COACHCARE | SERVICE LINE STRATEGY

Traverse Heart & Vascular

Phoenix, Arizona. A newly independent cardiology group, formerly part of a large Phoenix health system: six cardiologists, one electrophysiologist and three nurse practitioners

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) designed into the founding operating model of a new practice: no capital, no clinical headcount, billed under the practice's own TIN at the Arizona fee schedule, and positive from month 2

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the physician owners and administrator of Traverse Heart & Vascular. The practice reports about 12,000 patients, roughly 8,000 of them Medicare, seen by 7 physicians and 3 nurse practitioners from one central Phoenix office. It is a new billing entity with a mature panel.

A practice standing up its own operation has to build enrollment, consent, care-plan documentation and a monthly billing rhythm regardless. Those are the same four things a remote care service line runs on. This report lays out what that service line is worth when it is part of the design rather than a retrofit.

The forecast in section 6 sizes it: $3,202,620 of net reimbursement over 24 months at a 42.6% practice margin, positive from month 2, with the care team and the on-site enrollment specialist carried by CoachCare.

Connor Knapp · Head of Sales · CoachCare · connor.k@coachcare.com

Anthony Pappas · Director of Sales · CoachCare · anthony.p@coachcare.com

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Executive Summary

Traverse Heart & Vascular is a newly independent cardiology group in central Phoenix, formerly part of a large Phoenix health system. The practice reports **six cardiologists, one electrophysiologist and three nurse practitioners**, about 12,000 patients, and roughly 8,000 of them on Medicare, with the balance commercial and AHCCCS. It runs on Epic. It has a new tax identifier, a new billing operation, no legacy remote-care program to displace and no vendor to unwind.

That last sentence is the whole argument. A practice at this stage has to build an enrollment process, a consent process, care-plan documentation and a monthly billing rhythm anyway. A remote care service line is those four things applied to the patients the practice already sees between visits. Built in now, it is part of how the practice works from the first quarter. Added later, it is a project.

The forecast

The Value Analysis models a remote care service line across an in-scope cohort of 6,400 patients drawn from the 8,000-patient Medicare panel, enrolled through the practice's 10 clinicians. Over 24 months it produces **$3,202,620 of net reimbursement** to the practice against $1,838,430 of CoachCare fees, leaving **$1,364,189 retained, a 42.60% practice margin** (41.67% in year 1, 42.91% in year 2).[1] Month 1 is $4,648 negative, because implementation and the Epic integration setup post against a first-month census of 46 enrollments. The practice is positive from month 2 and stays there.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$809,874	$2,392,746	$3,202,620
CoachCare program and platform fees	$472,413	$1,366,018	$1,838,430
Net to the practice	**$337,461**	**$1,026,728**	**$1,364,189**
Practice margin	**41.67%**	**42.91%**	**42.60%**
Unique patients under management	1,153	1,924	1,924

Value Analysis summary. Unique patients are deduplicated across programs: a patient enrolled in both monitoring and care management is one person and two enrollments, so 1,924 unique patients carry 2,493 active program enrollments at month 24.

Transitional care management is priced in section 3 and is **not in that forecast**. The forecast contains remote physiologic monitoring and principal care management on the Medicare panel only. The commercial and AHCCCS third of the practice is scoped separately in section 9. About half of Maricopa County's Medicare beneficiaries are in Medicare Advantage (51.5%). Medicare Advantage plans reimburse at or above the Medicare rate as a floor; individual contracts set their own terms for the care-management code families.

The on-site enrollment specialist who drives that census, and the care team behind them, are **carried at CoachCare's expense**. They are not deducted from the margin above and they do not appear on the practice's payroll. For a group that is cash-constrained by definition in its first year, that is the point: no capital, no headcount, per-enrolled-patient economics.

The finding in one sentence

A new practice with an established 8,000-patient Medicare panel bills nothing today for the eleven months a year its patients spend between visits, and the operating pieces it must build regardless are the same pieces that would let it bill for them.

[1] CoachCare Value Analysis for this account, built on the CY2026 physician fee schedule at the Arizona statewide locality (Noridian JF, 03102-00) and recalculated 22 September 2026. Revenue is net of denials, patient coinsurance and coinsurance bad debt.

Why the timing is right

Three things line up. The practice is designing its operating model now, so the service line can be part of the design. CMS created two remote-monitoring codes for CY2026 that pay for the short post-discharge windows a cardiology practice needs, and they are already in Arizona Medicaid's telehealth code set. And Arizona prices the remote-care codes within a few points of national on a single statewide locality, so the forecast is not sensitive to which side of the county line a patient lives on.

The practice has no mandatory CMS specialty-model exposure today, which makes the timing pure upside, and the program produces the evidence such models score on if selection maps change.

2026–2027 priority recommendations

1. **Bill transitional care management on the discharges already happening.** No device, no new population, no consent hurdle. $215.45 and $292.37 per discharge at the Arizona locality, at every cardiac discharge from the hospitals where the group admits, outside the 24-month forecast entirely.
2. **Design the service line into the founding operating model.** Enrollment at the visit, consent language, the care-plan template and the monthly claim cadence are being written now. Write them once, for both the office visit and the between-visit program.
3. **Put the heart-failure cohort on weight and blood-pressure monitoring first.** Daily weight is the earliest signal of decompensation, and the thirty days after a cardiac discharge is where the avoided admissions in section 8 come from.
4. **Layer principal care management onto the same cohort from month 2.** One high-risk condition, monthly, at top-of-license staffing. Monitoring reaches its ceiling in month 20; care management is still climbing at month 24, so the start date sets how much of it the practice captures inside the horizon.
5. **Bring the plan mix within the Medicare panel to the first call.** With about half the county's beneficiaries in Medicare Advantage, the split of the practice's own 8,000 decides how much of this forecast is fee-schedule-set. Medicare Advantage plans reimburse at or above the Medicare rate as a floor; individual contracts set their own terms for the care-management code families.
6. **Read the CY2027 final rule when it lands in early November.** The proposed rule cuts the device-supply codes by 20.6% at the Arizona locality, which flows through to −7.0% on the service line. The final rule is effective 1 January 2027.

