

Aspirus Health

Wausau, Wisconsin. A nonprofit health system with 18 hospitals across north-central and northern Wisconsin, Michigan's Upper Peninsula and northeastern Minnesota, about 130 outpatient locations and more than 1,700 clinicians billing Medicare, all on the Epic system Aspirus St. Luke's joined in April 2025

Remote Care Service Line Performance & Optimization

2026 Strategy Report

It already runs in Duluth. CoachCare delivers remote patient monitoring with full-service care management inside the Aspirus St. Luke's cardiology clinic today, mostly for heart-failure patients. Aspirus can run the same program in every region, on the Epic system it already shares, without hiring for it, and then open it to the chronic-disease patients in primary care. This document prices that service line.

Purpose of this document

Prepared by Connor Knapp, Head of Sales, CoachCare, in October 2026, as a discussion document for the leadership of Aspirus Health. It brings together the system's CY2024 Medicare discharge and claims record by provider number, its FY2026 heart-failure readmission ratios hospital by hospital, its verified position in two CMS payment programs, CoachCare's documented results, the CY2026 payment environment at the Wisconsin locality, and a twenty-four-month financial forecast for two clinical arms run on one engine.

Figures are drawn from CMS files pulled in September and October 2026 and from Aspirus's own public statements; the numbered footnotes give the file and vintage for each.

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Executive Summary

Aspirus Health operates 18 hospitals across 3 states: 7 acute-care hospitals and 10 Critical Access Hospitals with a Medicare provider number, plus Aspirus Chippewa Falls, which opened on 22 September 2026.¹ More than 1,700 clinicians bill Medicare through Aspirus entities, 37 of them cardiologists and 329 of them primary-care physicians.² In CY2024 the 7 acute hospitals discharged 483 Medicare fee-for-service patients in the heart-failure diagnosis groups.³

The readmission record starts with a compliment. In the FY2026 Hospital Readmissions Reduction Program file, Aspirus Wausau Hospital's heart-failure excess readmission ratio is 0.9006, better than 94.6% of the 2,621 hospitals in the file, and every Aspirus acute hospital sits at or below 1.00.⁴ Wausau and St. Luke's both run TAVR programs: Wausau's earned the TVT Registry three-star rating in January 2026, and St. Luke's marked its 500th procedure in September 2025. Wausau also runs a nurse-led Heart Failure Resource Center. The gap is absolute rather than relative. Care Compare puts the 30-day heart-failure readmission rate at 20.6% to 23.8% across the acute hospitals, so about one heart-failure patient in five is back within thirty days even where the ratio is better than expected.

The central argument

It already runs in Duluth. CoachCare delivers remote patient monitoring with full-service care management inside the Aspirus St. Luke's cardiology clinic today, mostly for heart-failure patients. After a discussion of heart-failure readmissions, leaders across Aspirus asked what it would take to run that program across the system and extend it to other chronic conditions. This document is the answer.

Outside the Duluth cardiology program, CY2024 Medicare claims show no remote monitoring or chronic care management at meaningful scale. About 37 cardiologists cover 18 hospitals, 10 of them Critical Access Hospitals, across a region where the drive is the barrier.

The service line runs in two arms on one engine. Heart failure goes first, in every Aspirus cardiology group: transitional care at discharge, remote monitoring from the first week, principal care management once the patient is stable. The employed primary-care network opens in month 10 with remote monitoring and chronic care management.

On fee-for-service economics alone, the whole service line returns \$9,745,480 of net reimbursement over 24 months and \$4,257,880 net to Aspirus, its 24-month contribution margin, a 43.69% margin. The recurring programs alone, without transitional care, return \$9,494,997 and \$4,063,731, a 42.80% margin. Heart failure on its own returns \$4,682,931 and \$2,051,765 (Section 8.3). About 41 CoachCare care managers deliver the full scope at month 24, none of them on an Aspirus requisition.

One market condition shapes every figure here. About two-thirds of Medicare beneficiaries in the core counties are in Medicare Advantage: 64.8% in St. Louis County, 65.0% in Marathon County, 67.1% in Wood County, and 60.2% weighted by the acute hospitals' heart-failure discharges.⁵ The forecast prices every patient at the Medicare rate. Medicare Advantage plans pay the remote-care code families at no less than that rate, which makes it a floor, and individual contracts set their own terms.

¹ CMS Hospital General Information, provider-data dataset xubh-q36u, and CMS Provider of Services file Q2 2025, both pulled 13 October 2026, resolved by name, city and state for every Aspirus hospital: 17 active provider numbers, 7 acute-care (1,149 certified beds) and 10 Critical Access (232 beds). Aspirus Chippewa Falls Hospital & Clinic opened for patients on 22 September 2026 (Wausau Pilot & Review, 23 September 2026; Becker's Hospital Review) and is not yet in the CMS files.

² CMS Doctors and Clinicians national file, dataset mj5m-pzi6, pulled 13 October 2026: Medicare-enrolled clinicians reassigning billing to Aspirus and St. Luke's group practices, by primary specialty. These are billing clinicians, not an employee count.

³ CMS Medicare Inpatient Hospitals by Provider and Service, CY2024, dataset 690ddc6c-2767-4618-b277-420ffb2bf27c, queried for each Aspirus provider number: heart failure MS-DRG 291 to 293. Cells under 11 discharges are suppressed, so each figure is a floor; the Critical Access Hospitals carry no reported heart-failure line.

⁴ CMS Hospital Readmissions Reduction Program, FY2026 hospital file, provider-data dataset 9n3s-kdb3, discharges 1 July 2021 to 30 June 2024, pulled October 2026. Standing computed against the 2,621 hospitals in the file that report a heart-failure ratio.

⁵ CMS Medicare Advantage State/County Penetration file, September 2026. The weighted figure weights each acute hospital's county penetration by its CY2024 fee-for-service heart-failure discharges.

The opening is dated. New CY2026 remote-monitoring codes, 99445 and 99470, make the first two weeks after a discharge billable, and transitional care management pays for the thirty days after it. Aspirus St. Luke's is a mandatory hospital in the Transforming Episode Accountability Model (TEAM), and it participates with Aspirus Lake View in an Enhanced-track Medicare Shared Savings Program ACO.

The forecast in one view

Line, 24 months	Net reimbursement	CoachCare fees	Net to Aspirus	Margin
Heart-failure arm (cardiology: RPM and PCM)	\$4,432,448	\$2,574,832	\$1,857,616	41.91%
Chronic-care arm (primary care: RPM and CCM, from month 10)	\$5,062,549	\$2,856,434	\$2,206,115	43.58%
Recurring programs, combined	\$9,494,997	\$5,431,266	\$4,063,731	42.80%
Transitional care at heart-failure discharge (own line)	\$250,483	\$56,334	\$194,149	77.51%
Whole service line, including transitional care	\$9,745,480	\$5,487,601	\$4,257,880	43.69%

Operating measure	Month 12	Month 24
Unique patients in active remote care	2,257	6,816
Active program enrollments	3,028	9,856
CoachCare care managers, at 165 patients each	about 14	about 41
Hospitalizations avoided, both arms		395 over 24 months
Care-team hours delivered by CoachCare		84,513, about 40.6 FTE-years, plus 1,159 hours of transitional care
Monthly result, whole service line	Month 1: \$36 negative	Positive every month from month 2

1. The Organization and the Panel

1.1 Eighteen hospitals in three states, on the Epic system Aspirus shares

Aspirus Health is a nonprofit, community-directed system headquartered in Wausau, Wisconsin, with a corporate office in Duluth. It serves north-central and northern Wisconsin, Michigan's Upper Peninsula and northeastern Minnesota through about 130 outpatient locations.⁶ Resolved against the CMS hospital files, 17 Aspirus hospitals carry a Medicare provider number today: 7 acute-care hospitals with 1,149 certified beds and 10 Critical Access Hospitals with 232. Aspirus Chippewa Falls Hospital & Clinic opened on 22 September 2026 as the eighteenth.

Hospital	Location	Provider number	Type	Certified beds
Aspirus Wausau Hospital	Wausau, WI	520030	Acute care	321
Aspirus St. Luke's Hospital	Duluth, MN	240047	Acute care	267
Aspirus Stevens Point Hospital	Stevens Point, WI	520002	Acute care	181
Howard Young Medical Center	Woodruff, WI	520091	Acute care	109
Aspirus Rhinelander Hospital	Rhinelander, WI	520019	Acute care	99

⁶ Aspirus Health, About page and St. Luke's affiliation page, aspirus.org, retrieved 13 October 2026.

