcount.
4. **Positive from month 2, and $168,969 a month by month 24.** Contribution margin runs slightly negative in month 1 while the program ramps; every month after is positive, and by month 24, with both programs at their ceilings, it is $168,969 a month.
5. **The program lives in eClinicalWorks.** CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically, and a flagged patient reaches the first day of service in under five days (Section 4).
6. **Pulmonary is in from the start.** Granger's own pulmonary clinic and its COPD patients get home pulse oximetry and symptom check-ins on the same program, and the endocrinologist and nephrologist see home glucose and blood pressure in the chart.
7. **Advanced primary care management is the named next lever, at zero dollars.** APCM bills in place of chronic care management, and which patients move is a program decision to make together.
8. **The CY2027 proposed rule takes $289,880 off the 24-month contribution margin.** A 20.6% cut to device supply leaves $1,802,229 of contribution margin over 24 months instead of $2,092,109, with enrollment held constant (Section 8).

The ask is a working session: confirm Granger's Medicare chart count by payer and by clinic, check how each Medicare Advantage contract covers the care-management codes, decide which primary care clinics and the pulmonary clinic go first, and scope the eClinicalWorks integration before the first patient enrolls.

1. Why Now: Medicare Pays for the Time Between Visits

Medicare is changing what it pays primary care for. Four shifts are under way at once, and each lands in the same place: the weeks between a patient's visits. For a panel that carries hypertension, diabetes, kidney disease and COPD together, those weeks decide how the year goes.

The shift	What it means for Granger
1. From visits to panels	A patient on a chronic medication sees a clinician a few times a year. Blood pressure drifts in the months between, glucose climbs in them, and the admission that follows starts in them. Managing a panel means knowing which of roughly 15,600 Medicare patients are trending the wrong way before they reach an emergency department, and that takes home data and a team assigned to act on it every month.
2. Accountability for total cost	Granger bills inside an Enhanced-track Medicare Shared Savings Program ACO. Every admission among assigned patients counts against the ACO's spending benchmark, and the Enhanced track shares the difference in both directions.

The shift	What it means for Granger
3. Value-based care, with Medicare Advantage at 58.0%	CMS wants every Traditional Medicare beneficiary in an accountable care relationship by 2030, and since 2025 advanced primary care management has paid a monthly amount for running the whole panel. In Salt Lake County about 58.0% of Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
4. Codes for the work between visits	Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for shorter months; in this forecast they carry 17.0% of remote-monitoring Medicare payments.[5] At Utah's CY2026 rates one hypertensive patient on remote monitoring and chronic care management (99454, 99457 and 99490) is worth **$162.87 a month** in Medicare allowed charges.

Each shift pays for, or measures, what happens between visits. A remote care service line is how Granger covers that time for every eligible patient, and remote monitoring and chronic care management bill for it under Medicare fee-for-service today. Granger's revenue cycle already picks up new codes: its primary care clinicians billed the visit-complexity add-on, G2211, more than 4,500 times in CY2024, its first year.

2. Granger Today: Seventy Years on the West Side

Granger is a multispecialty group with a primary care spine: family and internal medicine clinics across the valley, its own specialists in the conditions remote care manages, one record, and one physician-owned governance structure. Its Medicare panel is older than average, and the group already runs the visit rhythm a remote care program needs, from the annual wellness visit to the call after a hospital stay.

2.1 Twenty-four locations, one record

Area	Granger sites	Clinicians in scope	CY2024 established-visit relationships
West Valley City	Fairbourne Station: family and internal medicine, urgent care, lab and imaging	21	2,693
Holladay, Millcreek, east bench	Holladay and Wasatch (Millcreek) clinics; internal medicine	15	3,013
West Jordan	West Jordan Clinic, two buildings	10	1,465
Murray	Pulmonary & sleep medicine	4	919
Riverton	Riverton Clinic	7	672
Draper	Draper Clinic	4	441

grangermedical.com locations, October 2026; clinicians and established-visit (99212 to 99215) beneficiary-clinician relationships from CMS CY2024 claims, by the billing address each clinician reported. A patient seen by two clinicians counts twice. Two in-scope clinicians billed from addresses outside these areas.

The 63 clinicians in scope are 44 family and internal medicine physicians, 14 nurse practitioners and physician assistants, and 5 pulmonary, endocrine and kidney specialists. Granger's other specialties, from urology and orthopedics to allergy, dermatology and obstetrics, carry their own Medicare patients and sit outside this forecast. Every clinic runs on one eClinicalWorks system with the healow patient portal, and labs and imaging run inside Granger's own clinics.[6]

[5] CoachCare Value Analysis for Granger Medical Clinic, 2026: 99445 and 99470 together, 17.0% of 24-month remote-monitoring Medicare payments.

[6] CMS Doctors and Clinicians (July 2026) and PECOS reassignment (September 2026) files for Granger's two billing organizations: 233 NPIs, 181 of them with a CY2024 claims profile. grangermedical.com news page (healow Prime+).

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician enrolled under Granger's billing organizations. The profile below is the traditional-Medicare panel of the 58 primary care clinicians in scope.[7]

Panel	CY2024	Condition	Share
Beneficiary-clinician relationships	8,301	**Hypertension**	**66%**
Medicare allowed	$3,121,994	High cholesterol	59%
Average age	**74.1**	Arthritis	46%
Weighted HCC risk score	**1.08**	**Diabetes**	**30%**
Dual-eligible, where reported	10%	**Chronic kidney disease**	**25%**
Annual wellness visits	**About 4,000**	Depression	24%
Depression screening	About 2,900	Ischemic heart disease	21%
Transitional care	**About 40**	Atrial fibrillation	16%
Advance care planning	About 240	**Heart failure**	**14%**
Remote monitoring, chronic or principal care management, APCM, behavioral health integration	No program at meaningful scale	**COPD**	**11%**

CMS Medicare Physician & Other Practitioners, CY2024, the 58 primary care clinicians in scope. Program rows are beneficiaries; relationships count a patient once per clinician seen. CMS caps published prevalence at 75% per clinician and suppresses lines under 11 beneficiaries.