1. Where the Practice Is Today

1.1 A new practice, a mature panel

Most cardiology groups that consider a remote care service line have a decade of habits to work around: a billing office with its own rhythm, a legacy vendor, a program someone started and nobody finished. Traverse Heart & Vascular has none of that. What it has is a panel that took years to build, seen by clinicians who have been managing it together for years, now billed under a new entity that is writing its operating model from a clean sheet.

What the practice reports	Value	What it means here
Physicians	7, including 1 electrophysiologist	Enough referral volume to fill an on-site enrollment specialist's calendar
Nurse practitioners	3	The clinicians who see the between-visit patients most often
Referring clinicians in the forecast	10	7 physicians and 3 nurse practitioners
Total patients	about 12,000	An established metro-wide referral panel

What the practice reports	Value	What it means here
Medicare patients	about 8,000	The panel the Value Analysis is built on
Commercial and AHCCCS patients	about 4,000	Scoped separately; Arizona Medicaid and Arizona parity law both cover remote monitoring
Electronic health record	Epic	CoachCare's Epic integration applies; see section 4
Locations	One, central Phoenix	One enrollment desk covers the whole panel

Practice profile as reported by the practice, September 2026. The first-call agenda in section 12 is built around confirming these figures against the practice's own chart and billing data.

Two readings follow from the panel. First, a two-thirds Medicare share is typical for cardiology and means the fee-schedule arithmetic in this report covers most of the practice. Second, the central Phoenix address sits in a young neighbourhood; an 8,000-patient Medicare panel there is drawn from across the metro, which is a referral practice with established patients who come back, and a monthly program enrolls from the patients who come back.

1.2 The between-visit months

A cardiology patient with heart failure, atrial fibrillation or resistant hypertension is in the office perhaps two to four times a year. The clinical work that keeps that patient out of the hospital happens in the other months: the weight that drifts up over a week, the blood pressure that never came down after the last titration, the medication that was stopped because of a side effect nobody was told about. Today that work happens by phone call and portal message and carries no separate payment, or it does not happen until the next visit.

Medicare pays for exactly that work under two code families a cardiology practice can bill together for the same patient in the same month: remote physiologic monitoring for the device data and the time spent acting on it, and principal care management for the monthly management of one high-risk condition against a written care plan. Neither requires a new patient population. Both require an operating model, which is the thing this practice is building now anyway.

> **The clean-sheet advantage, stated precisely**
>
> Every practice that launches a remote care service line has to do four things: consent and enroll the patient, document a care plan, capture time against it every month, and turn the month into a claim. An established practice bolts those onto an existing workflow and meets resistance at each join.
>
> **A new practice is writing the workflow. The join points do not exist yet. That is why the forecast in section 6 is positive from month 2 and why the month-1 census is the only slow month in it.**

1.3 What the specialty's routine already proves

An electrophysiology practice reviews remote device transmissions as a matter of routine. Pacemakers, defibrillators and loop recorders send data on a schedule; someone owns the incoming queue, reads it on a calendar, documents what they found and bills the interrogation. That routine is the operational core of remote care, and cardiology is the one specialty where it is already normal.

What the routine does not cover is the far larger group of established patients with no implanted hardware: the heart-failure patient on a weight scale, the hypertensive patient on a cuff. The service line in section 3 extends the same habit, a queue reviewed on a calendar and billed, from the device panel to the rest of the practice, with CoachCare's care team owning the queue. The practice's own device volume under the new entity is one of the open items in section 12.

2. The Phoenix Medicare Market

Maricopa County carried 801,802 Medicare beneficiaries in 2025, split almost evenly between Original Medicare (394,208) and Medicare Advantage (407,595). Medicare Advantage penetration stood at 51.5% in September 2026, and 14.7% of beneficiaries are dual-eligible for Medicare and AHCCCS.[2]

Maricopa County	Value	Vintage
Medicare beneficiaries	801,802	CY2025 annual county row
Original Medicare	394,208	CY2025
Medicare Advantage and other	407,595	CY2025
Medicare Advantage penetration	51.5%	September 2026
Dual-eligible share of beneficiaries	14.7%	CY2025

CMS Medicare Monthly Enrollment and CMS Medicare Advantage State/County Penetration files.

Three features of this market shape the business case.

- **Half the panel is Medicare Advantage.** At 51.5% county penetration, roughly half of the practice's 8,000 Medicare patients are in Advantage plans. Medicare Advantage plans reimburse at or above the Medicare rate as a floor; individual contracts set their own terms for the care-management code families. The plan mix within the practice's own panel is on the first-call agenda.
- **Arizona is one fee-schedule locality.** The whole state prices at a single Medicare locality, at 96.5% to 98.5% of the national amount on the remote-care codes. Every rate in section 3 applies to every patient the practice sees, wherever in the metro they live.[3]
- **Arizona Medicaid and Arizona parity law both cover remote monitoring.** AHCCCS covers synchronous and asynchronous remote patient monitoring, and its 2026 telehealth code set lists the full remote-monitoring family including the two codes new for CY2026. Arizona's telehealth parity statute defines telehealth to include remote patient monitoring for commercial coverage. Section 9 takes this up for the non-Medicare third of the practice.[4]

3. The Service Line: TCM, RPM, PCM

3.1 Transitional care: the fastest first dollar

Transitional care management is the entry point on this account, for reasons that have nothing to do with the forecast. It requires no device, no new patient population, no consent conversation and no enrollment funnel. It requires a contact within two business days of discharge, medication reconciliation, and a face-to-face visit inside 14 days for moderate complexity or 7 days for high complexity, at every cardiac discharge from the hospitals where the group admits.