Hospital	Location	Provider number	Type	Certified beds
Aspirus Riverview Hospital	Wisconsin Rapids, WI	520033	Acute care	99
Aspirus Divine Savior Hospital	Portage, WI	520041	Acute care	73
Ten Critical Access Hospitals	Two Harbors, MN; Iron River, Laurium and Ironwood, MI; Eagle River, Stanley, Tomahawk, Medford, Merrill and Antigo, WI	10 provider numbers	Critical Access	232
Aspirus Chippewa Falls Hospital & Clinic	Chippewa Falls, WI	Opened 22 September 2026	New hospital and clinic	Not yet in CMS files

Aspirus St. Luke's joined the system on 1 March 2024, and it moved onto Aspirus's Epic system in April 2025 together with Aspirus Lake View in Two Harbors.⁷ MyAspirus, the patient portal, is Epic MyChart. That migration is what makes a system-wide design possible: the Duluth program and every region it extends to sit on the Epic system and MyAspirus portal the rest of Aspirus uses. Aspirus leadership has said publicly that it expects more remote and telehealth care where on-site physicians are hard to staff, and that it favors tools that work inside Epic.⁸

1.2 The cardiology bench and the primary-care network

The CMS clinician file lists 37 cardiologists billing Medicare through Aspirus entities: 21 general cardiologists, 7 interventional, 7 electrophysiologists, 1 advanced heart-failure and transplant cardiologist and 1 adult congenital specialist.⁹ Two benches carry most of them. 13 cardiology physicians bill through St. Luke's Hospital of Duluth and 17 list Wausau or Weston addresses. Smaller clinics, outreach and telemedicine cover the rest of the system.

Site	What is there	What it means for the service line
Aspirus St. Luke's Heart & Vascular Care, Duluth	13 cardiology physicians in the CMS file, 3 of them electrophysiologists; outreach clinics in Hibbing, Virginia, Moose Lake and Two Harbors; a TAVR program past 500 procedures; relocated and expanded cath labs, with 33 coronary ICU beds in the next phase	The template. The CoachCare program runs here today; the expansion is the rest of the Duluth heart-failure panel and the outreach communities.
Aspirus Heart Care, Wausau	17 cardiology physicians on Wausau and Weston addresses; the Heart Failure Resource Center, a nurse and nurse-practitioner clinic that gives IV diuretics and makes follow-up calls; valve and A-fib clinics; a TAVR program with the TVT Registry three-star rating	The largest heart-failure discharge volume in the system and its lowest readmission ratio. The Resource Center's panel is a ready-made second cohort.
Rhineland and Woodruff	Aspirus Cardiology in Rhineland with electrophysiology, interventional and pediatric cardiology; a cardiology clinic at Howard Young Medical Center	The north-woods hub for the Eagle River, Tomahawk and Merrill Critical Access Hospitals.
Stevens Point, Wisconsin Rapids and Portage	Cardiology at three central Wisconsin acute hospitals; Aspirus Heart Care expanded to Divine Savior in Portage; the system's advanced heart-failure cardiologist practices in Portage and Stevens Point	Three acute hospitals within reach of Wausau's protocols.
Upper Peninsula	Aspirus Cardiology clinics in Ironwood and Laurium; cardiology telemedicine at Keweenaw	The longest drives in the system, where cellular devices and a central care team do the most work.

⁷ Aspirus, St. Luke's affiliation page (affiliation closed 1 March 2024; Epic committed within 24 months); Duluth News Tribune, 16 September 2024, reporting Epic implementation the following April. MyAspirus verified as Epic MyChart at the myaspirus.org login page, 13 October 2026.

⁸ Interview with Aspirus Health's chief executive, Chief Healthcare Executive, 21 May 2026.

⁹ See note 2. Cardiology-family primary specialties: general cardiology, interventional cardiology, clinical cardiac electrophysiology, advanced heart failure and transplant cardiology, adult congenital heart disease.

The primary-care arm draws on the employed network: Aspirus Medical Group and the hospital-based clinic corporations. The CMS file lists 329 primary-care physicians, 201 in family medicine, 126 in internal medicine and 2 in general practice, alongside about 615 nurse practitioners and physician assistants.¹⁰ The forecast counts the physicians as its referral base and leaves the nurse practitioners and physician assistants out of it. Aspirus St. Luke's alone runs primary-care clinics in Duluth, Hermantown, Hibbing, Mountain Iron, Superior and Ashland.

1.3 Sizing the two panels

The heart-failure arm is sized two independent ways, and they converge. The 7 acute hospitals discharged 483 Medicare fee-for-service heart-failure patients in CY2024; at about five prevalent heart-failure patients for every annual discharge, that is about 2,400 traditional-Medicare heart-failure patients under Aspirus care. The CY2024 Medicare claims of Aspirus's cardiologists give about the same figure.¹¹ Grossed up for the 60.2% discharge-weighted Medicare Advantage share, that is about 6,000 Medicare heart-failure patients. The forecast models about 5,700 Medicare heart-failure patients across the Aspirus cardiology groups, not counting the patients already enrolled in Duluth.

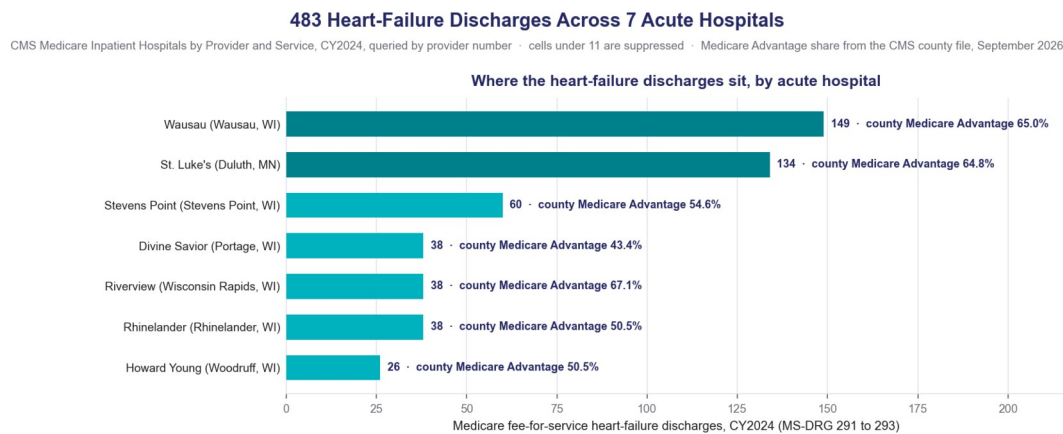


Figure 1. CY2024 Medicare fee-for-service heart-failure discharges by acute hospital, from the CMS inpatient file queried by provider number, with each hospital's county Medicare Advantage share.

The chronic-care arm is sized from the CY2024 claims of Aspirus primary-care physicians, nurse practitioners and physician assistants: established-visit beneficiaries, de-duplicated and grossed up for Medicare Advantage. That gives about 72,000 Medicare patients in the employed primary-care panel and 66,000 in scope once the heart-failure cohort is set aside.¹² The panel carries the conditions these programs are built for: about seven in ten patients have hypertension, 31% diabetes, 27% chronic kidney disease, 28% heart failure and 18% COPD.

CY2024 Medicare claims profile	Clinicians with a claims line	Beneficiaries	With heart failure	With diabetes	With kidney disease	With COPD
Cardiologists	22	23,063	10,058	7,682	7,404	4,691
Primary-care physicians	196	40,444	11,814	12,696	11,663	7,562
Nurse practitioners and physician assistants	364	41,932	10,842	12,679	10,881	7,057

¹⁰ See note 2. Primary-care physicians: family medicine, internal medicine and general practice. Nurse practitioners and physician assistants are counted separately.

¹¹ See note 3 for discharges. Claims: CMS Medicare Physician & Other Practitioners by Provider, CY2024, for Aspirus cardiologists, heart-failure beneficiary counts from the file's chronic-condition fields. The two methods give 2,415 and 2,347.

¹² CMS Medicare Physician & Other Practitioners by Provider, CY2024, for Aspirus primary-care physicians, nurse practitioners and physician assistants: established office-visit beneficiaries, de-duplicated across clinicians, grossed up for the county Medicare Advantage share. Prevalence from the same file's chronic-condition fields.