This is the panel remote care is built for: hypertension in two of three patients, diabetes in three in ten, kidney disease in a quarter, heart disease, atrial fibrillation and COPD common, and an average age of 74.1. Most patients qualify for chronic care management, and hypertension with diabetes or kidney disease is the largest group whose home readings would change treatment. The clinics see these patients on a steady rhythm, but **none of Granger's primary care clinicians bills remote monitoring or chronic care management at a volume CMS publishes**.[8]

2.3 From one west-side practice to six counties

Year	What happened
1954	Two physicians open a practice in Granger, now West Valley City, the first west of the Jordan River, so west-side families no longer have to cross the river to see a doctor
2013	The group moves onto eClinicalWorks for documentation, patient engagement and population-health reporting, with interfaces to the region's hospital systems
2014	A 14-provider internal medicine group merges in, taking Granger past 100 providers and into Millcreek
2015–2018	Independent allergy, gynecology, urology, sports medicine and rheumatology groups join, so Granger patients can see a specialist without leaving the group or its chart
2020	Fairbourne Station opens in West Valley City: 94,000 square feet on four floors, with urgent care, a pharmacy, lab and imaging

[7] Medicare Physician & Other Practitioners, CY2024, for the 58 primary care clinicians: 8,301 beneficiary-clinician relationships, 8,180 established-visit relationships, $3,121,994 allowed. Prevalence is weighted by beneficiaries. The 5 pulmonary, endocrine and kidney specialists add 1,179 established-visit relationships.

[8] CMS by Provider and Service, CY2024, searched code by code for the remote monitoring, chronic care management, principal care management, APCM, transitional care and behavioral health integration codes for all 181 Granger clinicians with a claims profile. In primary care: 99495, 41 beneficiaries across three clinicians; no other code in these families at 11 or more beneficiaries. The group's only care-management billing at that scale sits in one specialty clinic outside this program's scope.

Year	What happened
Today	More than 160 providers at 24 locations in six counties; family and internal medicine from Tooele to Draper, a pulmonary and sleep clinic, endocrinology and nephrology; about 4,000 wellness visits a year
Next	**Daily readings and monthly care management for every eligible Medicare patient in primary care and pulmonary, run by a CoachCare care team inside eClinicalWorks and billed under Granger's NPIs**

2.4 What the group already runs, and the gap

What exists	Status	What it means for this program
eClinicalWorks and the healow portal	**Live at every clinic since 2013**	The program's host: flags, orders, readings, care documents and claims (Section 4)
Annual wellness visits	**About 4,000 a year**	The enrollment moment: eligibility checked, consent taken and devices ordered the same day
Pulmonary & sleep, endocrinology, nephrology	**In the group**	COPD, diabetes and kidney patients co-managed inside one chart; home readings reach the specialist too
Transitional care	**About 40 patients**	Credited and kept. CoachCare makes the two-business-day contact after more of the discharges and carries the patient past day 30
Lab, imaging and urgent care	In house	Home readings tell the care team when a lab is due; an urgent-care visit becomes a follow-up flag
Shared Savings Program participation	**Enhanced track**	Avoided admissions and the quality measures accrue to the ACO the group already belongs to
Chronic care management, remote monitoring	No program in primary care claims	Devices, daily readings, monthly care time and business-hours alert triage come from CoachCare

The gap is specific: daily readings for the hypertension, diabetes, heart and COPD patients, and monthly billable care time for every patient with two or more chronic conditions, across the primary care clinics and all 63 clinicians in scope. Granger has the specialists, the lab and the visit rhythm; it does not have a care team assigned to act on home data every month.

2.5 The market, and the rate basis

Salt Lake County held 167,146 Medicare beneficiaries in July 2026, and about 58.0% of them were in a Medicare Advantage plan; the neighboring counties Granger serves run from 41.1% (Summit) to 58.0% (Utah County). Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. With well over half the panel on Medicare Advantage, Granger's own payer mix and each plan's coverage of remote monitoring and chronic care management decide how much of this forecast is billable as modeled. At about 9% of Salt Lake County's Medicare beneficiaries, the modeled panel is a credible share for a group this size.[9]

Every clinic sits in Utah's single statewide payment locality, locality 09, under the Noridian JF contractor. Every dollar in this report is priced at those CY2026 amounts.[10]

[9] CMS Medicare Monthly Enrollment, July 2026, by county: Salt Lake 58.0%, Davis 54.9%, Utah 58.0%, Tooele 53.6%, Wasatch 49.6%, Summit 41.1% in Medicare Advantage and other health plans.

[10] CY2026 Physician Fee Schedule, Noridian JF carrier 03502, Utah locality 09: geographic indices work 1.000, practice expense 0.940, malpractice 0.898; conversion factor $33.4009.

3. The Service Line: Remote Monitoring and Chronic Care Management

3.1 The clinical and billing stack

Two monthly programs and one episode code, with one enrollment conversation, one care team and one billing pipeline into Granger's own billing through eClinicalWorks. The forecast carries the two monthly programs; transitional care, which the group already bills, stays on the stack and carries no dollars.

Program	What it does clinically	Who it fits on this panel
Chronic care management (CCM)	A documented care plan and at least 20 minutes of clinical staff time a month for patients with two or more chronic conditions; 99490, 99439	The multi-chronic core: hypertension with diabetes, kidney disease, heart disease or COPD
Remote physiologic monitoring (RPM)	Cellular cuffs, glucometers, scales and pulse oximeters send readings between visits against thresholds Granger's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470	Hypertension and diabetes first, then COPD, kidney disease, heart failure and atrial fibrillation
Transitional care management (TCM)	Contact within two business days of discharge, medication reconciliation, a visit within 14 days (99495) or 7 days (99496)	Every panel patient discharged from a hospital or observation stay; already billed, not in the forecast

Codes	What they pay for	CY2026 Utah locality 09
99490 · 99439	Chronic care management, first 20 minutes · each additional 20	$64.07 · $48.74
99453	Remote monitoring setup and education, once	$20.38
99454 · 99445	**Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)**	**$48.97 · $48.97**
99457 · 99458	Treatment management, first 20 minutes · each additional 20	$49.83 · $40.10
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$25.08**
99495 · 99496	Transitional care, visit within 14 days · within 7 days	$212.21 · $287.95
G0556 · G0557 · G0558	Advanced primary care management, levels 1 to 3	$15.86 · $52.02 · $113.38
99484	Behavioral health integration, 20 minutes a month	$55.78

How the rates apply

CY2026 non-facility amounts, Utah locality 09 (Noridian JF, carrier 03502), ZIP 84119. One device code, one first-tier management code and one care-management program (chronic care management or advanced primary care management) bill for a patient in a given month; transitional care bills once per discharge alongside either.