Code	Service	CY2026 rate, Arizona
99495	Transitional care management, moderate medical decision complexity, face-to-face within 14 days	$215.45

[2] CMS Medicare Advantage State/County Penetration file, September 2026, Maricopa County; CMS Medicare Monthly Enrollment, calendar year 2025 county row. Dual-eligible share is the beneficiary-count denominator.

[3] CY2026 Medicare physician fee schedule, Arizona statewide locality (carrier 03102, locality 00), non-facility amounts against the national non-facility amount for codes 99453, 99454, 99445, 99457, 99458, 99470, 99424 through 99427, 99091, 99495 and 99496. Geographic practice cost indices: work 1.000, practice expense 0.969, malpractice 0.856; conversion factor $33.4009.

[4] AHCCCS Medical Policy Manual, Policy 320-I Telehealth, section D Remote Patient Monitoring (effective 1 October 2023); AHCCCS Telehealth Code Set, 2026 Final sheet, effective 1 June 2026; AHCCCS Medical Policy Manual, Policy 310-P Medical Equipment and Supplies. Arizona Revised Statutes section 20-841.09, telehealth coverage, whose definition of telehealth includes remote patient monitoring technologies.

Code	Service	CY2026 rate, Arizona
99496	Transitional care management, high medical decision complexity, face-to-face within 7 days	$292.37

CY2026 physician fee schedule, non-facility, Arizona statewide locality, resolved from ZIP 85006.

Worth saying plainly

Transitional care management is not in the 24-month forecast. The Value Analysis in section 6 contains remote physiologic monitoring and principal care management only. Every dollar of transitional care revenue sits outside those numbers.

It also does more than pay. The 30-day window it covers is the window in which cardiac readmissions happen and the window in which the post-discharge cadence in section 5 does its work.

3.2 The clinical and billing stack

Three programs, one infrastructure, one patient record. A patient enters at discharge, moves onto a short monitoring window, and settles into a longitudinal cadence that continues for as long as the condition does.

Stage	Program	What happens	Cadence
At discharge	Transitional care management	Contact within two business days, medication reconciliation against the discharge summary, face-to-face visit booked and confirmed	Once per discharge
Days 1–30	Remote physiologic monitoring, short window	Weight and blood pressure from the patient's home, daily review, escalation on critical values and established trends	Monthly, from 2 days of data
Month 2 onward	Remote physiologic monitoring, longitudinal	Continuous physiologic data with treatment-management time logged against it	Monthly
Month 2 onward	Principal care management	One high-risk condition, heart failure or atrial fibrillation or hypertension with chronic kidney disease, managed against a written care plan with monthly clinical staff time	Monthly

Remote monitoring and principal care management may be billed together for the same patient in the same month, on discrete documented time. That is what makes a single enrollment carry two revenue lines and one care plan. Principal care management is the right care-management family for a cardiology practice: it pays for one high-risk condition, which is what a cardiologist manages, and it does not require the practice to own the patient's whole chronic-disease list.

3.3 CY2026 rates at the Arizona locality

Code	Service	CY2026 rate
99453	Remote monitoring setup and patient education, once per enrollment	$20.96
99454	Device supply with daily recording, 16–30 days	$50.45
99445	**Device supply with daily recording, 2–15 days, new for CY2026**	**$50.45**
99457	Treatment management, first 20 minutes	$50.65
99470	**Treatment management, first 10 minutes, new for CY2026**	**$25.49**
99458	Treatment management, each additional 20 minutes	$40.61
99426	Principal care management, clinical staff, first 30 minutes	$66.47

Code	Service	CY2026 rate
99427	Principal care management, clinical staff, each additional 30 minutes	$52.98
99424	Principal care management, physician or qualified professional, first 30 minutes	$85.88
99425	Principal care management, physician or qualified professional, each additional 30 minutes	$60.32
99495	Transitional care management, moderate complexity	$215.45
99496	Transitional care management, high complexity	$292.37

CY2026 physician fee schedule, non-facility, Arizona statewide locality (Noridian JF, 03102-00), resolved from ZIP 85006. The forecast bills principal care management on the clinical-staff codes 99426 and 99427; the physician codes and the transitional care codes are shown for completeness and are not in the forecast.

The two codes new for CY2026 change the shape of a cardiology program. 99445 pays the device-supply rate for a 2-to-15-day window instead of requiring sixteen days of data, which makes the immediate post-discharge fortnight billable on its own terms. 99470 pays for the first ten minutes of treatment management instead of requiring twenty, which makes a stable patient's month billable without inflating the time spent. Across the 24-month forecast the two together carry **$427,669** of gross remote-monitoring reimbursement, 17% of the monitoring arm's gross and about 12% of the whole service line's net reimbursement.[5]

Every rate above is the Original Medicare amount. About half the county's beneficiaries are in Medicare Advantage. Medicare Advantage plans reimburse at or above the Medicare rate as a floor; individual contracts set their own terms for the care-management code families. The Original Medicare half of the panel is where these rates apply exactly as printed.

3.4 Who does the work

The practice's clinicians order, review escalations that need a cardiologist, and see the patient. Everything else is done by CoachCare's care team under the practice's protocols: outreach and consent, device shipment and setup, daily reading review, monthly care-management contact, time capture, documentation into the chart, and claim generation. The on-site enrollment specialist who drives the census is CoachCare's employee and CoachCare's expense.

