COACHCARE | SERVICE LINE STRATEGY

Cardiology Consultants of East Michigan, PLLC

Flint Township and Lapeer, Michigan. An independent, physician-owned cardiology practice at two locations, in practice since 2001: four cardiologists and three nurse practitioners

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) built as an extension of the remote device clinic the practice already runs, sized against its own Medicare claims, the readmission record of its four admitting hospitals, and a margin-positive P&L billed under the practice's own TIN

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the physician owners and administrator of Cardiology Consultants of East Michigan. It starts from the practice's own Medicare claims. Four cardiologists carried 2,613 beneficiaries and $1,461,166 of Medicare allowed charges in CY2024. The average patient is 76 years old, roughly half carry a heart failure diagnosis, and the practice already runs a remote device clinic with about 248 remotely monitored patients.

What the same claims do not contain is any remote physiologic monitoring, principal care management or transitional care management at meaningful scale. The practice reviews remote data on a calendar for patients with hardware. It bills nothing for the same kind of watch over the far larger group of established patients without it.

The forecast in section 6 sizes that gap: $1,836,285 of net reimbursement over 24 months at a 42.6% practice margin, positive from month 2, with no clinical headcount added to the practice's payroll.

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Table of Contents

Executive Summary

Cardiology Consultants of East Michigan is an independent, physician-owned cardiology practice with offices in Flint Township (Genesee County) and Lapeer (Lapeer County). CMS registry data resolve **five clinicians** to the practice's own billing entity: four cardiologists and one nurse practitioner, with two further nurse practitioners on the website roster.[1] In CY2024 the four physicians billed **$1,461,166** of Medicare fee-for-service allowed charges on 2,613 beneficiaries.[2] The practice does its own electrophysiology, interventional and structural work at the hospital, runs a device clinic, an anticoagulation clinic and a vein center in the office, and holds admitting privileges at four hospitals across three systems.

The panel is the strongest argument on the account. The average patient is **76 years old** and carries a hierarchical condition category risk score between **1.76–1.93** against a national average of 1.00. Heart failure runs 47–53% of each physician's beneficiaries, atrial fibrillation 45–53%, ischemic heart disease 62–68%, chronic kidney disease 39–43%, diabetes 41–43% and COPD 31–36%. Hypertension reports at 75%, which is the ceiling CMS publishes chronic-condition prevalence to rather than a measured rate.[3]

What is already running

The practice runs a remote device clinic. In CY2024 it billed remote interrogation on about 200 pacemaker patients, 52 defibrillator patients and 139 implantable loop recorder patients, with the technical component on 248 patients, plus mobile cardiac telemetry on 140. Loop-recorder remote review alone ran 761 services in the year.[4] Someone in that office owns an incoming remote-data queue, reviews it on a calendar, documents what they found and bills it. That is the hard part of remote care, and it is already solved here for the patients who have hardware.

What is absent

Across all four physicians, every remote physiologic monitoring, chronic care management, principal care management and transitional care management code is absent from the same year's claims.[5] CMS suppresses any line below eleven beneficiaries, so the exact reading is that the practice ran **no such program at meaningful scale in CY2024**. The clinical work those codes pay for is being done. It is being done inside office visits and phone calls that carry no separate payment.

The finding in one sentence

A practice that already reviews remote data on a calendar for about 248 device patients bills nothing for managing the 1,520 established patients it sees in the office, most of whom have no implanted device and roughly half of whom have heart failure.

[1] CMS Doctors & Clinicians national file and the NPPES registry, retrieved 14 September 2026. Five clinicians are listed under the practice's CMS group identifier: four physicians with cardiovascular disease as primary specialty and one nurse practitioner. Two additional nurse practitioners appear on the practice website and do not yet resolve to the practice in CMS data.

[2] Medicare Physician & Other Practitioners — by Provider, calendar year 2024, queried per national provider identifier for the four physicians billing under the practice's CMS group identifier, 14 September 2026. Beneficiary counts are summed across the four physicians and are not deduplicated; a patient seen by two physicians is counted twice.

[3] Medicare Physician & Other Practitioners — by Provider, calendar year 2024, queried per national provider identifier for the four physicians billing under the practice's CMS group identifier, 14 September 2026. Risk score, average age and chronic-condition prevalence are read per physician; the ranges shown are the lowest and highest of the four. CMS caps published prevalence at 75.0%, so hypertension reports at that ceiling.

[4] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code, 14 September 2026. Codes 93294 (pacemaker remote interrogation), 93295 (defibrillator), 93297 (implantable loop recorder), 93296 and 93298 (technical components) and 93228/93229 (mobile cardiac telemetry). Monitoring codes only; implant and programming procedures are counted separately and never summed with monitoring.