About 58.0% of Salt Lake County's Medicare beneficiaries are in Medicare Advantage. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount.

3.2 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 8 care managers for the 1,400 unique patients at month 12, and 16 for the 2,600 at month 24. An on-site enrollment specialist on CoachCare's payroll works the clinic schedules beside Granger's medical assistants and enrolls patients during the visit, telephonic outreach reaches the rest, and the clinicians order from the chart. Devices are cellular, with no Wi-Fi, smartphone or pairing needed. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. in the patient's time zone,

the hours the clinics keep. Patients are told at consent to call 911 for an emergency and their clinic for anything urgent.

3.3 Transitional care: more discharges that qualify

Granger already bills transitional care management: about 40 traditional-Medicare patients in CY2024 at the volumes CMS publishes, at $212.21 for the 14-day level and $287.95 for the 7-day level. The CoachCare care team can make the two-business-day contact and the medication reconciliation after every discharge the group learns of, so more discharges meet the requirement, and Granger furnishes the visit and bills the code. Remote monitoring and chronic care management then carry the patient past day 30, when most readmissions happen. The forecast carries no transitional care dollars.

3.4 The next levers: APCM and behavioral health integration

Advanced primary care management (G0556 to G0558) pays a monthly amount per patient, in place of chronic care management, to a practice that takes on the whole-panel primary care elements, tiered by complexity. Granger can bill it for its primary care panel, and for a group already accountable for total cost it fits the way the group is measured.[11] It appears here at zero dollars. Moving patients from chronic care management to APCM is a program decision to make together; remote monitoring bills alongside either, and the same staff and workflow carry over.

Behavioral health integration is the adjacency. Depression appears on 24% of the panel's claims, about one patient in four, and Granger's primary care clinicians screened about 2,900 Medicare patients for it in CY2024. Behavioral health integration (99484, $55.78 a month) can run on the same care-manager calls once the program is running. It carries no dollars here.

3.5 Beside the ACO and the group's own teams

Granger is not starting from nothing on value-based care. It sits inside an Enhanced-track Shared Savings Program ACO, its clinics already run the wellness and screening work the ACO is measured on, and its own specialists co-manage the hardest patients. None of that delivers billable, monthly care time inside the practice for every eligible patient, and none of it puts a cuff or a pulse oximeter in anyone's home. CoachCare adds those pieces, and the work is divided so that no patient is called twice.

Deployment	What CoachCare runs	What stays with Granger
Remote monitoring on its own	Remote monitoring for the hypertension, diabetes, kidney, heart and COPD patients	Care coordination, as Granger's own teams and its value-based support run it today, with home readings in the chart
Full service line, RPM + CCM (the forecast of record)	Both programs, enrolling every eligible patient into chronic care management as well as monitoring	Clinical governance, the visits, transitional care billing, quality reporting and the patients

- **The group keeps clinical governance, the patients and the revenue.** Its clinicians set thresholds, routing and discharge criteria and sign the care plans; claims go out under Granger's NPIs, and in the full service line Granger keeps $2,092,109 of contribution margin over 24 months.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims. None of it is the group's headcount, inventory or software.
- **Independence is part of the return.** A recurring service line with its own margin funds the group's next decisions from its own panel.

[11] CY2025 and CY2026 Physician Fee Schedule final rules: APCM (G0556 to G0558) effective January 1, 2025, billed in place of chronic care management for the same patient and month.

4. eClinicalWorks: The Program Lives in the Chart

CoachCare works inside eClinicalWorks' own workflows, so Granger's clinicians and staff do not learn a second system. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible at every clinic, and a flagged patient reaches the first day of service in under five days.[12] CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically.

Integration pillar	What happens in eClinicalWorks
Integrated enrollment	Flags in the chart prompt the order for patients who meet criteria Granger's clinicians approve, at a chronic-care visit, a wellness visit or on an outreach list
Enrollment by services and devices	The clinician orders by service and by device (cuff, glucometer, scale, pulse oximeter), the way a lab is ordered
Exchange of health history	Diagnoses, medications, vitals and lab results pass to the care team at intake; the care plan comes back
Integrated vital reports	Home readings land in the chart, so the clinician sees home averages at the next visit
Compliance documentation and care summary	Evidence of care, vitals and the care plan attached monthly for every enrolled patient
Automated claim generation	Claims built for every patient, every month, once a code's requirements are met; Granger's billing team reconciles and files them

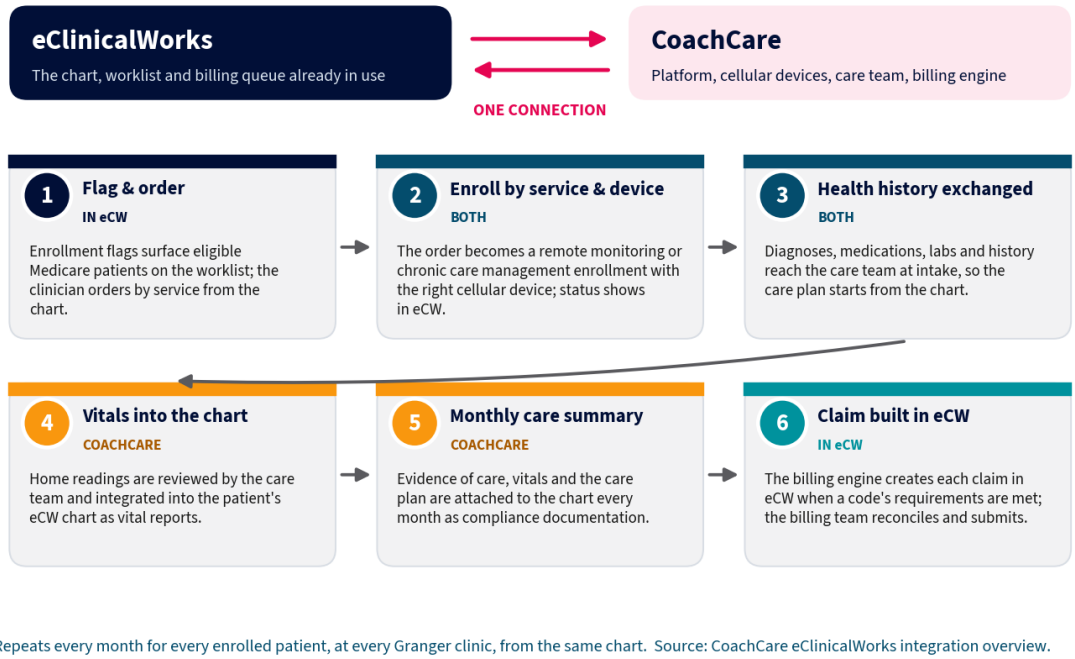


Figure 1. From a flag in the chart to a claim: the six steps CoachCare and eClinicalWorks run every month for every enrolled patient. CoachCare eClinicalWorks integration overview.