Function	Practice	CoachCare
Eligibility and ordering	Physician or nurse practitioner orders by program	Screens the panel by diagnosis and flags candidates in the chart
Enrollment and consent	Introduces the program at the visit where useful	On-site enrollment specialist consents, educates and ships the device
Daily monitoring	Receives only what needs a clinical decision	Reviews every reading against patient-specific thresholds
Escalation	Named clinical contact decides on non-critical findings	Runs the escalation engine, calls the patient, activates 911 where indicated
Monthly care management	Reviews and signs the care plan	Delivers the monthly contact, titration prompts and documentation
Billing	Submits claims under its own TIN	Captures time, attaches monthly documents, creates the claim in Epic

[5] As the Value Analysis source. 99445 carries $366,024 and 99470 carries $61,645 of gross remote-monitoring reimbursement across the 24-month horizon, against $2,490,739 of gross for the monitoring arm, read from the per-code rows on 22 September 2026.

CoachCare runs this division of labour at scale: more than 500,000 patients managed across over 400 conditions, 10,000 or more clinicians running remote care programs day to day, more than 1,000 programs stood up and running in market, care-plan coding and billing behind more than 5 million claims, and over 100 million vitals recorded.[6]

4. Inside Epic

The practice reports that it runs on Epic. CoachCare's Epic integration is direct and bi-directional: the program lives inside the practice's Epic environment rather than in a second system the clinicians have to open. One item needs settling before the interface work is scheduled: which Epic instance hosts the practice, and who owns the interface. That is the first discovery item in section 12, and it sets the sequencing of the integration inside the roadmap in section 11, not whether it happens.

What the integration does	What it means in this office
Integrated ordering and enrollment	Enrollment flags and trigger ordering inside the clinical workflow; CoachCare enrolls qualified Medicare patients on the practice's behalf; enrollment status is visible in Epic in real time, and patients begin receiving services in under five days
Exchange of health history	Bi-directional at intake, so the care team starts from the practice's problem list, medications and allergies rather than re-collecting them
Integrated discrete vitals	Home weight and blood pressure land in the chart as discrete vitals, not attached PDFs, reviewable by any clinician in the practice and trended alongside office readings
Compliance documentation and integrated care summary	Evidence of care, the vitals summary and the care plan are filed to the chart every month, so the record supports the claim without a second system
Automated claim generation	Claims are created by the CoachCare billing engine, which removes the manual claim step for every patient every month. CoachCare is the only care-management application integrated with Epic that does this

CoachCare Epic integration overview.

The last row matters most for a practice that is standing up its billing operation. By month 24 the service line carries about 2,493 active enrollments, each generating a monthly claim. The integration means each of those claims is created from captured time and attached documentation, and the billing staff review rather than key.

Integration economics carried in the forecast are $4,000 of one-time setup, $150 per month, and $1.50 per enrolled patient per month, confirmed in contracting.

5. Clinical Governance and Escalation

The economics establish that the service line pays. This section establishes that it is safe and disciplined, which is the question a physician-owned group asks first. Every reading generated by the program routes through one escalation engine before it reaches the practice. The engine, the emergent pathway, the routing and the post-discharge cadence below are drawn from CoachCare's Care Management Standard Operating Procedures and the SOP process maps derived from them.[7]

5.1 The escalation engine

- **Reading received.** Values are evaluated against the patient's own thresholds, not a generic band.

[6] CoachCare company figures, coachcare.com, as approved for external use in July 2026.

[7] CoachCare Care Management Programs Standard Operating Procedures, version March 2026, and the Care Management Process Maps derived from sections 4, 5, 6, 7, 11 and 13.

- **Critical value.** Escalates regardless of whether the patient reports symptoms. There is no symptom gate on a critical value and no waiting for a confirmatory reading.
- **Out of range, not critical.** A retake, then a structured symptom check, before anything is routed to the practice.
- **Trend, defined objectively.** Three consecutive readings at least one hour apart for blood pressure, or three readings within seven days for heart rate. An established trend escalates on the same footing as a single critical value.
- **Patient unreachable.** Voicemail and a scheduled callback; if the value is critical or the trend is established, the escalation proceeds regardless.
- **Documentation.** Every escalation records the vital, the findings, the contact method, who was reached, the outcome and the follow-up, so the record supports the clinical decision and the billing equally.

5.2 The emergent pathway

Chest pain, new shortness of breath, stroke signs, syncope, a worst-ever headache or sudden swelling trigger an immediate emergency activation: the care manager calls emergency services with the patient still on the line. If the patient declines, they are directed to the clinic; if they decline that, emergency services are activated regardless.

> **The rule that makes delegation possible**
>
> **CoachCare's urgent and emergent policy supersedes any practice-specific escalation preference.** It is not a configurable setting. It is the reason a 7-physician practice can delegate the overnight and weekend watch without inheriting the risk of having done so.

5.3 Routing, so the practice sees signal rather than noise

Escalations route three ways. Emergencies go to emergency services. Non-critical findings that require a clinical decision go to a named member of the practice's team, agreed during protocol design. Stable, resolved events post to the chart as a notification and no one is paged. The volume that reaches a cardiologist is the volume that requires a cardiologist. In a practice whose physicians also run hospital procedure days, that distinction is the difference between a program that gets adopted and one that gets ignored.

5.4 The post-discharge cadence

Touch	Timing	Content
First	Day 1–2	Medication reconciliation against the discharge summary; symptom and red-flag screen; confirm the follow-up appointment is booked; device set up or re-checked
Second	Day 5–8	Adherence and side-effect review; weight and blood-pressure trend read; titration questions routed to the practice; barriers surfaced: transport, cost, comprehension
Third	Day 12–14	Confirm the follow-up visit happened; reassess against the discharge plan; hand off to the longitudinal cadence; close the loop in the chart

Post-discharge follow-up sequence, triggered by any emergency-room visit or hospitalization reported in the previous 60 days.

That sequence is where the 161 avoided hospitalizations in the forecast come from. It runs inside the same 30-day window transitional care management pays for. One cadence, two reasons to run it.