[5] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code, 14 September 2026. Codes 99453, 99454, 99457, 99458, 99091, 99490, 99491, 99424 through 99427, 99495 and 99496 were searched by exact procedure code for each of the four physicians. None appears. CMS suppresses any provider and procedure line below eleven beneficiaries.

Why the timing is right

Three facts outside the practice's walls line up with the one inside them. Its principal admitting hospital is penalized under the Hospital Readmissions Reduction Program on every measure it reports, with the largest heart-failure discharge volume in the market. The practice is a participant in an Enhanced-track Medicare Shared Savings Program ACO, where avoided admissions among assigned beneficiaries land under a two-sided benchmark. And CMS created two remote-monitoring codes for CY2026 that pay for exactly the short post-discharge windows a cardiology practice needs.

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 changes.

The forecast

The Value Analysis models a remote care service line across an in-scope cohort of 2,500 patients drawn from a 3,130-patient Medicare panel, enrolled through the practice's 5 clinicians. Over 24 months it produces **$1,836,285 of net reimbursement** to the practice against $1,054,299 of CoachCare fees, leaving **$781,986 retained, a 42.6% practice margin**.[6] Year 1 runs 41.0% and year 2 runs 43.3%. Month 1 is $5,218 negative, because implementation and integration setup post against a first-month census of 35 patients; the practice is positive from month 2 and stays there.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$582,589	$1,253,696	$1,836,285
CoachCare program and platform fees	$343,925	$710,374	$1,054,299
Net to the practice	$238,664	$543,322	$781,986
Practice margin	41.0%	43.3%	42.6%
Unique patients under management	756	848	848

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 848 unique patients carry 1,294 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 only. Two-thirds of the seniors in this market are in Medicare Advantage (69.8% in Genesee County, 62.9% in Lapeer County). Advantage plans must reimburse at least the Medicare rate. That is a floor; individual contracts set their own terms for the care-management code families.

The 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. That matters in a practice with three nurse practitioners and a back office that one administrator runs.

2026–2027 priority recommendations

1. **Bill transitional care management on the discharges already happening.** Four certified hospitals, admitting privileges at all of them, and no 99495 or 99496 in the claims. No device, no new population, no consent hurdle. $210.41 and $285.37 per discharge at this locality, outside the 24-month forecast entirely.
2. **Extend the device-clinic operating model rather than building a second one.** The queue, the review calendar, the documentation habit and the billing path exist for about 248 device patients. They need to reach the established patients with no hardware.

[6] CoachCare Value Analysis for this account, built on the CY2026 physician fee schedule at WPS Michigan locality 99 and recalculated 14 September 2026. Revenue is net of modeled denials, patient coinsurance and coinsurance bad debt.

3. **Put the heart-failure cohort on weight and blood-pressure monitoring first.** Heart failure runs 47–53% of the panel. It is the diagnosis that drives the admitting hospitals' penalties and the ACO's benchmark, and daily weight is the earliest signal of decompensation.
4. **Layer principal care management onto the same cohort from month 2.** One high-risk condition, monthly, at top-of-license staffing. It reaches its ceiling in month 23, which is the argument for starting early rather than late.
5. **Take the Medicare Advantage plan mix off the table on the first call.** With roughly two seniors in three in Advantage across the two counties, the plan mix of the practice's own panel decides how much of this forecast is fee-schedule-certain. Advantage plans must reimburse at least the Medicare rate. That is 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 20.5% at this locality, which flows through to −5.9% on the service line. The final rule is effective 1 January 2027.

1. Where the Practice Is Today

1.1 The panel: what the claims say

CMS publishes, per physician, the beneficiaries seen, the allowed charges, the average risk score and the share of beneficiaries carrying each chronic condition. Read across the four cardiologists, the file describes a mature, established, high-acuity panel.

Panel measure	Value	What it means here
Beneficiaries, four physicians	2,613	Summed across physicians, not deduplicated across them
Established-visit beneficiaries	1,520	Patients who return to the office (99213 and 99214): the enrollable population
Medicare allowed, CY2024	$1,461,166	Professional and in-office technical services across the four physicians
Average risk score	1.76–1.93	Every physician's panel sits 76% to 93% above the national 1.00 benchmark
Average beneficiary age	76	A panel in the highest-utilization Medicare decade
Heart failure	47–53%	Roughly one patient in two. The cohort that drives admissions
Atrial fibrillation	45–53%	The population the device clinic already serves
Ischemic heart disease	62–68%	Two patients in three
Chronic kidney disease	39–43%	Drives both admission risk and titration caution
Diabetes	41–43%	Two-condition eligibility is effectively universal
COPD	31–36%	One patient in three
Hypertension	75% (CMS ceiling)	The ceiling CMS publishes prevalence to, not a measured rate

CY2024 Medicare Physician & Other Practitioners data, by provider, for the four physicians billing under the practice. Ranges are the lowest and highest physician values. CMS publishes chronic-condition prevalence to a ceiling of 75.0%, so hypertension reports at that ceiling rather than at a measured rate.