The build runs alongside onboarding, so it does not hold up the first enrollments.

[12] CoachCare eClinicalWorks integration overview, 2026: the six integration pillars; patients begin chronic care management and remote monitoring in less than five days.

5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so the group never carries surveillance liability it did not agree to. Thresholds and routing are set with Granger's clinicians, for each clinic, before the first patient enrolls.[13]

5.1 One shared escalation engine

Branch	The rule	Why
Critical value	**Escalate to the practice, regardless of symptoms**	No practice preference can suppress it. A critical reading on its own goes to the clinic, not to 911
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps inboxes usable
Trend	**Three consecutive readings an hour or more apart for blood pressure, glucose or oxygen saturation; three within seven days for heart rate; weight gain past the agreed threshold**	A confirmed trend escalates like a single threshold breach
Patient unreachable	Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding
Documentation	**Six fields: vital · findings · method · contact · outcome · follow-up**	Any episode can be reconstructed end to end

5.2 The emergent pathway

Non-negotiable, and stated as such

Triggers. Chest pain · new shortness of breath · signs of stroke · syncope · worst-ever headache · sudden swelling, reported by the patient on a call.

Action. The care team calls 911 with the patient on the line, then notifies the patient's clinic the same day. A critical reading alone, without those symptoms, goes to the clinic instead.

If the patient refuses. The clinic is called with the patient still on the line and directs care; if the clinic cannot be reached, CoachCare activates emergency services.

The floor. CoachCare's emergent policy supersedes any practice escalation preference. This cannot be configured away. The group shapes routing for everything else.

5.3 Three-way routing, on business hours

Route	What goes there	Who sees it
Emergency	Active emergent symptoms reported on a call	911 with the patient on the line; the clinic notified
Needs the practice	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse each clinic designates, in eClinicalWorks, with readings and a recommended next step; COPD trends can route to the pulmonary clinic
Stable or resolved	**Worked, retaken and resolved**	**Documented as an FYI in the chart, without paging anyone**

The matrix is agreed for each clinic. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, which matches the hours the clinics are open, so every escalation lands while a clinician

[13] CoachCare Care Management Programs standard operating procedures, March 2026: escalation logic, trend definitions, emergent protocol, care-management hours (Monday to Friday, 8:00 a.m. to 5:00 p.m. local patient time), post-discharge sequence and discharge governance.

is in the building. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is the clinic's own line, Granger urgent care, or 911.

5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence. After a hospital or observation stay it is also the transitional care episode the group already bills, and inside the ACO each admission it prevents is spending that never posts against the benchmark.

Touch	Window	What happens
1 · Stabilize	**Day 1–2**	What led to the visit; discharge medications reconciled against what is in the house; a follow-up visit confirmed within 7 to 14 days
2 · Detect	**Day 5–8**	Adherence verified, triggers re-checked, appointment and ordered labs confirmed
3 · Secure	**Day 12–14**	Medication and risk review, visit outcome, and a handoff into monthly monitoring

5.5 Built for an older, phone-first panel

Granger's traditional-Medicare patients average 74.1 years old, and some clinics serve rural Tooele and mountain counties. The program is set up for them. Devices are cellular and arrive ready to use, with no home internet, smartphone or pairing. The welcome call, the monthly care-management call and every escalation call are made by phone, so no patient has to learn an app. Patients who already use the healow portal can keep using it, and nothing in the program depends on it. A monitoring patient unreachable 45 days from enrollment is escalated to the clinic; without an instruction from the clinic, discharge from monitoring follows at 180 days, and discharge criteria always belong to Granger's clinicians.

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers remote monitoring and chronic care management across a Medicare panel of 15,600, 12,480 in scope, at the CY2026 Utah locality 09 amounts, with 63 referring clinicians and one CoachCare-funded on-site enrollment specialist. No transitional care, APCM, behavioral health integration or ACO payment is in these numbers.[14]

Full service line	Year 1	Year 2	24 months
Unique patients, end of period	1,374	2,590	2,590
Contribution margin	**$404,102**	**$1,688,008**	**$2,092,109**

Year two is about four times year one because enrollment builds through year one, so the program enters year two with 1,374 unique patients and finishes it at the panel's ceilings. Year two returns **$1,688,008 of the $2,092,109 contribution margin**, and by month 24 the line runs at $168,969 a month to the group, about $2,027,627 a year if the census holds.

6.2 Two deployments, side by side

Each deployment is shown on its own, and the full service line is the forecast of record. Both run on the same enrollment plan, so remote monitoring reaches the same 2,028 patients in both, by month 19. The full line adds chronic care management for 1,872 patients by month 24 and $1,013,788 more contribution margin over 24 months.

[14] CoachCare Value Analysis for Granger Medical Clinic, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

24 months	Remote monitoring on its own	Full service line, RPM + CCM
Contribution margin	**$1,078,322**	**$2,092,109**
Unique patients at month 24	2,028	2,590
Hospitalizations avoided	About 182	About 182

6.3 Where the patients come from

Program	Active enrollments, month 12	Active enrollments, month 24	Ceiling reached
Remote physiologic monitoring	1,119	**2,028**	M19
Chronic care management	849	**1,872**	M23
Unique patients	**1,374**	**2,590**	

The two programs are close in size: remote monitoring reaches 2,028 enrollments at month 24 and chronic care management 1,872, because the multi-chronic core of the panel is large. The **3,900 active program enrollments at month 24 belong to 2,590 unique patients**, because most care-management patients are also monitored.