Discharge from the program is governed the same way. A patient who cannot be reached is escalated to the clinic and re-escalated on a fixed cadence rather than dropped, and the practice is notified at every decision point. Patient qualification at the front end runs the other direction: the panel is screened by diagnosis code and each patient is routed to the device and program that the highest-priority qualifying diagnosis calls for.

6. The Value Analysis

6.1 Inputs and how the panel was sized

Input	Value
Medicare panel	8,000 patients, as reported by the practice
In scope	6,400, 80% of the panel
Program eligibility within the in-scope cohort	Remote monitoring 75% (4,800 patients); principal care management 85% (5,440 patients)
Acceptance	Remote monitoring 35%; principal care management 30%
Referring clinicians	10 (7 physicians and 3 nurse practitioners), 8 referrals per clinician per month
On-site enrollment specialists	1, funded by CoachCare, 80 enrollments per month at capacity
Telephonic outreach	On, run by CoachCare
Programs in the forecast	Remote physiologic monitoring and principal care management
Monthly attrition	1.5%
MAC and locality	Noridian (JF), Arizona statewide locality 00, resolved from ZIP 85006
Electronic health record	Epic, direct integration
Medicare Advantage penetration	51.5%, Maricopa County, September 2026. Medicare Advantage plans reimburse at or above the Medicare rate as a floor; individual contracts set their own terms for the care-management code families.
Forecast horizon	24 months

The practice reports about 8,000 Medicare patients. The forecast treats 6,400 of them, 80%, as condition-eligible for a cardiology service line, the same scope-down used on comparable cardiology groups. Within that cohort, 75% are eligible for remote monitoring and 85% for principal care management, and the forecast enrolls 35% and 30% of those respectively. That produces a monitoring ceiling of 1,680 enrollments and a care-management ceiling of 1,632.[8]

The forecast contains two programs. Principal care management is the care-management family for a single high-risk condition, which is the cardiology case, and the forecast bills it on the clinical-staff codes. The 10 referring clinicians are the 7 physicians and 3 nurse practitioners the practice reports; section 7 shows what the physicians alone, or a larger roster, would produce.

[8] Ceilings: 6,400 in scope × 75% eligible × 35% acceptance = 1,680 for remote monitoring; 6,400 × 85% × 30% = 1,632 for principal care management. Enrollment arrives through three pathways: clinician referral at 8 per clinician per month with 80% accepted, one CoachCare-funded on-site enrollment specialist at 80 per month, and telephonic outreach. Each pathway ramps to full productivity over its first months.

6.2 The 24-month forecast

Figure 1. Active enrollments against the forecast ceilings, and how 24 months of net reimbursement splits between the practice and CoachCare.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$809,874	$2,392,746	$3,202,620
CoachCare program and platform fees	$472,413	$1,366,018	$1,838,430
Net to the practice	**$337,461**	**$1,026,728**	**$1,364,189**
Practice margin	**41.67%**	**42.91%**	**42.60%**

By program	Year 1	Year 2	24 months	24-month fees	24-month net to the practice
Remote physiologic monitoring	$593,256	$1,713,791	$2,307,047	$1,290,426	$1,016,621
Principal care management	$216,618	$678,955	$895,573	$467,419	$428,154
Implementation, Epic integration and telephonic outreach				$80,585	−$80,585
Total	**$809,874**	**$2,392,746**	**$3,202,620**	**$1,838,430**	**$1,364,189**

Year 1, Year 2 and 24-month columns are net reimbursement. Per-program year splits are read from the workbook's summary, not allocated from the ramp, and reconcile to the annual totals above. Net to the practice is net reimbursement less program fees; the third row carries the one-time and fixed fees.

Program	Ceiling	Month 12	Month 24	Status at month 24
Remote physiologic monitoring	1,680	1,030	1,680	At ceiling since month 20
Principal care management	1,632	411	813	Still climbing, 50% of ceiling

The two programs are in different regimes, and it is worth being exact about that. Monitoring reaches its ceiling of 1,680 enrollments in month 20 and is flat afterwards because the forecast has run out of patients it counts as eligible. Care management has not: it stands at 813 of a 1,632 ceiling at month 24 and is still adding about 43 enrollments a month. For care management the ceiling is not the constraint; enrollment capacity is. Section 7 puts a number on it.

6.3 Month by month

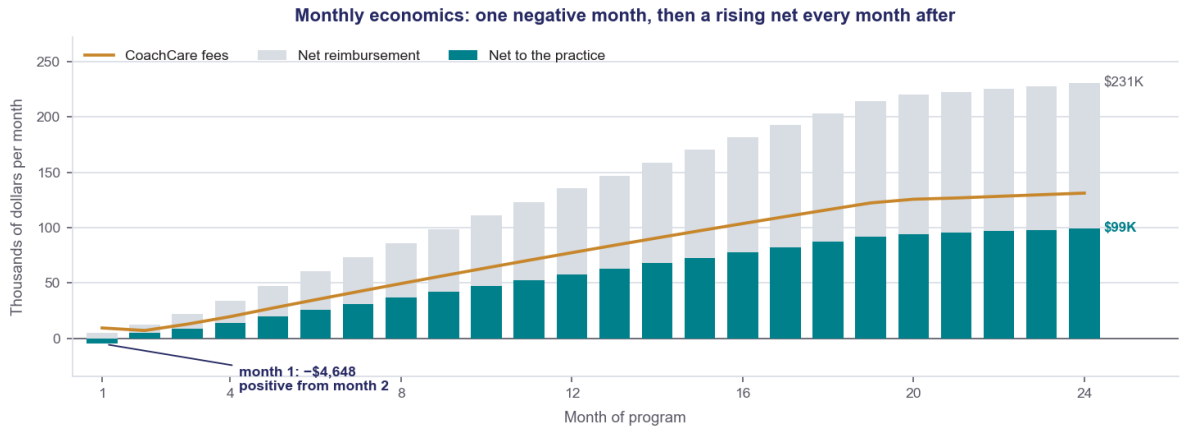

Figure 2. Net reimbursement, CoachCare fees and net to the practice by month. Month 1 is the only negative month.