Each clinician's beneficiaries are counted once per clinician in that table, so a patient seen by two clinicians appears twice; the panel figures above are de-duplicated. Outside the Duluth cardiology program, CY2024 Medicare claims show no remote monitoring or chronic care management at meaningful scale. What the claims do show is 285 beneficiaries with transitional care management and about 2,400 with remote checks of an implanted cardiac device.¹³

1.4 The market: about two-thirds Medicare Advantage

County (hospital)	State	Medicare eligibles	MA enrolled	MA penetration
St. Louis (Aspirus St. Luke's, Duluth)	MN	52,270	33,870	64.8%
Lake (Aspirus Lake View, Two Harbors)	MN	3,405	2,230	65.5%
Marathon (Aspirus Wausau)	WI	32,513	21,120	65.0%
Wood (Aspirus Riverview, Wisconsin Rapids)	WI	20,577	13,799	67.1%
Portage (Aspirus Stevens Point)	WI	16,750	9,153	54.6%
Oneida (Rhineland; Howard Young, Woodruff)	WI	13,670	6,905	50.5%
Columbia (Aspirus Divine Savior, Portage)	WI	14,814	6,430	43.4%
Vilas (Aspirus Eagle River)	WI	9,664	4,253	44.0%
Houghton (Aspirus Keweenaw, Laurium)	MI	8,175	4,359	53.3%
Gogebic (Aspirus Ironwood)	MI	4,712	2,160	45.8%
Weighted by acute-hospital heart-failure discharges				60.2%

Two-thirds of Medicare lives in Duluth and Wausau are in Medicare Advantage, and the share runs from 43.4% in Columbia County to 67.1% in Wood County.¹⁴ That number does two things to this analysis. It sets the panel arithmetic in Section 1.3, because discharge and claims counts are fee-for-service only and have to be grossed up to reach a total Medicare population. And it makes plan treatment of the care-management codes a contracting question. The forecast prices every patient at the Medicare rate; Medicare Advantage plans pay the remote-care code families at no less than that rate, a floor, and individual contracts set their own terms.

2. The Proof Inside the System

2.1 The program running in Duluth

CoachCare runs remote patient monitoring with full-service care management inside the Aspirus St. Luke's cardiology clinic in Duluth today, mostly for heart-failure patients. CoachCare's team enrolls the patients, ships the cellular devices, reviews the readings, makes the monthly clinical contact and builds the claims. The cardiologists set the thresholds and make every clinical decision. After a discussion of heart-failure readmissions, leaders across Aspirus asked what it would take to run the same program across the system and extend it to other chronic conditions. This document answers that question.

The Duluth program is the template for everything in Sections 4 through 9. Its own results (enrollment to date, readmissions and emergency visits on the enrolled cohort) are the first item for the working session in Section 12. They are the figures Aspirus will weigh most heavily, and they are Aspirus's to present.

¹³ See note 12. Remote-care codes across all Aspirus billing clinicians, CY2024: remote physiologic monitoring, chronic care management, principal care management, transitional care management, and implanted-device remote interrogation.

¹⁴ See note 5. County figures from the September 2026 release.

2.2 CoachCare's results in other programs

Program	Population	Result
Iowa Heart Center ¹⁵	450 advanced heart-failure patients, NYHA class III and IV, over a six-month evaluation	Zero readmissions, against an 18% 30-day readmission rate on the same patient panel before the program
Cardiac Solutions, readmissions ¹⁶	26,689 cardiology patients over twelve months, on chronic care management and remote monitoring	A 30-day readmission rate of 7% among enrolled patients against 15% among patients not enrolled, about half
Cardiac Solutions, hypertension ¹⁷	2,738 patients in a cardiology remote-monitoring program	A 29.1 mmHg average blood-pressure reduction among patients with Stage 2 hypertension

Read together, these show the operating recipe this document proposes: daily physiologic data, a triage protocol and a documented monthly clinical contact, on top of the care the physician already gives. The Iowa Heart cohort is the closest match to Aspirus's heart-failure arm, and the Cardiac Solutions readmission result shows the same effect across a whole cardiology practice. The Cardiac Solutions hypertension result is the closest match to a primary-care panel in which about seven patients in ten have hypertension.

2.3 What Aspirus has built, and what it leaves open

Program	What it does	What it leaves open
CoachCare remote monitoring, St. Luke's cardiology	Daily readings and monthly care management for heart-failure patients of the Duluth clinic	The heart-failure patients of every other Aspirus cardiology group, and primary care
Heart Failure Resource Center, Wausau	Nurse and nurse-practitioner clinic: IV diuretics in clinic; medication, diet and symptom education; follow-up phone calls; takes outside referrals	Daily physiologic monitoring between visits, and monthly care management billed for it
Implanted-device remote checks	Remote interrogation of pacemakers and defibrillators, about 2,400 Medicare patients in CY2024	Heart-failure patients without an implanted device
MyAspirus portal and e-visits	Epic MyChart portal; asynchronous e-visits for minor acute conditions, expanded in September 2025	Scheduled monitoring and care management for chronic disease
Cardiology outreach and telemedicine	Circuit clinics from Duluth; telemedicine cardiology at Keweenaw	Contact between visits

Every item in that table stays, and the service line displaces none of it. The record shows a specific gap: daily physiologic monitoring and monthly care management for the heart-failure population outside Duluth, and anything at all in primary care. The service line completes what is there, and that gap is what this document prices.¹⁸

¹⁵ CoachCare, Iowa Heart Center case study, 2026: six-month evaluation of 450 advanced heart-failure patients enrolled in remote patient monitoring alongside standard care; 0% readmissions against an 18% 30-day readmission benchmark on the same patient panel.

¹⁶ CoachCare, Cardiac Solutions readmissions case study, 2026: 26,689 unique patients over twelve months in a cardiology practice running chronic care management and remote monitoring integrated with its EHR; 30-day readmission rate 7% among enrolled patients against 15% among patients not enrolled.

¹⁷ CoachCare, Cardiac Solutions case study, April 2026: 2,738 patients monitored; 29.1 mmHg average reduction among patients with Stage 2 hypertension.

¹⁸ Aspirus cardiology and heart and vascular services pages, aspirus.org, retrieved 13 October 2026; Wausau Pilot & Review, 24 September 2025, on the MyAspirus e-visit expansion. Device checks from the CY2024 claims in note 13.

3. The Heart-Failure Readmission Record

3.1 The compliment first: Wausau at 0.9006

The FY2026 Hospital Readmissions Reduction Program file covers discharges from July 2021 through June 2024 and gives each hospital a heart-failure excess readmission ratio: its predicted readmissions divided by the readmissions CMS would expect for the same patients at an average hospital. Below 1.00 means fewer than expected.¹⁹ Aspirus Wausau Hospital sits at 0.9006 on 436 heart-failure discharges in the window, better than 94.6% of the 2,621 hospitals in the file, in the top 6% nationally. Aspirus Riverview follows at 0.9505 and Howard Young at 0.9695. Aspirus St. Luke's, at 0.9940, is better than 53% of hospitals. No Aspirus acute hospital is above 1.00, and Stevens Point sits exactly on it.

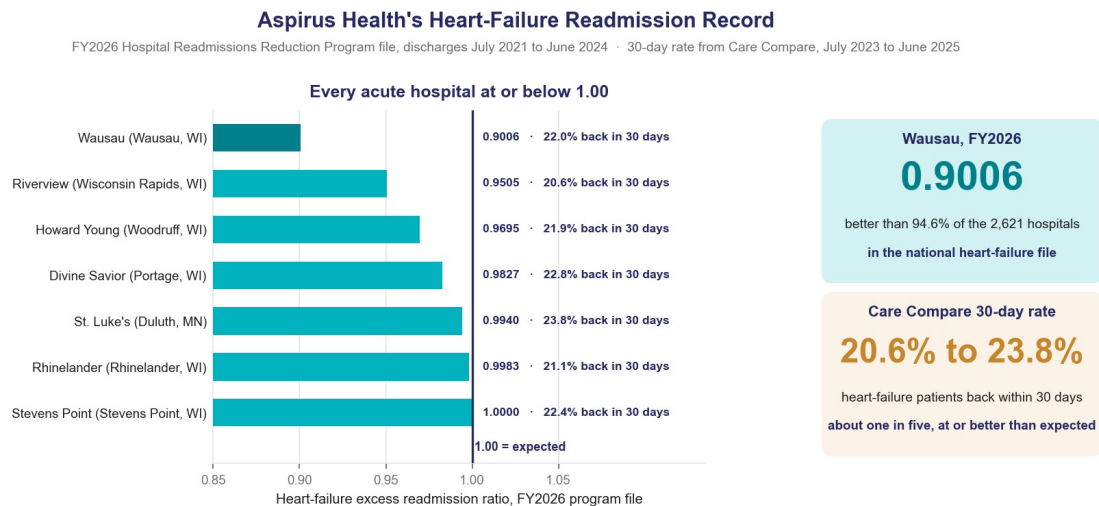


Figure 2. FY2026 heart-failure excess readmission ratios for the seven Aspirus acute hospitals, with each hospital's Care Compare 30-day heart-failure readmission rate.