6.4 The ramp, month by month

Contribution margin runs −$5,131 in month 1 while the program ramps, on 35 enrollments. It is positive from month 2, with $3,551 on 86 enrollments, and cumulative contribution margin is above zero by the end of month 3. New patients join at a rising pace through year one, about 220 a month at full speed from month 12; remote monitoring reaches its ceiling in month 19 and chronic care management in month 23, after which new enrollments replace attrition and the monthly contribution margin holds at $168,969. Cumulative contribution margin passes $59,282 at month 6, $404,102 at month 12 and $2,092,109 at month 24.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M1	35	**−$5,131**	−$5,131
M2	86	$3,551	−$1,580
M3	167	$7,020	$5,441
M6	577	$24,533	$59,282
M12	1,968	$83,922	$404,102
M18	3,368	$143,590	$1,121,771
M24	3,900	**$168,969**	**$2,092,109**

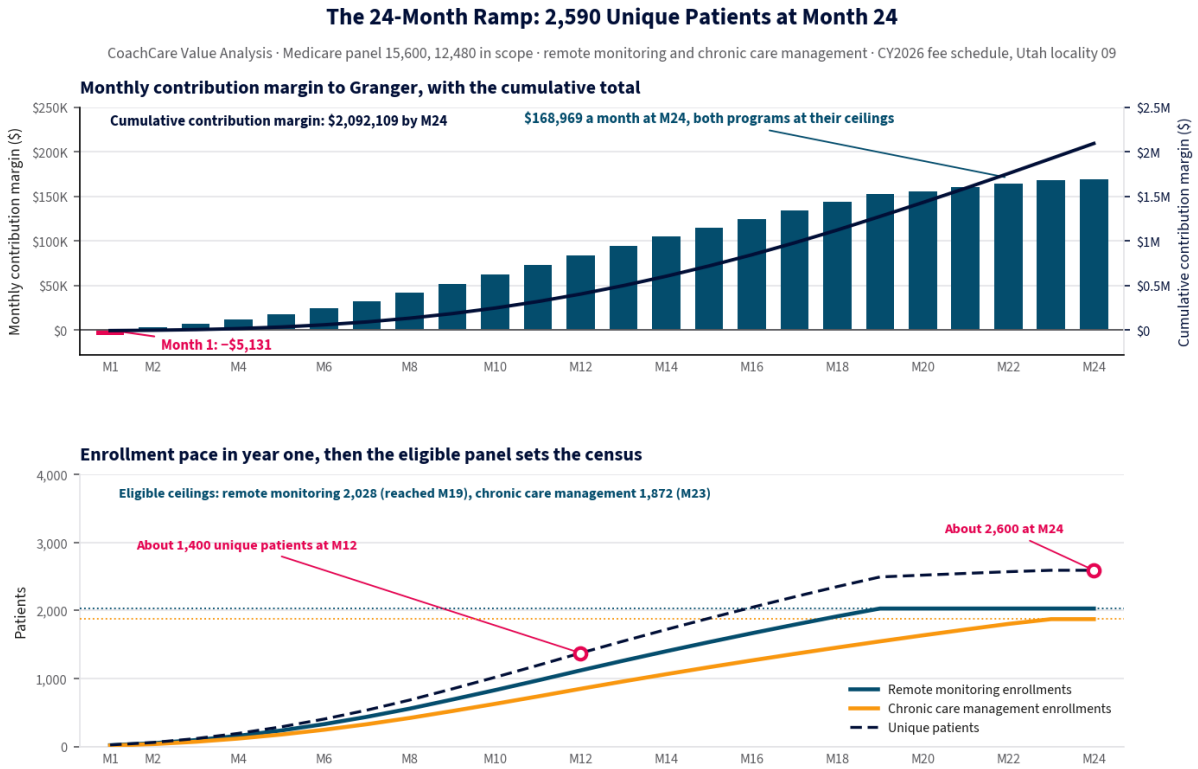


Figure 2. Monthly contribution margin, with cumulative contribution margin, and the enrollment census by program against the two eligible ceilings, with unique patients at months 12 and 24. CoachCare Value Analysis, full service line.

6.5 Two limits: enrollment pace, then the panel

Program	Eligible share of the 12,480 in scope	Acceptance	Ceiling	Reached
Remote physiologic monitoring	65%, 8,112 patients	25%	**2,028**	**Month 19**
Chronic care management	75%, 9,360 patients	20%	**1,872**	**Month 23**

Say the constraint out loud

Two limits set this forecast, in order. In year one it is enrollment pace: referrals from 63 clinicians and the on-site enrollment specialist build to full speed over twelve months, which lands at about 1,400 unique patients at month 12. In year two it is the panel: both programs reach their eligible ceilings, remote monitoring in month 19 and chronic care management in month 23, and the census reaches about 2,600 unique patients by month 24. The forecast holds new enrollment to what one care team can onboard well: no more than 1,500 new patients a year. At this panel the forecast stays inside that: about 1,400 new patients in year one and 1,200 in year two.

Read it as a chart-count question and a staffing plan. A smaller Medicare panel than modeled lowers the forecast directly, and a larger one meets the 1,500-a-year limit in year two, so Granger's own chart count is the first number to confirm. 8 CoachCare care managers at month 12 and 16 at month 24, at 165 patients each, are hired ahead of the census. A second on-site enrollment specialist would add $205,015 of contribution margin by enrolling faster in year one.

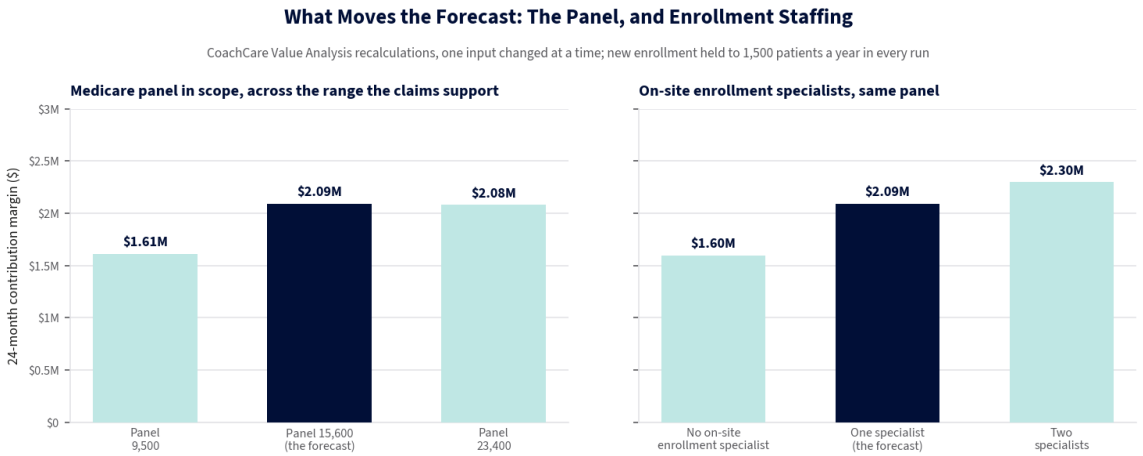


Figure 3. 24-month contribution margin across the panel sizes the claims support, and with none, one or two on-site enrollment specialists on the same panel. CoachCare Value Analysis recalculations.