Month 1 runs **$4,648 negative**. Implementation and the Epic integration setup both post in the first month against a census of 46 enrollments. The practice is positive from **month 2** onward and stays there. Enrollments stand at 46 after month 1, 121 after month 2 and 224 after month 3, and net new enrollment peaks at about 119 a month once every pathway is at full productivity. By month 12 the practice nets $57,834 a month; by month 24, $99,327.

6.4 Patients, readings and avoided admissions

What the service line produces over 24 months	Value
Unique patients under management at month 12	1,153
Unique patients under management at month 24	1,924
Active program enrollments at month 12	1,441
Active program enrollments at month 24	2,493
Physiologic readings reviewed	253,932
Claims generated	60,764
Hospitalizations avoided	161
Care-team hours delivered	27,778, about 13.4 full-time-equivalent years

Unique patients are deduplicated across programs. A patient enrolled in both monitoring and care management is one person and two enrollments, which is why 1,924 unique patients carry 2,493 active enrollments at month 24. Care-team hours describe labor supplied by CoachCare, not headcount the practice hires.

Those hours are the number to hold against the practice's own staffing. About 13.4 full-time-equivalent years of care-management labor over the horizon, supplied by CoachCare, against a practice with 3 nurse practitioners and 7 physicians who also run hospital procedure days. Any version of this program

that assumes existing headcount absorbs the work is a proposal that the nurse practitioners stop seeing patients.

7. What Moves the Forecast

Four inputs move the 24-month answer, and each can be settled on the first call or in the first fortnight. The table holds every other input at the base case.

Input	Setting	24-month net reimbursement	Net to the practice	Margin	Unique patients, month 24
Base case	**1 enrollment specialist, 6,400 in scope, 10 clinicians**	**$3,202,620**	**$1,364,189**	**42.6%**	**1,924**
On-site enrollment specialists	0	$1,540,809	$646,842	42.0%	1,110
	2	$4,243,966	$1,823,027	43.0%	2,077
	3	$5,001,346	$2,163,975	43.3%	2,170
In-scope share of the panel	60% (4,800)	$2,883,525	$1,230,846	42.7%	1,502
	100% (8,000)	$3,334,086	$1,419,569	42.6%	2,303
Medicare panel	7,100	$3,081,745	$1,313,618	42.6%	1,734
	6,500	$2,980,800	$1,271,449	42.7%	1,608
Referring clinicians	7, physicians only	$2,868,419	$1,221,027	42.6%	1,898
	12	$3,389,128	$1,444,562	42.6%	1,941

Sensitivities recalculated from the same workbook, one input at a time.

Read the enrollment rows first

The panel barely moves the number. Take 900 patients off it and the 24-month net reimbursement moves about 4%; add the whole panel to scope and it moves about 4%. Going from one on-site enrollment specialist to none takes $1,661,811 off. Going from one to two adds $1,041,346 (+32.5%) in net reimbursement and $458,838 net to the practice; a third adds $1,798,726 and $799,786.

The reason is the split regime in section 6. Monitoring is already at its ceiling with one specialist, so a second one only brings it there sooner. Care management is not, and a second specialist carries it from 813 to 1,322 enrollments at month 24, a third to its ceiling of 1,632. The month-24 unique-patient count moves from 1,924 to 2,077 to 2,170.

On a group standing up its operation from scratch, that is the argument for CoachCare staffing the front end. The ceiling is not the constraint on care management; enrollment capacity is, and CoachCare funds it.

8. The Thirty Days After Discharge

Every hospital that admits a heart-failure patient is paid less on every Medicare inpatient discharge if too many of those patients come back within thirty days. The Hospital Readmissions Reduction Program has run on that basis for more than a decade, and heart failure remains one of its measured conditions. What decides a hospital's heart-failure readmission ratio is what happens to its discharged patients after they go home, and those patients are, in large part, the cardiology practice's patients.

The two-business-day contact, the medication reconciliation, the daily weight and the titration call in the first fortnight are all things a cardiology office does, or does not do, and the hospital's ratio moves either way. A practice that runs that cadence for its own patients is worth more to each hospital where it admits than one that does not, and it is paid for the cadence directly under its own TIN. For a group establishing its hospital relationships under a new name, that is a referral-relationship asset as much as a clinical one.

Avoided hospitalizations over 24 months	Value
At the forecast's 20% annual admission rate in the enrolled cohort	161
Avoided inpatient cost at $15,000 per admission	$2.42 million
At a 40% annual admission rate, which is closer to a heart-failure-heavy cardiology cohort	about 322

Avoided admissions scale with the cohort's baseline admission rate, holding the enrolled census and the forecast's reduction rate constant.

None of those dollars are in the forecast. The forecast in section 6 is Part B professional fees billed under the practice's own TIN, and it is margin-positive on that basis alone, before any value-based dollar and before any hospital counts what the practice's post-discharge cadence did for its readmission ratio.

9. The Commercial and AHCCCS Third of the Panel

About 4,000 of the practice's patients are not on Medicare. The forecast leaves them out; Arizona's payer rules do not.

- **AHCCCS covers remote patient monitoring.** Arizona Medicaid covers both synchronous and asynchronous remote patient monitoring under its telehealth policy, with no originating-site restriction. The 2026 telehealth code set lists 99091, 99445, 99453, 99454, 99457, 99458 and 99470, each with its required modifier and office place of service. The professional service is billed by the AHCCCS-registered provider; the device is covered as a medical supply under the durable medical equipment policy when medically necessary. Managed-care plans apply their own authorization rules per contract.[9]
- **Arizona commercial parity includes remote monitoring.** Arizona's telehealth statute requires insurers to cover a service delivered through telehealth when the in-person equivalent is covered, and its definition of telehealth names remote patient monitoring technologies. A commercial denial of a remote-monitoring claim on telehealth grounds has little to stand on in this state.[10]
- **Dual-eligible patients bill as Medicare patients.** For the 14.7% of Maricopa beneficiaries who hold both Medicare and AHCCCS, Medicare pays the professional service and AHCCCS handles the cost-sharing, with qualified Medicare beneficiary billing protections applying. They are inside the 8,000-patient Medicare panel already.