Two readings follow. First, new-patient visit volumes are small for every physician, between eleven and sixty-two a year, so this is an established panel that comes back rather than a referral mill that turns over.[7] A monthly care-management program enrolls from the patients who return. Second, heart failure at roughly half the panel is high even for cardiology. It is the diagnosis that puts patients in the hospital, the diagnosis the admitting hospitals are penalized on, and the diagnosis where a daily weight from the patient's home changes what happens next.

1.2 The device clinic the practice already runs

Most remote care proposals to an independent practice have to argue the concept first. This one does not. The practice has run a remote device-monitoring clinic for years and the claims prove it.

Remote device monitoring, CY2024	Beneficiaries	Services
Pacemaker remote interrogation, up to 91 days (93294)	200	470
Implantable loop recorder remote interrogation, up to 30 days (93297)	139	761
Defibrillator remote interrogation, up to 91 days (93295)	52	reported
Device remote interrogation, technical component (93296)	248	reported
Mobile cardiac telemetry, physician review (93228)	140	reported

CY2024 Medicare claims, monitoring codes only. In-person interrogation and programming codes, and device implant procedures, are reported separately by CMS and are not combined with the monitoring lines above.

Three readings matter. The loop-recorder line sustains more than five remote reviews per patient per year on 139 patients, which is a cadence discipline, not a pilot. The technical component on 248 patients means the practice, not a hospital, owns the receiving end of the transmissions. And the whole remote book sits inside the practice, so the operating model exists and has an owner.

What this changes about the proposal

The hard parts of remote care are the parts that need a person doing them every week: someone owns the incoming queue, reviews it on a schedule, documents what they found, and gets it billed. This practice solved those four problems years ago for its device patients.

What follows is the extension of an operating model the practice already runs, from the roughly 248 patients with hardware to the 1,520 established patients it sees in the office, most of whom have none.

1.3 The codes that are absent

Every remote physiologic monitoring, chronic care management, principal care management and transitional care management code was searched by exact procedure code across the four physicians in the CY2024 file. None is present.[8]

Code family	Codes searched	CY2024 result
Remote physiologic monitoring	99453, 99454, 99457, 99458, 99091	None present
Chronic care management	99490, 99491	None present
Principal care management	99424, 99425, 99426, 99427	None present

[7] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code, 14 September 2026. New-patient codes 99204 and 99205 report between 11 and 62 beneficiaries per physician. Established codes 99213 and 99214 report 1,520 beneficiaries across the four.

[8] As the by-Provider-and-Service source above. Fourteen codes were searched: 99453, 99454, 99457, 99458, 99091, 99490, 99491, 99424, 99425, 99426, 99427, 99495 and 99496, plus the CY2026 codes 99445 and 99470, which could not appear in a CY2024 file.

Code family	Codes searched	CY2024 result
Transitional care management	99495, 99496	None present

CMS suppresses any provider and procedure line below eleven beneficiaries, so the defensible reading is that no such program ran at meaningful scale in CY2024.

The transitional care absence is the loudest of the four. The practice's physicians hold privileges at McLaren Flint, McLaren Lapeer Region, Hurley Medical Center and Henry Ford Genesys Hospital. Their patients are admitted, discharged and seen back in the office. The clinical work of a transition is being done. The payment attached to it is not being captured.

2. The Admitting Hospitals' Readmission Record

The Hospital Readmissions Reduction Program adjusts every Medicare inpatient payment a hospital receives, based on its excess readmission ratio for six conditions. Heart failure is one of them. The FY2026 program file, which sets payment from October 2025, records the following for the four hospitals where the practice's physicians admit.[9]

Hospital	Payment adjustment	HF excess readmission ratio	HF discharges	Penalized on
McLaren Flint (CCN 230141)	-1.01%	1.0148	627	All 6 of 6 measures, heart failure included
McLaren Lapeer Region (CCN 230193)	-0.16%	0.9791	262	Two measures; heart failure not penalized
Hurley Medical Center (CCN 230132)	reported	1.0761	217	Heart failure
Henry Ford Genesys Hospital (CCN 230197)	reported	0.9183	421	Three measures; heart failure not penalized

FY2026 HRRP program file. A ratio above 1.0000 means more heart-failure readmissions than expected for the hospital's case mix. The payment adjustment applies to every Medicare inpatient discharge, not only the penalized conditions.