Scenario	24-month contribution margin	Unique at M12	Unique at M24	Ceilings reached (RPM / CCM)
Base: panel 15,600, 12,480 in scope, 63 clinicians, one enrollment specialist	**$2,092,109**	**1,374**	**2,590**	**M19 / M23**
Panel 9,500, 7,600 in scope	$1,611,749	1,346	1,577	M13 / M15
Panel 23,400, 18,720 in scope	$2,079,067	1,410	2,910	not by M24 / not by M24
Panel 15,600 with 60% in scope (9,360)	$1,836,571	1,356	1,942	M15 / M18
Panel 15,600 with all of it in scope	$2,061,322	1,392	2,892	not by M24 / not by M24
No on-site enrollment specialist	$1,596,951	1,050	2,407	not by M24 / not by M24
The 44 primary care physicians referring alone	$1,705,183	1,079	2,475	not by M24 / not by M24
85 clinicians: adds 22 advanced practice clinicians outside the primary care pattern	$2,260,415	1,500	2,590	M17 / M20
A second on-site enrollment specialist	$2,297,124	1,500	2,590	M17 / M19

CoachCare Value Analysis recalculations, one input changed at a time; panel runs keep 80% in scope, and every run that changes referral volume or enrollment staffing is held to 1,500 new patients a year.

The panel and the on-site enrollment specialist move this forecast most. At 9,500 patients 24-month contribution margin falls to $1,611,749, $480,360 less. A larger panel barely moves it: at 23,400 it is $2,079,067, because the 1,500-a-year limit binds in year two before the larger ceilings are reached. The CoachCare-funded on-site enrollment specialist is worth $495,158 of contribution margin; without one, neither program reaches its ceiling inside two years. A second specialist adds $205,015. Fewer referring clinicians lower the answer: the 44 primary care physicians alone reach $1,705,183.[15]

6.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**285,930**	Blood pressure, glucose, weight and oxygen saturation values arriving between visits
Claims and billable units	**96,485**	Created in eClinicalWorks for Granger's billing team
Care-management tasks	192,969	Outreach, care-plan updates and medication reviews

[15] Panel sizes 9,500 to 23,400 bracket Granger's CY2024 claims: the annual wellness visit count and the total beneficiary-clinician relationship count, each grossed up for the 58.0% Medicare Advantage share. The 15,600 forecast follows established-visit relationships × 0.70 ÷ (1 − 0.580) = 15,602.

Output over 24 months	Volume	What it represents
Patient conversations	28,945	Live contacts across 1,608 hours of call time
Care-team hours	**42,085**	**About 20.2 full-time-equivalent years of work the group does not employ**
Hospitalizations avoided	**About 182**	Admissions that never post against the ACO's spending benchmark

Annual admission rate among enrolled patients	20% (the workbook's baseline)	30%	40%	50%
Hospitalizations avoided over 24 months	182	272	**363**	454

CoachCare Value Analysis, full service line. The workbook prices avoided admissions at a 20% annual admission rate; the first patients enrolled, uncontrolled hypertension with diabetes, kidney disease, COPD or heart failure, run closer to 40%, which puts the figure near 363.

Two ledgers, kept separate

Contribution margin funds the program. $2,092,109 to Granger over 24 months, paid claim by claim.

Avoided admissions and quality speak to the ACO. About 182 admissions avoided at the workbook's baseline, plus monthly work on the five measures in Section 7. Under two-sided risk the new Part B care-management spend also sits on the ACO's ledger, which is why the avoided admissions and the quality measures carry the argument there, more than the contribution margin does. The Value Analysis is fee-for-service and does not model shared savings.

6.7 Published results from CoachCare programs

- **Blood pressure.** Cardiac Solutions, a physician-owned cardiology practice with three West Phoenix offices, put 2,738 patients on CoachCare remote monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.[16]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[17]
- **Heart failure.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[18]

7. Quality: The Measures the ACO Is Scored On

The Shared Savings Program scores every ACO each year on a fixed set of quality measures, and the score decides whether the ACO meets the program's quality standard. Five move with this program's monthly work, and Granger's patients count in all five.[19]

Measure	What it counts	What the program does each month
Q236 Controlling high blood pressure	Hypertensive patients whose latest blood pressure is under 140/90	Home averages give an accurate reading of control and a monthly chance to act
Q001 Diabetes: A1c poor control (> 9%)	Patients with diabetes whose latest A1c is above 9%; lower is better	Care management keeps A1c testing and medication changes on schedule; home glucose shows slippage early

[16] Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.

[17] Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.

[18] Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.

[19] Shared Savings Program quality reporting through the APM Performance Pathway: measures 001, 134 and 236 reported by the ACO; 479 and 484 calculated by CMS from claims.

Measure	What it counts	What the program does each month
Q484 Admissions, multiple chronic conditions	Unplanned admissions among patients with several chronic conditions, from claims	Daily readings, outreach on a confirmed trend, a fixed cadence after any admission
Q134 Depression screening and follow-up	Patients screened, with a follow-up plan when the screen is positive	PHQ-2 and PHQ-9 in monthly care management; positives routed to the clinician
Q479 Hospital-wide 30-day readmission	Unplanned readmissions within 30 days of discharge, from claims	A call within two business days, devices home before the follow-up visit

Two of the five come from claims, so an admission that does not happen does not count. With hypertension in two of three of Granger's Medicare patients, Q236 covers most of the panel; the primary care clinicians already screen about 2,900 Medicare patients for depression a year, and monthly care management supplies the follow-up half of Q134.