Care-management coverage under AHCCCS is a separate question: the principal care management codes are not telehealth services and sit outside the telehealth code set, so the practice's contracted AHCCCS plans decide it. That, and which plans the practice holds, are on the first-call agenda. The remote-monitoring coverage above is enough to say that the non-Medicare third of the practice is a second phase of the same program, on the same devices and the same care team, rather than a different program.

[9] AHCCCS Medical Policy Manual, Policy 320-I Telehealth, section D Remote Patient Monitoring (effective 1 October 2023); AHCCCS Telehealth Code Set, 2026 Final sheet, effective 1 June 2026; AHCCCS Medical Policy Manual, Policy 310-P Medical Equipment and Supplies. AHCCCS Fee-For-Service Provider Billing Manual, chapter 10, 29 April 2026 revision.

[10] Arizona Revised Statutes section 20-841.09 (and the parallel provisions at sections 20-1057.13, 20-1376.05 and 20-1406.05), as amended by House Bill 2454 of 2021.

10. The CY2027 Proposed Rule

CMS published the CY2027 physician fee schedule proposed rule on 16 July 2026. The comment period closed on 14 September 2026; the final rule is expected in early November 2026 and takes effect on 1 January 2027.[11] Two things in it bear directly on this forecast: the conversion factor moves from $33.4009 to $32.8409, and the remote-monitoring device-supply codes take a large cut in practice-expense value. Every code in the forecast was repriced on the practice's own billing mix at the Arizona statewide locality.

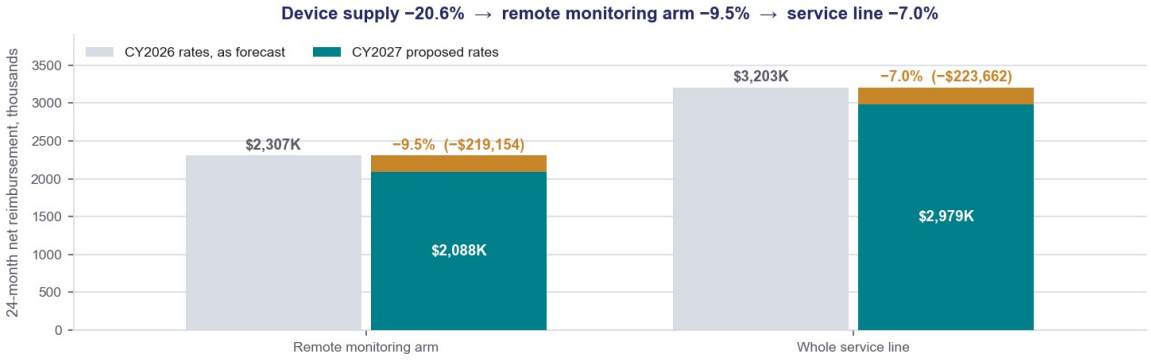

Figure 3. The CY2027 cascade on one dollar scale: the device-supply cut flows through the remote-monitoring arm to the whole service line, each percentage smaller only because its base is larger.

Device supply (99454 and 99445) falls −20.6% at the Arizona locality, from $50.45 to $40.06 per patient-month. Device supply is 32% of the remote-monitoring basket on the practice's mix, so the monitoring arm falls −9.5%, or −$219,154 over 24 months. The monitoring arm is 72% of the service line, so the whole line falls −7.0%, or −$223,662 of $3,202,620. Principal care management moves −0.5%, through the conversion factor and practice-expense churn rather than any targeted change.

Code	Service	Arizona, CY2026	Arizona, CY2027 proposed	Change	National, CY2026	National, CY2027 proposed
99453	Remote monitoring setup	$20.96	$19.37	−7.6%	$21.71	$20.03
99454	Device supply, 16–30 days	$50.45	$40.06	−20.6%	$52.11	$41.38
99445	Device supply, 2–15 days	$50.45	$40.06	−20.6%	$52.11	$41.38
99457	Treatment management, first 20 min	$50.65	$48.49	−4.3%	$51.77	$49.59
99470	Treatment management, first 10 min	$25.49	$20.29	−20.4%	$26.05	$20.69
99458	Treatment management, additional 20 min	$40.61	$39.58	−2.5%	$41.42	$40.39
99426	Principal care management, staff, first 30 min	$66.47	$65.71	−1.1%	$67.80	$67.00
99427	Principal care management, staff, additional 30 min	$52.98	$53.36	+0.7%	$54.11	$54.52

Locality amounts are used for the cascade and the repricing; national Addendum B amounts are shown side by side for reference. The two bases do not reconcile to the dollar, by design.

[11] CY2027 Physician Fee Schedule proposed rule (CMS-1848-P), published 16 July 2026, with the accompanying RVU and conversion-factor public use files. Comments closed 14 September 2026.

The proposal does not change the case. The service line at CY2027 proposed rates still produces $2,978,958 of net reimbursement over 24 months on the same census. It does change what the practice should expect from the device-supply line, and it is one more reason to start in 2026 rather than wait for the final rule.

11. Implementation Roadmap

Ninety days from signature to a running program, with the first enrollments inside the first six weeks. The sequence is built so that nothing in the first 45 days waits on the Epic interface.