3.2 One in five, even at or better than expected

Hospital	Provider number	HF discharges in the window	HF excess readmission ratio	30-day HF readmission rate	CY2024 Medicare FFS HF discharges
Aspirus Wausau Hospital	520030	436	0.9006	22.0%	149
Aspirus Riverview Hospital	520033	109	0.9505	20.6%	38
Howard Young Medical Center	520091	Too few to report	0.9695	21.9%	26
Aspirus Divine Savior Hospital	520041	84	0.9827	22.8%	38
Aspirus St. Luke's Hospital	240047	193	0.9940	23.8%	134
Aspirus Rhinelander Hospital	520019	130	0.9983	21.1%	38
Aspirus Stevens Point Hospital	520002	110	1.0000	22.4%	60

The gap that matters is absolute. Care Compare's 30-day heart-failure readmission rate for July 2023 through June 2025 runs from 20.6% at Riverview to 23.8% at St. Luke's.²⁰ Even at or better than expected, about one Aspirus heart-failure patient in five is back within thirty days. The ratio measures

¹⁹ See note 4. Predicted and expected rates as published in the file.

²⁰ CMS Care Compare, Unplanned Hospital Visits, measure READM_30_HF, 1 July 2023 to 30 June 2025, pulled October 2026.

each hospital against a peer expectation, and the rate measures what happens to the patient. The service line in Section 4 is aimed at the rate.

Why the thirty days after discharge are the target

Most heart-failure readmissions start at home in the first two weeks, often before the follow-up visit. That is the window the new CY2026 short-window codes now pay for, and the window the three-touch cadence in Section 4.4 is built around.

At St. Luke's the same thirty days are scored twice more: inside every TEAM surgical episode, and on the benchmark of the Enhanced-track ACO (Section 6).

Wausau's 0.9006 shows what good looks like inside the same system. The aim is a lower rate at every hospital, and it starts with the Duluth patients the program already reaches.

4. The Service Line

4.1 The heart-failure arm: transitional care, monitoring, principal care

The service line is one operating engine with two clinical arms. The heart-failure arm runs in cardiology and follows the patient in the order the codes do: a transitional care contact at discharge, remote physiologic monitoring from the first week, and principal care management for heart failure as the single dominant condition once the patient is stable enough to manage rather than watch. Patients enter two ways: at the cardiology visit, where the referring cardiologists and CoachCare's on-site enrollment specialist flag eligible patients, and by post-discharge outreach after a heart-failure admission.

Step	Program	Population	What it is for
At discharge	Transitional care management, 99495 and 99496	Medicare heart-failure discharges from the 7 acute hospitals, about 101 a month once Medicare Advantage is counted	The contact within two business days and the visit within seven or fourteen that open the thirty-day window. Modeled as its own line at 50% capture, about 53 episodes a month at steady state.
From the first week	Remote physiologic monitoring: 99453 at setup, 99445 or 99454 for the device, 99470, 99457 or 99458 for management	The heart-failure cohort in Section 1.3, from post-discharge outreach and from the office visit	Daily weight, blood pressure and heart rate with a triage protocol behind them. Fills its ceiling of 1,496 at month 9.
Once stable	Principal care management, 99426 and 99427	Patients with heart failure as the single dominant condition, managed for three months or more	The monthly clinical contact, medication reconciliation and care-plan work that close guideline-therapy gaps. Reaches its ceiling of 1,454 at month 22.

The short-window codes are what make the first month work. A patient home from the hospital rarely produces the sixteen device-days the standard supply code requires in that first month, so under the older codes alone it went unbilled. Codes 99445 and 99470, new for CY2026, pay for two to fifteen device-days and for ten to twenty minutes of management, which is the pattern a post-discharge patient produces.

4.2 The chronic-care arm in primary care

The second arm runs in the employed primary-care network and opens in month 10, once the heart-failure arm has filled its monitoring ceiling. It pairs remote physiologic monitoring for patients with a reading to manage, most often blood pressure or glucose, with chronic care management, 99490 and 99439, for patients with two or more chronic conditions. In a panel where about seven patients in ten

have hypertension and nearly a third have diabetes, the eligible population is large: 42,900 for monitoring and 49,500 for chronic care management. The 329 primary-care physicians refer at the visit, and the arm has its own CoachCare enrollment specialist working the primary-care clinics.

Three further tracks run on the same engine and carry no revenue in this forecast:

- **Advanced primary care management, G0556 to G0558.** The build-toward step for the primary-care arm: a monthly code family for practices that take on the full primary-care model. Modeled at \$0.
- **Behavioral health integration, 99484.** Depression and anxiety screening and follow-up for patients already enrolled. Modeled at \$0.
- **COPD and chronic kidney disease through pulmonology and nephrology.** Aspirus bills Medicare through 15 pulmonologists and 12 nephrologists, and their patients run on remote monitoring and principal care management the same way heart failure does. Modeled at \$0.

One Operating System, Every Value Lever

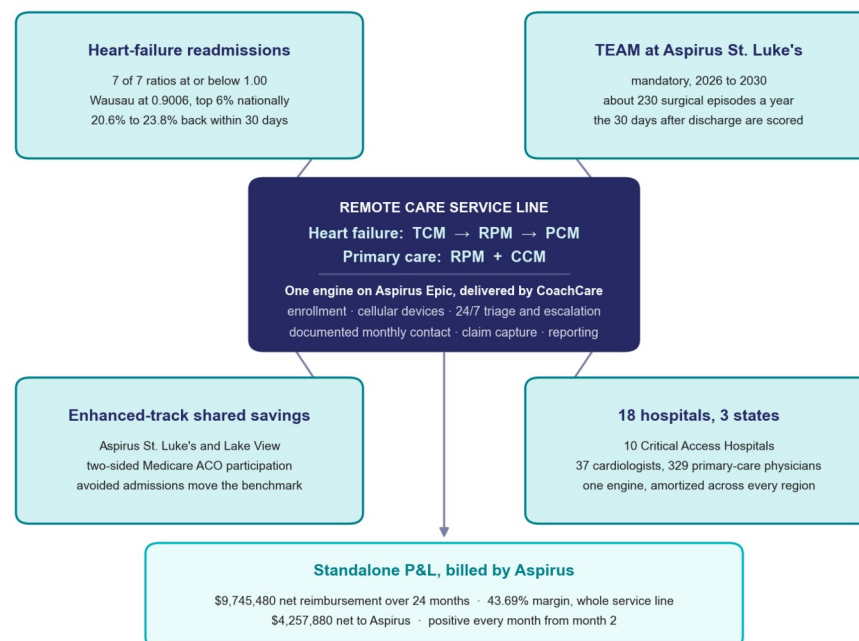


Figure 3. The same enrollment, device, triage, documentation and billing engine carries both arms, the standalone service-line P&L and each verified payment program in Section 6.

4.3 Built for a rural footprint

Ten of the seventeen Aspirus hospitals with a provider number are Critical Access Hospitals, and their heart-failure patients go home a long way from a cardiologist. Cardiology reaches the Upper Peninsula and the north woods by circuit clinics and telemedicine. The service line is designed for that geography from the start.

- **Cellular devices.** Scales, blood-pressure cuffs and pulse oximeters transmit over the cellular network. No home internet, Wi-Fi or smartphone is needed, and CoachCare ships, sets up and replaces the devices.
- **A central care team.** Care managers work by phone from one central team, so a patient in Ironwood gets the same daily review and monthly contact as a patient in Wausau.

- **The cardiologist stays local.** Alerts route to the patient's own Aspirus cardiology clinic, including the outreach and telemedicine clinics, under thresholds that clinic sets.
- **Critical Access discharges count.** A patient discharged home from Eagle River or Iron River enters the same post-discharge cadence as one discharged from Duluth.

4.4 Clinical governance and escalation

The economics show the service line pays. Governance is what makes it safe to run in every region at once. Every reading a patient takes routes through one escalation engine, and only signal reaches the clinical team.²¹

Tier	Trigger	What happens
Emergency	Active emergent symptoms reported during outreach: chest pain, new shortness of breath, stroke signs, fainting	CoachCare calls 911 with the patient still on the line. If the patient refuses, the case routes to the clinic. If the patient cannot be reached, 911 is activated anyway.
Critical values	A critical reading, with or without symptoms	Escalates regardless of symptoms. If the patient is unreachable, CoachCare leaves a voicemail, sets a callback and escalates anyway.
Non-critical	An out-of-range reading	The reading is retaken with a symptom check first. A confirmed trend routes to the clinic team member named for that cohort.
Stable and resolved	In-range readings and resolved trends	Documented in the record. No page, no call; the clinician sees the trend at the next visit.