8. Policy Watch: The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at Utah locality 09 on the forecast's own billing mix, with enrollment held constant.[20]

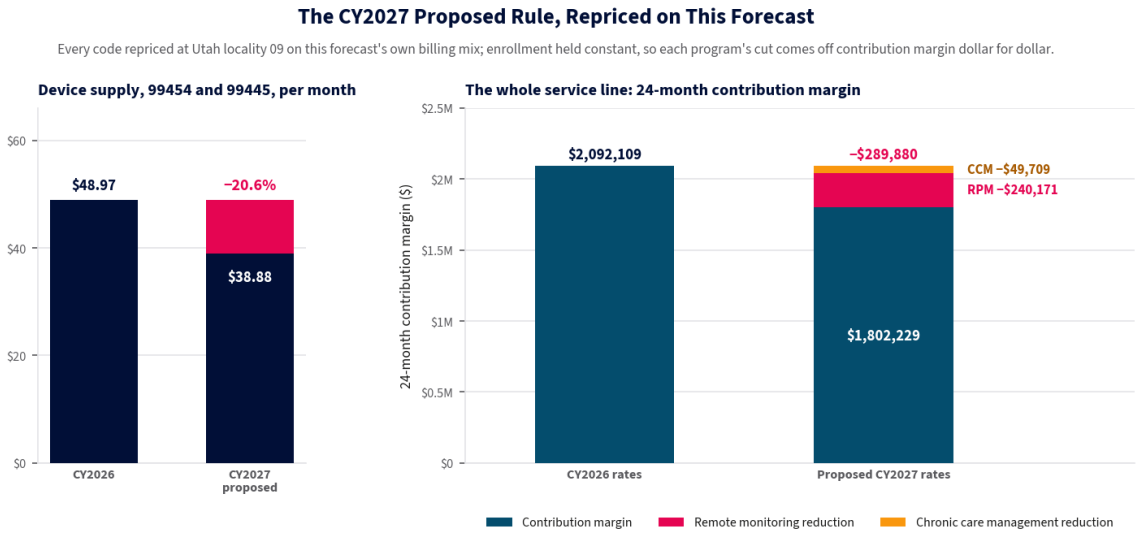


Figure 4. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the 24-month contribution margin of the whole service line at CY2026 and proposed CY2027 rates, with the reduction from each program shown. Enrollment held constant.

Level	CY2026 rates	Proposed CY2027 rates	What changes
Device supply, 99454 and 99445	$48.97 a month	**$38.88 a month, −20.6%**	The code CMS proposes to cut

[20] CMS-1848-P, published July 2026. CoachCare repricing at Utah locality 09, conversion factor $32.8409 against $33.4009: device supply 31.6% of the remote-monitoring basket; remote monitoring 52.2% of the line.

Level	CY2026 rates	Proposed CY2027 rates	What changes
Remote monitoring arm, change in contribution margin		**−$240,171**	Device supply is 31.6% of the remote monitoring basket
Chronic care management, change in contribution margin		−$49,709	Routine rate changes only (−2.1%); not targeted
Whole service line, 24-month contribution margin	**$2,092,109**	**$1,802,229 (−$289,880)**	Enrollment held constant, so the repricing passes through dollar for dollar

With enrollment held constant, every dollar of repricing comes off contribution margin: $240,171 from remote monitoring and $49,709 from chronic care management, which leaves $1,802,229 over 24 months. CoachCare will rerun the forecast at the final rates. A contingency is already in build in which CoachCare manages the staffing while the group owns the clinical program and the billing.

Code	What it pays for	CY2026 national	Proposed CY2027 national	Change
99453	Remote monitoring setup	$21.71	$20.03	−7.7%
99454 / 99445	**Device supply, 16+ days / 2–15 days**	**$52.11**	**$41.38**	**−20.6%**
99457	Treatment management, first 20 minutes	$51.77	$49.59	−4.2%
99458	Each additional 20 minutes	$41.42	$40.39	−2.5%
99470	Treatment management, 10–19 minutes	$26.05	$20.69	−20.6%
99490	Chronic care management, first 20 minutes	$66.13	$64.04	−3.2%
99439	Each additional 20 minutes	$50.44	$49.92	−1.0%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts; the repricing above uses Utah locality 09 amounts, and the two bases do not reconcile to the dollar, by design. Section 1848(c)(7) of the Act limits how far a code's relative value can fall in one year.

9. Implementation Roadmap

9.1 Who runs what

Function	CoachCare	Granger
Identification and enrollment	Registry query in eClinicalWorks starting with the hypertension, diabetes, COPD, kidney and heart-failure patients; an on-site enrollment specialist; telephonic outreach; devices shipped, cellular-paired and replaced	Approves the criteria and target list; clinicians order at the chronic-care or wellness visit
Transitional care	Two-business-day contact and medication reconciliation after each discharge the group learns of; visit booked inside the 7- or 14-day window	Furnishes the visit and bills 99495 or 99496, as today
Monitoring and escalation	Reading review, monthly outreach, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager	**Sets thresholds and routing for each clinic; receives escalations**
Coordination with existing work	Works beside the clinics' own care teams, the specialists and the ACO's programs so that no patient is called twice	Decides how the work divides
Documentation, billing, reporting	Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports by clinic and clinician	**Reconciles and files under its own NPIs; keeps the revenue; names a program lead**

9.2 The model inputs

Input	Value in this forecast
Medicare panel	**15,600 patients in the primary care, pulmonary, endocrine and kidney panels, 12,480 in scope; all payers**
Medicare Advantage	About 58.0% of Salt Lake County's Medicare beneficiaries; every patient priced at the Medicare amount. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
Referring clinicians	63: 44 family and internal medicine physicians, 14 nurse practitioners and physician assistants, and 5 pulmonary, endocrine and kidney specialists
Programs	Remote monitoring and chronic care management; transitional care, APCM and behavioral health integration at zero dollars
Eligibility and acceptance	Remote monitoring 65% eligible, 25% accept; chronic care management 75%, 20%; 70% of care-management patients also monitored; 3% monthly attrition
Enrollment plan	5 referrals per clinician a month, 70% accepted, building to full speed over 12 months; one CoachCare-funded on-site enrollment specialist plus telephonic outreach; about 1,400 unique patients by month 12. The forecast holds new enrollment to what one care team can onboard well: no more than 1,500 new patients a year.
EMR	eClinicalWorks, integrated as described in Section 4
Rates	CY2026 fee schedule, non-facility, Utah locality 09, ZIP 84119

9.3 The staffing plan, and the order the clinics go live

The enrollment plan is the staffing plan. CoachCare brings on care managers ahead of the census: 8 by month 12, when about 1,400 unique patients are enrolled, and 16 by month 24 at about 2,600. New patients arrive at a rising pace through year one, about 220 a month by month 12. The on-site enrollment specialist and telephonic outreach cover the clinics the schedule does not reach on a given day, and the clinicians' own orders at the visit do the rest.