Phase	Window	What happens
Charter	Days 1–30	Clinical protocol design, escalation routing and thresholds; eligibility definition agreed against the practice's own chart count; billing path confirmed under the practice's TIN; the Epic instance and interface owner identified and the integration scheduled; plan mix within the Medicare panel reviewed
First enrollments	Days 31–45	On-site enrollment specialist starts; transitional care management goes live on current discharges; the first monitoring cohort is set up from the heart-failure list; telephonic outreach begins
Ramp	Days 46–90	Referral, on-site and telephonic pathways reach full productivity; first monthly billing cycle closes; principal care management enrollment opens on the monitored cohort; enrollments stand at about 224 by the end of month 3
Beyond 90 days	Months 4–20	Monitoring census climbs to its ceiling of 1,680; care management builds alongside it; first read of readmissions in the post-discharge cohort; the commercial and AHCCCS phase is scoped
Steady state	Month 21 onward	Monitoring at ceiling; care management still climbing toward 1,632; the conversation turns to enrollment capacity and the in-scope definition

The dashboard the practice should hold CoachCare to

Domain	Measures
Clinical	Weight and blood-pressure control in the monitored cohort; guideline-directed therapy titration events prompted and completed; 30-day readmissions in the post-discharge cohort; escalations by severity and outcome
Operational	Enrolled census against ceiling by program; time to first billable enrollment; monthly reading adherence; escalation response times; unreachable-patient resolution
Financial	Net reimbursement per enrolled patient per month; capture rate against eligible patient-months; denial rate by code and by payer; transitional care management capture against discharges

12. Open Items for the First Call

Eight questions decide how much of this report's forecast survives contact with the practice's own data, and all eight can be answered on the first call.

1. **The Epic instance.** Which Epic instance hosts the practice, since when, and who owns the interface. This sets the sequencing of the integration in the roadmap.
2. **Legal entity and TIN status.** The legal entity name, the group NPI if issued, the TIN effective date, and whether the Medicare enrollment and reassignments are complete. Every claim in the forecast bills under that TIN.
3. **Admitting hospitals.** Where the group admits and holds call today. Transitional care management starts on those discharges, and the post-discharge cadence is worth the most to those hospitals.
4. **The plan mix within the Medicare panel.** The split of the 8,000 between Original Medicare and Medicare Advantage, and which Advantage plans. Medicare Advantage plans reimburse at or above the Medicare rate as a floor; individual contracts set their own terms for the care-management code families.
5. **The chart count.** A unique-patient count from Epic, by diagnosis, replaces the reported 8,000 and the 6,400 in-scope figure outright, and section 7 shows what it moves.
6. **How the nurse practitioners bill.** Under their own NPIs or incident-to. It decides who the ordering clinician is on each enrollment and how the 10 referring clinicians are counted.
7. **AHCCCS plans.** Which AHCCCS managed-care plans the practice contracts with, and whether principal care management is covered under each. Remote monitoring is covered; care management is the question.
8. **Device-clinic volume.** How many patients the electrophysiology practice follows on remote device transmissions under the new entity. It is the existing remote-review habit the service line extends.

The case in three sentences

A remote care service line built on the panel this practice already manages produces $3,202,620 of net reimbursement and $1,364,189 of retained margin over 24 months, at a 42.6% practice margin, billed under the practice's own TIN.

It does that with no capital and no clinical headcount, positive from month 2, on the same enrollment, consent, documentation and billing rhythm the practice has to build anyway.

The operating model is being written now. The service line belongs in the first draft.

To take any of this further, the next step is a working session with the practice's physician owners and administrator to walk the chart count, the plan mix and the Epic question against this forecast. Connor Knapp · Head of Sales · CoachCare · connor.k@coachcare.com. Anthony Pappas · Director of Sales · CoachCare · anthony.p@coachcare.com.

References & Data Sources

Every figure in this report traces to one of the sources below. CMS files were queried directly rather than through an aggregator, and each query date is recorded in the numbered notes throughout. Practice-level figures are as reported by the practice in September 2026.

Source	Used for	Vintage
Practice-reported profile	Clinician roster counts, total and Medicare patient counts, electronic health record	September 2026
CMS Medicare Advantage State/County Penetration file	Maricopa County Medicare Advantage penetration	September 2026
CMS Medicare Monthly Enrollment	Maricopa County beneficiaries, Original Medicare and Medicare Advantage counts, dual-eligible share	CY2025 annual county row; CY2024 for comparison
American Community Survey five-year estimates, Maricopa County and ZCTA 85006	Neighbourhood context in section 1	2020–2024
CY2026 physician fee schedule, Arizona statewide locality (Noridian JF, 03102-00)	Every CY2026 rate quoted in section 3	CY2026, conversion factor $33.4009
CY2027 physician fee schedule proposed rule (CMS-1848-P) and public use files	Repricing in section 10, locality and national	Published 16 July 2026
AHCCCS Medical Policy Manual 320-I (Telehealth) and 310-P (Medical Equipment and Supplies); AHCCCS Telehealth Code Set; AHCCCS Fee-For-Service Provider Billing Manual chapter 10	Arizona Medicaid coverage of remote patient monitoring in sections 2 and 9	320-I effective 1 October 2023; code set 2026 Final, effective 1 June 2026; manual revised 29 April 2026
Arizona Revised Statutes section 20-841.09	Commercial telehealth parity including remote patient monitoring	As amended 2021
CMS Hospital Readmissions Reduction Program	Program design as described in section 8	FY2026 program
CoachCare Epic integration overview	Section 4	Current
CoachCare Care Management Standard Operating Procedures and SOP process maps	Section 5: patient qualification, escalation engine, emergent pathway, routing, post-discharge cadence, discharge flow	Version March 2026
CoachCare company figures	Section 3.4	Approved July 2026
CoachCare Value Analysis for this account	The 24-month forecast, per-program detail, sensitivities and clinical outputs	Recalculated 22 September 2026