Routing runs three ways: emergencies to 911, clinical escalations to the patient's Aspirus clinic, and everything else into the record. On top of that, any hospitalization or emergency department visit in the previous sixty days triggers a fixed three-touch cadence: a contact on days 1 to 2, a second on days 5 to 8 and a third on days 12 to 14. Each one carries medication reconciliation, a structured symptom check, confirmation of the follow-up appointment and a device reading taken inside a window that bills.²² That cadence is the operating mechanism behind the 395 hospitalizations the forecast avoids, and it runs inside the thirty-day transitional care window.

What Aspirus sets, and what CoachCare runs

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

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

Discharge from the program is governed too. Unreachable patients follow a program-specific escalation timeline, the clinic is notified in every case, and a recommended discharge is re-escalated every thirty days before it proceeds.

²¹ CoachCare Care Management Programs Standard Operating Procedures, version March 2026: process map 04, Clinical Alert and Escalation Decision Logic, sections 4.7 to 4.10; process map 05, Emergent and Urgent Communication Protocol, section 5; process map 07, Patient Discharge Decision Flow, section 11.

²² Same source as note 21: process map 06, Post-Discharge Follow-Up Sequence, section 7.6.1.

5. The Epic Integration

The program runs inside Aspirus's Epic system rather than beside it. Clinicians in every region work in the record they already use, the revenue cycle gains no manual step, and the integration is built once. Aspirus St. Luke's joined the Epic system in April 2025, so the Duluth program and every region it extends to sit on the Epic system and MyAspirus portal the rest of Aspirus uses.

Integration pillar	What it does in the record
Integrated enrollment	Enrollment flags and trigger ordering sit inside the clinical workflow. CoachCare enrolls qualified Medicare patients on Aspirus's behalf, and enrollment status is visible in Epic in real time.
Exchange of health history	Bi-directional at intake, so the care team starts from what is already in the chart instead of from a phone call.
Integrated discrete vitals	Device readings land in the chart as discrete vitals, not as scanned documents or in a separate portal. A cardiologist can trend a weight series; nobody trends an attachment.
Compliance documentation and integrated care summary	The care summary and time documentation each code requires are written into the record as the work happens, which is what makes each claim defensible on audit.
Automated claim generation	CoachCare is the only care-management application integrated with Epic that creates claims automatically. That removes one manual step per patient per month, across 6,816 patients at month 24.

Two consequences carry into the ramp in Section 8. Patients begin receiving monitoring and care-management services in under five days from the enrollment flag, which is why the census climbs as steeply as it does through the first year. And because claim construction is automatic, the 185,975 claims in Section 8.6 never reach a billing desk as manual work. The integration fee is charged once, on the heart-failure arm. The primary-care arm uses the same build and adds only the per-patient fee.

6. The Payment Programs

Two CMS payment programs reach Aspirus today, both through Aspirus St. Luke's, and each is verified against the provider number in the live CMS file. No dollars from either program are claimed in this document, and none are in the Value Analysis in Section 8, which is priced on the fee-for-service codes alone.

6.1 TEAM at Aspirus St. Luke's

Aspirus St. Luke's, provider number 240047, is a mandatory participant in the Transforming Episode Accountability Model from 1 January 2026 through 31 December 2030, in CBSA 20260 Duluth, MN-WI.²³ No other Aspirus hospital is on the participant list, and the ten Critical Access Hospitals sit outside the model by category. TEAM holds the hospital accountable for the cost of a surgical episode through the thirty days after discharge. In CY2024 St. Luke's discharged about 230 Medicare fee-for-service patients in the TEAM episode groups.²⁴

TEAM episode group, CY2024	Medicare FFS discharges at St. Luke's
LEJR (470)	85
Hip/femur (480,481,522)	83

²³ CMS TEAM participant list as of 18 August 2026, pulled October 2026; provider number 240047, mandatory, 1 January 2026 to 31 December 2030. No other Aspirus provider number appears. Critical Access Hospitals are outside the model by category.

²⁴ See note 3. St. Luke's CY2024 Medicare fee-for-service discharges in the TEAM episode MS-DRGs; cells under 11 are suppressed, so each figure is a floor.

TEAM episode group, CY2024	Medicare FFS discharges at St. Luke's
Major bowel (329,330)	37
CABG (236)	12
Spinal fusion (460)	11
Total, about	230

Heart failure is not a TEAM episode. Coronary artery bypass grafting, joint replacement, hip fracture, spinal fusion and major bowel surgery are. For those patients the transitional care contact and the short-window monitoring codes sit inside the thirty-day episode CMS reconciles, so the same post-discharge cadence that serves heart failure serves a surgical episode too. That is the whole of the episode story here, scoped to one hospital.

6.2 An Enhanced-track shared savings ACO in Duluth

Aspirus St. Luke's and Aspirus Lake View participate in an Enhanced-track Medicare Shared Savings Program ACO in performance year 2026.²⁵ Enhanced is the two-sided track: the ACO shares in savings below its benchmark and carries losses above it. An avoided heart-failure admission on an assigned beneficiary is fee-for-service margin for the service line and, separately, spend that stays under the ACO's benchmark. The shared-savings layer is specific to the Duluth market. How St. Luke's participation runs, who owns its performance, and whether there is an ACO care-management team for the service line to work with are items in Section 12.

The ACO is also scored on quality. The Shared Savings Program measure set includes controlling high blood pressure (quality ID 236), hemoglobin A1c poor control in diabetes (001), depression screening and follow-up (134), and unplanned admissions for patients with multiple chronic conditions (484).²⁶ Each one moves with work the service line does every month: home blood-pressure averages and titration, glucose readings and chronic care management, PHQ screening inside the monthly contact, and outreach on a confirmed trend before it becomes an admission. The same measures sit in MIPS reporting, where heart-failure therapy measures 008 and 005 also reward the monthly titration that principal care management makes routine.

7. The CY2026 Billing Stack at the Wisconsin Locality

Every rate below is the CY2026 non-facility physician fee schedule amount at Aspirus's headquarters locality: National Government Services (J6), Wisconsin locality 00, MAC 06302-00, resolved from ZIP 54401.²⁷ The forecast is priced there. Wisconsin and Michigan entities bill at their own localities, and Aspirus St. Luke's bills at the Minnesota locality, which pays these codes a few percent more: \$53.37 against \$49.70 for 99454, and \$65.37 against \$63.24 for 99490. Section 8.7 prices both arms at the Minnesota rate.

²⁵ CMS Medicare Shared Savings Program ACO participants file, performance year 2026, dataset 9767cb68-8ea9-4f0b-8179-9431abc89f11, pulled 13 October 2026: St. Luke's Hospital of Duluth and Lake View Memorial Hospital, Inc. are participants of one Enhanced-track ACO. Assigned beneficiaries are not carried in the file.

²⁶ CMS Medicare Shared Savings Program quality performance standard, APP Plus quality measure set, which includes CAHPS for MIPS (321), hospital-wide readmission (479), admissions for patients with multiple chronic conditions (484), diabetes hemoglobin A1c poor control (001), depression screening and follow-up plan (134) and controlling high blood pressure (236). MIPS quality measures 008 and 005: beta-blocker, and ACE inhibitor, ARB or ARNI therapy, for left ventricular systolic dysfunction.

²⁷ CMS Medicare Physician Fee Schedule, CY2026 RVU file and GPCIs, non-facility amounts for MAC locality 06302-00, Wisconsin, resolved from ZIP 54401 through the CY2026 ZIP-to-locality crosswalk; conversion factor \$33.4009.