The order the clinics go live is a decision to make together. One sensible sequence starts at Fairbourne Station and the Holladay and Wasatch internal medicine clinics, where most of the in-scope Medicare relationships sit, brings the pulmonary clinic on in the same first wave for its COPD patients, and adds West Jordan, Riverton, Draper and Tooele by the end of the first quarter. Every clinic uses the same flags, devices and care team, so a later start changes only when its patients join, not how the program runs.

9.4 The first 90 days, and after

Window	What happens	Result
Weeks 0–6 Integrate and charter	eClinicalWorks workshop with the EHR administrators and billing leads; chart counts and payer mix, plan by plan; today's transitional care workflow mapped; thresholds, routing and the clinic go-live order agreed	Integration live, protocol signed, go-live order set
Weeks 6–12 Launch the first clinics	Enrollment from the first week; remote monitoring for hypertension, diabetes and COPD, care management for two-plus conditions; the post-discharge cadence live	35 enrollments in month 1, 86 by month 2, 167 by month 3
Months 3–12 Every clinic in scope	Same protocols at every clinic; heart failure, kidney disease and atrial fibrillation cohorts added; care managers added as the census grows	1,968 enrollments, 1,374 unique patients at month 12
Months 13–24 At the ceilings	Both programs reach their eligible ceilings (remote monitoring month 19, chronic care management month 23); the APCM mix decided together; behavioral health integration scoped; the next cohorts sized from the chart count	Year 2: $1,688,008 of contribution margin

Remote monitoring and chronic care management carry Part B coinsurance, so the consent conversation explains the monthly cost plainly before the device ships.

9.5 What we would confirm together

1. **The Medicare chart count, by payer and clinic.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry hypertension, diabetes, COPD or two or more conditions. A smaller panel than modeled lowers the forecast directly, so this is the first number to confirm.
2. **The Medicare Advantage contracts.** Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Which plans Granger's patients hold, and whether each pays chronic care management and remote monitoring, is confirmed plan by plan.
3. **Which clinicians and panels are in scope.** Whether the 63 clinicians modeled are the right referral base, and whether other specialties' Medicare patients should join later.
4. **How the work divides with what exists today.** Who in the clinics, the specialty teams and the ACO's programs already calls these patients, so that no patient is called twice.
5. **Transitional care today.** Where discharge notices come from, who makes the first call, and how many discharges a year reach the group in time.
6. **The eClinicalWorks configuration.** The version, the healow and care-management modules licensed, and any device connection already in place.
7. **Coinsurance at consent.** How the monthly Part B coinsurance is explained at enrollment, and who answers billing questions afterwards.
8. **The clinic go-live order.** Which clinics launch first, and where the on-site enrollment specialist works each day.

10. Recommendations

1. **Launch the full service line on the enrollment plan.** $2,092,109 of contribution margin over 24 months ($404,102 in year one, $1,688,008 in year two), positive from month 2, with nobody hired.
2. **Pull the Medicare chart count by payer and clinic in week one.** The panel in scope sets where the census settles in year two.
3. **Confirm Medicare Advantage coverage plan by plan before launch.** With well over half the panel on Medicare Advantage, each contract's terms for the care-management codes decide how much of the forecast bills as modeled.
4. **Start with the hypertension, diabetes and COPD patients at chronic-care and wellness visits.** Care management for the plan, a cellular cuff, glucometer or pulse oximeter for the readings, the visit as the enrollment conversation.
5. **Bring the pulmonary clinic in with the first wave.** Its COPD patients get home oxygen saturation and symptom check-ins, with escalations routed back to the pulmonologists.
6. **Staff to the plan.** 8 care managers by month 12 and 16 by month 24, on CoachCare's payroll.
7. **Extend the transitional care the group already bills.** CoachCare makes the two-business-day call after every discharge the group learns of; Granger bills 99495 or 99496.
8. **Aim the monthly work at the ACO's quality measures.** Each of the roughly 182 admissions avoided over 24 months is spending that never posts against the ACO's benchmark.
9. **Hold APCM as the next lever, and scope behavioral health integration once running.** Both run on the same care team and the same chart.

The Medicare panel Granger already manages supports a service line that returns $2,092,109 of contribution margin over 24 months, on staff the group does not hire and devices it does not buy. How large it grows depends

on the panel in scope and on how fast patients enroll, which CoachCare staffs. What remains is to build it once, with a partner, and run it as the group's own.

About CoachCare

> **The experience to get it right**
>
> CoachCare manages more than 500,000 patients across over 400 conditions, with more than 10,000 clinicians running remote care programs on its platform day to day. Its teams have stood up more than 1,000 programs, built the care-plan coding and billing behind more than 5 million claims, and recorded over 100 million vitals.

- **It builds on what the group already does.** Wellness visits, in-house lab and imaging, a pulmonary and sleep clinic, urgent care, and transitional care after hospital stays are already part of the week across Granger's clinics. Remote monitoring and chronic care management fill the months between them.
- **It runs inside the chart the group already uses.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible at every clinic.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll.
- **Clinicians stay in charge.** Granger's physicians and advanced practice clinicians set the protocols, sign the care plans and make every clinical decision.
- **Designed for an older panel.** Cellular devices with nothing to pair, and outreach by phone, so no patient has to learn an app.
- **Published results.** A 29.1 mmHg drop in Stage 2 hypertension across 2,738 patients at Cardiac Solutions, half the 30-day readmission rate across 26,689 patients at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session to confirm Granger's Medicare chart count by payer and by clinic, check how each Medicare Advantage contract covers the care-management codes, decide which primary care clinics and the pulmonary clinic go first, and scope the eClinicalWorks integration before the first patient enrolls.

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- **Market:** CMS Medicare Monthly Enrollment, July 2026, by county.
- **CoachCare:** eClinicalWorks integration overview, 2026; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for Granger Medical Clinic, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 6 to 10.

Unique patients and program enrollments are different numbers. At month 24 the program holds 3,900 active program enrollments belonging to 2,590 unique patients, because a patient may hold both enrollments. The 15,600-patient panel covers all payers; the 8,301 beneficiary-clinician relationships in the CY2024 claims are traditional Medicare only.