Code	What it pays for	CY2026 rate	Where it fires
99495	Transitional care management, moderate complexity	\$210.64	Once per discharge, in the heart-failure arm
99496	Transitional care management, high complexity	\$286.17	Once per discharge; 30% of episodes in the forecast
99453	Remote monitoring setup and patient education	\$20.36	Once, at enrollment
99454	Device supply and transmission, 16 to 30 days	\$49.70	Monthly, at steady state
99445	Device supply and transmission, 2 to 15 days	\$49.70	New for CY2026. The post-discharge month, and any short month.
99457	Treatment management, first 20 minutes	\$49.58	Monthly
99458	Treatment management, each additional 20 minutes	\$39.66	Monthly, higher-touch patients
99470	Treatment management, 10 to 20 minutes	\$24.96	New for CY2026. Shorter months and step-down patients.
99490	Chronic care management, clinical staff, first 20 minutes	\$63.24	Monthly, primary-care arm
99439	Chronic care management, each additional 20 minutes	\$48.21	Monthly, primary-care arm
99426	Principal care management, clinical staff, first 30 minutes	\$64.84	Monthly, heart-failure arm
99427	Principal care management, each additional 30 minutes	\$51.75	Monthly, heart-failure arm
99424	Principal care management, physician, first 30 minutes	\$83.48	Where the cardiologist delivers the service directly
99425	Principal care management, physician, each additional 30 minutes	\$58.76	As above

What decides what this stack earns

The two care-management programs do not collide. Principal care management and chronic care management cannot both be billed for the same patient in the same month. The heart-failure arm uses principal care management and the primary-care arm uses chronic care management, and remote monitoring can be billed alongside either one.

The new codes carry real money. Codes 99445 and 99470 account for about \$1.03 million of gross reimbursement over 24 months in this forecast, about 11% of recurring net reimbursement.

Medicare Advantage sets a floor. At 60.2% discharge-weighted penetration, most of the panel's reimbursement runs through plan contracts. The forecast prices every patient at the Medicare rate; plans pay these code families at no less than that rate, and individual contracts set their own terms.

8. The Value Analysis

8.1 Model inputs

The forecast models two arms on one engine, billed by Aspirus at the Wisconsin locality, with transitional care at heart-failure discharge as its own line. Every input below is the one the Value Analysis runs on.

Input	Heart-failure arm	Chronic-care arm
Specialty and programs	Cardiology: remote monitoring and principal care management	Primary care: remote monitoring and chronic care management
Medicare patients in scope	5,700 across the cardiology groups, net of Duluth enrollees	66,000, from a primary-care panel of 72,000
Referring clinicians	37 cardiologists	329 primary-care physicians
Eligibility	Monitoring 75% (4,275) · principal care 85% (4,845)	Monitoring 65% (42,900) · chronic care 75% (49,500)
Acceptance of eligible patients	35% · 30%	35% · 30%
Program ceilings	Monitoring 1,496 · principal care 1,454	Monitoring 15,015 · chronic care 14,850
Opens	Month 1	Month 10
Enrollment support	One on-site enrollment specialist, employed by CoachCare	One on-site enrollment specialist, employed by CoachCare
Transitional care at discharge	About 101 Medicare heart-failure discharges a month, 50% captured, 30% at high complexity	Not applied
Rate basis and payer mix	CY2026 non-facility, locality 06302-00, ZIP 54401; 60.2% Medicare Advantage, priced at the Medicare rate	Same

8.2 The twenty-four-month forecast

The 24-Month Forecast: Heart Failure First, Primary Care From Month 10

6,816 unique patients and 9,856 active program enrollments at month 24 · \$9,745,480 net reimbursement · \$4,257,880 net to Aspirus, whole service line

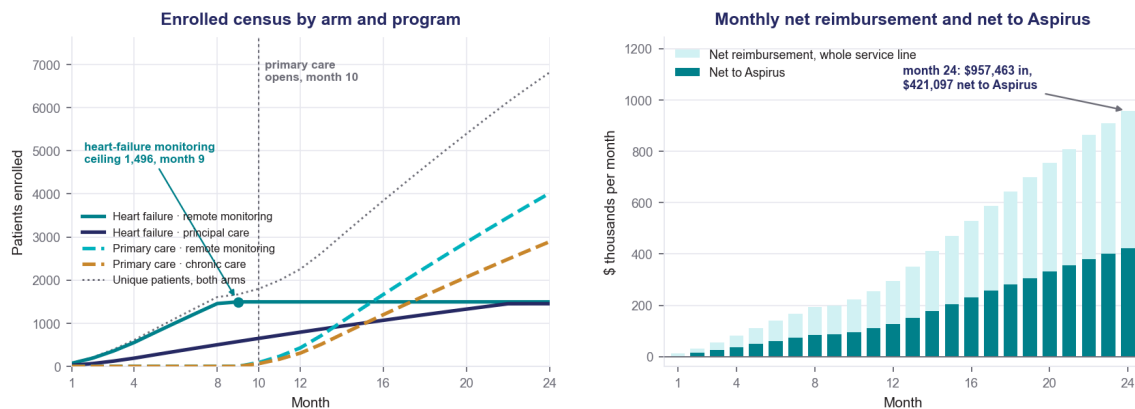


Figure 4. Enrolled census by arm and program, with unique patients across both arms; and monthly net reimbursement against what Aspirus keeps, whole service line.

Modeled result	Year 1	Year 2	24 months
Recurring programs			
Net reimbursement to Aspirus	\$1,645,434	\$7,849,563	\$9,494,997
CoachCare fees	\$971,201	\$4,460,066	\$5,431,266
Net to Aspirus	\$674,233	\$3,389,497	\$4,063,731
Margin, recurring programs	40.98%	43.18%	42.80%
Whole service line, including transitional care			
Net reimbursement to Aspirus	\$1,759,970	\$7,985,510	\$9,745,480
CoachCare fees	\$996,960	\$4,490,641	\$5,487,601

Modeled result	Year 1	Year 2	24 months
Net to Aspirus	\$763,009	\$3,494,870	\$4,257,880
Margin, whole service line	43.35%	43.77%	43.69%

Program, 24 months	Net reimbursement	CoachCare fees	Net to Aspirus	Margin
Heart failure · remote monitoring	\$2,758,175	\$1,579,883	\$1,178,292	42.72%
Heart failure · principal care management	\$1,674,272	\$895,394	\$778,878	46.52%
Heart failure · implementation, Epic integration and telephonic		\$99,554	-\$99,554	
Heart-failure arm	\$4,432,448	\$2,574,832	\$1,857,616	41.91%
Primary care · remote monitoring	\$2,806,622	\$1,580,831	\$1,225,791	43.67%
Primary care · chronic care management	\$2,255,928	\$1,145,908	\$1,110,020	49.20%
Primary care · per-patient Epic and telephonic fees		\$129,696	-\$129,696	
Chronic-care arm	\$5,062,549	\$2,856,434	\$2,206,115	43.58%
Recurring programs, combined	\$9,494,997	\$5,431,266	\$4,063,731	42.80%
Transitional care at heart-failure discharge	\$250,483	\$56,334	\$194,149	77.51%
Whole service line	\$9,745,480	\$5,487,601	\$4,257,880	43.69%

Program, by year	Year 1 net reimbursement	Year 1 net to Aspirus	Year 2 net reimbursement	Year 2 net to Aspirus
Heart failure · remote monitoring	\$1,102,446	\$480,619	\$1,655,729	\$697,673
Heart failure · principal care management	\$408,347	\$189,965	\$1,265,926	\$588,914
Heart failure · implementation, Epic integration and telephonic		-\$52,903		-\$46,651
Heart-failure arm	\$1,510,793	\$617,680	\$2,921,655	\$1,239,935
Primary care · remote monitoring	\$77,537	\$37,293	\$2,729,084	\$1,188,497
Primary care · chronic care management	\$57,104	\$28,098	\$2,198,823	\$1,081,922
Primary care · per-patient Epic and telephonic fees		-\$8,838		-\$120,857
Chronic-care arm	\$134,642	\$56,553	\$4,927,908	\$2,149,562
Transitional care at heart-failure discharge	\$114,535	\$88,776	\$135,948	\$105,373
Whole service line	\$1,759,970	\$763,009	\$7,985,510	\$3,494,870

The margin, and how it is defined

Margin is 24-month net to Aspirus divided by 24-month net reimbursement. On the whole service line, the headline figure in this document, that is $\$4,257,880 \div \$9,745,480 = 43.69\%$, with Year 1 at 43.35% and Year 2 at 43.77%. The recurring programs alone, without transitional care, run at 42.80%: $\$4,063,731 \div \$9,494,997$, with Year 1 at 40.98% and Year 2 at 43.18%. By arm, heart failure runs at 40.88% in Year 1 and 42.44% in Year 2, and primary care at 42.00% and 43.62%.

Month 1 of the whole service line is \$36 negative, as implementation and Epic integration setup post against a census that is still building. Every month from month 2 is positive, and by month 24 the service line takes in \$957,463 a month and Aspirus keeps \$421,097 of it.

The enrollment specialists, care managers, devices and logistics are CoachCare's expense. They sit inside the fee and are never deducted from the margin shown.

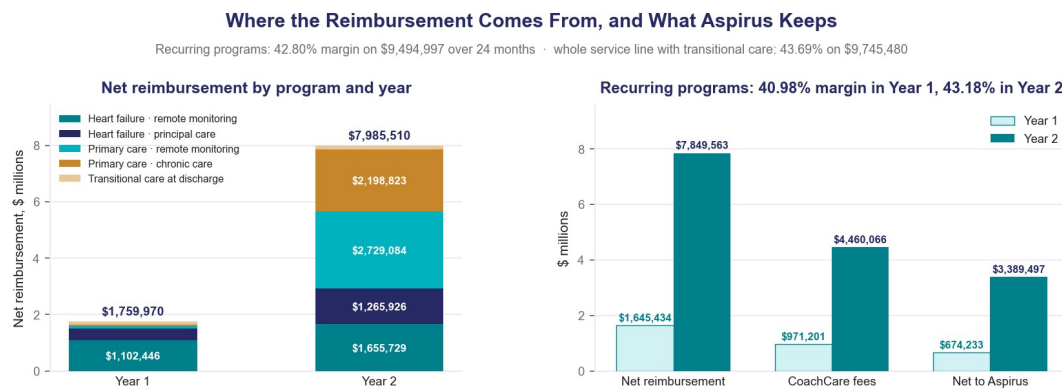


Figure 5. Net reimbursement by arm, program and year, and the recurring programs' result by year.

8.3 Three deployment scopes

The forecast above is the broad deployment: heart failure in every cardiology group and the full chronic-disease panel in primary care. Aspirus can start narrower. The heart-failure arm stands on its own, and primary care can open to its hypertension population first.

Scope	What is deployed	Net reimbursement, 24 months	Net to Aspirus	Margin	Unique patients, month 24	Hospital stays avoided
Low: heart failure only	The heart-failure population across every Aspirus cardiology group, with transitional care at each heart-failure discharge	\$4,682,931	\$2,051,765	43.81%	1,932	197
Moderate: heart failure and hypertension	Adds the primary-care hypertension population: uncontrolled patients on home blood-pressure monitoring and chronic care management	\$7,214,205	\$3,154,822	43.73%	4,374	296
High: broad deployment (the forecast)	Heart failure in cardiology, plus hypertension, diabetes, chronic kidney disease and COPD across the primary-care network	\$9,745,480	\$4,257,880	43.69%	6,816	395

Even the heart-failure-only scope is positive every month from month 2 and returns \$2,051,765 to Aspirus over 24 months. Each wider scope adds primary care on the same engine, with no second implementation or integration fee, and the margin holds within a fraction of a point across all three.

8.4 Two arms, two different constraints

The heart-failure arm is limited by its cohort. Remote monitoring fills to its ceiling of 1,496 enrolled patients by month 9 and holds. From then on, the size of the heart-failure population, not the pace of onboarding, is the binding constraint. Principal care management fills more slowly, to 1,454 by month 22, because patients join it once they are stable.

The primary-care arm is limited by onboarding capacity. Its eligible population is far larger than 24 months of enrollment can reach: at month 24 it carries 4,016 remote-monitoring and 2,890 chronic-care enrollments against ceilings of 15,015 and 14,850. The pace the care team can onboard responsibly across the account, about 325 net-new enrollments a month at the Year 1 peak and 489 at the Year 2 peak, is what sets its census, and it is why the primary-care arm opens in month 10, once heart failure has filled.

Unique patients and enrollments are different numbers, and both are true. At month 24 there are 9,856 active program enrollments (heart failure: 1,496 in monitoring and 1,454 in principal care; primary care: 4,016 in monitoring and 2,890 in chronic care) across 6,816 unique patients, because a patient carrying monitoring and a care-management program in the same month counts once as a person and twice as an enrollment. Unique patients reach 2,257 at month 12 (1,734 in heart failure, 522 in primary care) and 6,816 at month 24 (1,932 and 4,883).

8.5 Capacity as a staffing plan

Read as a staffing plan, at the documented caseload of 165 patients per care manager the enrolled population needs about 14 care managers at month 12 and about 41 at month 24. Care-team time over the 24 months is 84,513 hours on the recurring programs, about 40.6 FTE-years, plus 1,159 hours of transitional care. Each arm also has its own on-site enrollment specialist. Every one of those posts is on CoachCare's payroll, and none of them is an Aspirus requisition.

8.6 Clinical and operational output

Output over 24 months	Volume	What it represents
Hospitalizations avoided	395 (197 heart failure, 198 primary care)	Admissions prevented across both enrolled cohorts at the model's generic 20% annual admission rate.
Device readings received and reviewed	621,969	Each one a chance to intervene before an admission.
Claims generated	185,975	Built, documented and submitted automatically under Aspirus's own billing identifiers.
Care-team hours delivered	84,513, about 40.6 FTE-years	Clinical labor delivered rather than recruited, plus 1,159 hours of transitional care.
Care-management tasks and patient conversations	371,951 tasks · 55,793 conversations	Documented care-plan work, 92,988 of it chart updates written back into Epic, plus 3,100 hours of call time carrying the monthly contact and the post-discharge cadence.

The forecast's 395 avoided hospitalizations use the model's generic 20% annual admission rate on both arms. A heart-failure cohort admits more often than that, and the count scales with the rate:

Annual admission rate, heart-failure cohort	Heart-failure admissions avoided, 24 months
20% (the forecast)	197
30%	296
40% (the realistic figure for heart failure)	395
50%	493

8.7 Sensitivities

Scenario	24-month net reimbursement	Net to Aspirus	Margin
Recurring programs, both arms, base	\$9,494,997	\$4,063,731	42.80%
Both arms priced at the Minnesota locality	\$9,921,405	\$4,490,139	45.26%
Heart-failure arm, base	\$4,432,448	\$1,857,616	41.91%
Heart-failure arm, no on-site enrollment specialist	\$3,763,923	\$1,562,578	41.51%
Heart-failure arm, a second on-site enrollment specialist	\$4,844,582	\$2,041,650	42.14%

Scenario	24-month net reimbursement	Net to Aspirus	Margin
Heart-failure arm, 3,000 patients in scope	\$2,776,057	\$1,169,340	42.12%
Heart-failure arm, 9,000 patients in scope	\$5,630,077	\$2,342,139	41.60%

The margin stays between 41.5% and 45.3% in every case. The Minnesota row is the rate Aspirus St. Luke's bills at itself. The enrollment-specialist rows move the heart-failure arm's revenue because they change how fast it reaches its ceiling: a second specialist reaches the same ceiling sooner, with the care team scaled to match. The in-scope rows show what the chart count in Section 12 would do to the heart-failure arm.

9. The Rollout

The rollout order follows facts already in hand: where the program is running, where the bench and the volume are, and where the drive is longest. The heart-failure arm reaches every Aspirus cardiology group inside the first 9 months, when remote monitoring fills its ceiling, and primary care opens in month 10.

Wave	Where	Why these, in this order	County MA
1. Extend the template	Duluth: Aspirus St. Luke's cardiology and its outreach clinics in Hibbing, Virginia, Moose Lake and Two Harbors; Aspirus Lake View	The program is live; the expansion is the rest of the Duluth heart-failure panel. St. Luke's is also the TEAM hospital and the Enhanced-track ACO participant.	64.8%; 65.5%
2. Wausau	Aspirus Heart Care and the Heart Failure Resource Center	The largest heart-failure discharge volume in the system, 149 in CY2024, and its lowest ratio at 0.9006, with 17 cardiology physicians. The Resource Center's panel is a ready-made cohort.	65.0%
3. Central and north-woods acute hospitals	Stevens Point, Rhinelander, Woodruff, Wisconsin Rapids and Portage	200 heart-failure discharges a year among them. Rhinelander and Woodruff anchor the north woods; Stevens Point, Wisconsin Rapids and Portage sit within reach of Wausau's protocols.	43% to 67%
4. The Critical Access regions	Upper Peninsula: Ironwood, Laurium and Iron River. Wisconsin: Eagle River, Tomahawk, Merrill, Antigo, Medford, Stanley and Chippewa Falls	The longest drives in the system, where cellular devices, a central care team and local alert routing do the most work.	44% to 66%
5. Primary care, from month 10	The employed primary-care network in every region	329 physicians and 66,000 Medicare patients in scope, on remote monitoring and chronic care management. Advanced primary care management, behavioral health integration and the COPD and kidney-disease tracks follow on the same engine, at \$0 in this forecast.	As above

Heart failure is the right first cohort in every region. It is the cohort the Duluth program already serves, and it is the measure on which one Aspirus patient in five comes back within thirty days.

10. The CY2027 Proposed Rule

The CY2027 physician fee schedule proposed rule, CMS-1848-P, would lower the payment for the remote-monitoring device-supply codes. Repriced at the Wisconsin locality on this forecast's own code mix, the effect cascades in three steps. Device supply, 99454 and 99445, falls from \$49.70 to \$39.43, or 20.7%. Device supply is 31% of the remote-monitoring basket, so remote monitoring across both arms falls 9.7%. Remote monitoring is 57% of the service line, so the whole line falls 6.09%, or \$593,471 of \$9,745,480, with the census unchanged.²⁸

Program	24-month net reimbursement, CY2026 rates	At CY2027 proposed rates	Change
Heart failure · remote monitoring	\$2,758,175	\$2,487,450	−9.82%
Heart failure · principal care management	\$1,674,272	\$1,669,135	−0.31%
Primary care · remote monitoring	\$2,806,622	\$2,538,369	−9.56%
Primary care · chronic care management	\$2,255,928	\$2,211,491	−1.97%
Transitional care at heart-failure discharge	\$250,483	\$245,565	−1.96%
Whole service line	\$9,745,480	\$9,152,009	−6.09%

Code	CY2026 rate, locality 06302-00	CY2027 proposed, same locality
99453	\$20.36	\$18.98
99454	\$49.70	\$39.43
99445	\$49.70	\$39.43
99457	\$49.58	\$47.28
99458	\$39.66	\$38.47
99470	\$24.96	\$19.82
99490	\$63.24	\$61.45
99439	\$48.21	\$47.72
99426	\$64.84	\$64.28
99427	\$51.75	\$52.14
99495	\$210.64	\$206.38
99496	\$286.17	\$280.84

The conversion factor moves from \$33.4009 to \$32.8409 in the same rule. None of this is final.

Comments on CMS-1848-P closed on 14 September 2026; the final rule is expected in early November 2026 and takes effect on 1 January 2027. Section 1848(c)(7) of the Social Security Act phases in large reductions in a code's value over more than one year, and the CY2027 device-supply rate above is the first step of that phase-in. The forecast in Section 8 is priced at CY2026 rates throughout. Principal care management, chronic care management and transitional care, which carry most of the line, move by about two percent or less.

²⁸ CMS-1848-P, CY2027 Physician Fee Schedule proposed rule, Federal Register, with the proposed RVU and conversion-factor files, repriced at MAC locality 06302-00 against the forecast's own code frequencies.

11. Implementation and Contracting

Phase	Timing	Milestones
Design	Weeks 0 to 4	Name the service-line owner. Count the heart-failure cohort against chart data, region by region. Agree cohort thresholds, the escalation pathway and on-call routing with each region's cardiology leadership, and the billing identifiers and claim-review cadence with revenue cycle.
Build	Weeks 2 to 8	Epic integration on the Aspirus build: enrollment flags, trigger ordering, discrete-vitals write-back, documentation templates, automated claim generation. Heart-failure enrollment specialist recruited and placed by CoachCare.
Launch	Weeks 6 to 12	Extend the Duluth program to the rest of its heart-failure panel and open Wausau on the same protocols. Office referral, post-discharge outreach and transitional care start together. First claims inside the first month of live operation.
Extend	Months 4 to 24	The central, north-woods and Critical Access regions join through month 9. Primary care opens in month 10 with its own enrollment specialist. Reporting tracks the 30-day readmission rate on the enrolled cohort against its own pre-enrollment baseline.

Three contracting facts are worth settling in the first working session. The first is the contracting entity: a system agreement with Aspirus, Inc., or the Duluth agreement extended across the system. The second is billing: Wisconsin and Michigan entities bill at their own localities and St. Luke's bills in Minnesota, so one agreement carries more than one fee schedule, and the claims in this forecast go out under each entity's own identifiers. The third is Medicare Advantage, where the treatment of remote monitoring and care management is a question for each plan contract. The integration fee is charged once, on the heart-failure arm, and the primary-care arm adds only the per-patient fee.

The timing is favorable. The program bills from its first month and every month from month 2 is positive, so it adds to the operating result in the quarter it starts and asks for no capital. The Duluth template exists, the Epic system is shared, the new CY2026 codes are live, and the CY2027 final rule lands in November. CoachCare's ask is a working session with the cardiology, primary-care, population-health and revenue-cycle leads to settle the items in Section 12 and agree the design.

12. Open Items for the First Call

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

Question	Why it matters
How does the Duluth program bill today: on the professional claim from the cardiology clinic, or through the hospital?	The forecast prices every code at the non-facility office rate. The Duluth clinic's billing setup decides how that carries over to St. Luke's and to any other hospital-based clinic.
What has the Duluth cohort achieved so far: patients enrolled, readmissions and emergency visits against the same patients' prior year? Who owns the scorecard?	These are the figures Aspirus will weigh most heavily, and they are Aspirus's to present. They set the baseline every other region is measured against.
What is the chart count of the heart-failure population at each site: Duluth, Wausau, Rhinelander, Stevens Point and the Upper Peninsula? Does the Wausau Heart Failure Resource Center want monitoring for its panel?	The heart-failure arm is ceiling-limited at 5,700 in scope, so the cohort count is the single input that moves it most (Section 8.7).
Who makes the post-discharge contact after a heart-failure discharge in each region today, and is transitional care management billed?	The forecast adds transitional care as its own line. Where a contact already happens, the cadence plugs into it.
Is chronic care, principal care, advanced primary care or behavioral health integration billed anywhere in Aspirus Medical Group, and how is the RN care-coordinator role set up?	It decides where the primary-care arm starts and how the build-toward step to advanced primary care management is staged.

Question	Why it matters
How does St. Luke's Enhanced-track ACO participation run, who owns its performance, and is there an ACO care-management team to work with? Are the Wisconsin and Michigan entities weighing an ACO for 2027 or later?	The share of enrolled patients who are assigned beneficiaries decides what the shared-savings layer in Section 6.2 is worth.
How do the regional Medicare Advantage plans pay for remote monitoring, principal care, chronic care and transitional care?	60.2% discharge-weighted penetration. Plans pay at least the Medicare rate; each contract sets its own terms.
Is the Epic build one shared instance across Wisconsin, Michigan and Minnesota? Which modules are live, and who owns third-party integrations?	One build serves every region if the instance is shared; the integration plan in Section 5 follows the answer.
Is any other remote-monitoring or care-management program running or under evaluation elsewhere in the system?	The engine is built to be shared, and the rollout can absorb what exists.
Who sponsors a system agreement, which entity contracts, and where does the budget sit?	The contracting entity sets the billing identifiers and the fee schedules in Section 11.
Who owns COPD, chronic kidney disease, diabetes and hypertension care in pulmonology, nephrology and diabetes education?	Those owners decide when the \$0 tracks in Section 4.2 open.
Is remote care part of the rural plan for Iron River, Ironwood and Keweenaw, and what are Aspirus Chippewa Falls's provider number and designation?	The Critical Access wave in Section 9 depends on both.

References & Data Sources

Every figure in this report traces to a CMS file, to a document Aspirus Health has itself issued, or to CoachCare's own program results; the numbered footnotes give the file and vintage for each. A companion Disclosures document holds the modeling assumptions behind Section 8.

Source	Vintage
CMS Hospital General Information; Provider of Services file; Medicare Inpatient Hospitals by Provider and Service, queried by provider number	Pulled 13 October 2026; Q2 2025; CY2024
CMS Hospital Readmissions Reduction Program hospital file; Care Compare Unplanned Hospital Visits	FY2026, discharges 07/01/2021 to 06/30/2024; 07/01/2023 to 06/30/2025
CMS Doctors and Clinicians national file; Medicare Physician & Other Practitioners by Provider	Pulled 13 October 2026; CY2024
CMS TEAM participant list; Medicare Shared Savings Program ACO participants file	As of 2026-08-18; performance year 2026
CMS Medicare Advantage State/County Penetration; Medicare Physician Fee Schedule, MAC locality 06302-00; CMS-1848-P proposed rule	September 2026; CY2026; CY2027 proposed
Aspirus Health public pages, affiliation announcements and leadership interviews; Duluth News Tribune; Wausau Pilot & Review; Becker's Hospital Review; Chief Healthcare Executive	2024 to 2026
CoachCare case studies: Iowa Heart Center; Cardiac Solutions, readmissions and hypertension; CoachCare Care Management SOP process maps	2026; version March 2026