McLaren Flint is the readmission story in this market. It carries 627 eligible heart-failure discharges, the largest volume of the four, a heart-failure ratio above expected, and a 1.01% reduction on every Medicare inpatient payment for the year. McLaren Lapeer Region and Henry Ford Genesys both run below expected on heart failure. Hurley runs above.

One further figure belongs beside the readmission ratio. Thirty-day heart-failure mortality at McLaren Lapeer Region is 14.3%, the highest of the four, on the practice's larger Medicare site.[10] The window that decides both numbers is the same window: the thirty days after a heart-failure patient leaves the building.

[9] FY2026 Hospital Readmissions Reduction Program supplemental data file and Table 15 payment adjustment factors, CMS, performance period 1 July 2021 to 30 June 2024. The program file sets payment; the Care Compare significance test is a different measure and is not used here.

[10] CMS Care Compare, Complications and Deaths file, 30-day heart-failure mortality, performance period 1 July 2022 to 30 June 2025. McLaren Lapeer Region 14.3% on 238 cases; McLaren Flint 10.2%; Hurley 10.2%; Henry Ford Genesys 11.9%. All four are rated no different from the national rate.

Why this is the practice's lever and not only the hospitals'

A hospital's heart-failure readmission ratio is built from what happens to its discharged patients after they go home. Those patients are, in large part, this 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 post-discharge cadence for its own patients is worth more to each of its four admitting hospitals than one that does not, and it is paid for the cadence directly under its own TIN.

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, on patients the practice already discharges from four hospitals and already sees.

Code	Service	CY2026 rate at this locality
99495	Transitional care management, moderate medical decision complexity, face-to-face within 14 days	$210.41
99496	Transitional care management, high medical decision complexity, face-to-face within 7 days	$285.37

CY2026 physician fee schedule, non-facility, WPS Michigan locality 99 (Rest of Michigan), resolved from ZIP 48532. Both offices bill at the same locality.

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 the admitting hospitals' heart-failure ratio is calculated over, 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

Stage	Program	What happens	Cadence
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 Michigan locality 99

Code	Service	CY2026 rate
99453	Remote monitoring setup and patient education, once per enrollment	$19.97
99454	Device supply with daily recording, 16–30 days	$47.64
99445	**Device supply with daily recording, 2–15 days, new for CY2026**	**$47.64**
99457	Treatment management, first 20 minutes	$49.33
99470	**Treatment management, first 10 minutes, new for CY2026**	**$24.83**
99458	Treatment management, each additional 20 minutes	$39.87
99426	Principal care management, clinical staff, first 30 minutes	$65.32
99427	Principal care management, clinical staff, each additional 30 minutes	$51.83
99424	Principal care management, physician or qualified professional, first 30 minutes	$84.90
99425	Principal care management, physician or qualified professional, each additional 30 minutes	$59.52
99495	Transitional care management, moderate complexity	$210.41
99496	Transitional care management, high complexity	$285.37

CY2026 physician fee schedule, non-facility, WPS Michigan locality 99, resolved from ZIP 48532 by the model's locality crosswalk. 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 **$205,670** of gross remote-monitoring reimbursement, 17% of the monitoring arm's gross and about 10% of the whole service line's net reimbursement.[11]

Every rate above is the fee-for-service amount. Two-thirds of the seniors in Genesee and Lapeer counties are in Medicare Advantage. Advantage plans must reimburse at least the Medicare rate. That is a floor; individual contracts set their own terms for the care-management code families. The fee-for-service base, about 39,599 beneficiaries across the two counties, is where these rates are fee-schedule-certain.

[11] As the Value Analysis source. 99445 carries $175,227 and 99470 carries $30,443 of gross remote-monitoring reimbursement across the 24-month horizon, against $1,216,050 of gross for the monitoring arm, read from the model's per-code rows and verified on 14 September 2026.

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 eClinicalWorks

4. Inside eClinicalWorks

The practice runs eClinicalWorks. Its patient portal resolves to the vendor's cloud environment and returned a live login page on 14 September 2026.[12] That settles the integration question before the first call, because CoachCare's eClinicalWorks integration is native rather than interfaced. The care team works inside the practice's chart, not beside it.

What the integration does	What it means in this office
Integrated ordering and enrollment	Enrollment flags and ordering by service inside the eClinicalWorks workflow; enrollment status is visible in the chart in real time, and patients begin receiving services in under five days
Exchange of health history	The care team starts from the practice's problem list, medications and allergies rather than re-collecting them
Integrated vital reports	Home weight and blood pressure land in the patient's chart as structured vitals, reviewable by any clinician in the practice
Monthly compliance documents	Evidence of care, vitals summary and the care plan are attached 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 eClinicalWorks that does this

CoachCare eClinicalWorks integration overview.

The last row is the one that matters most here. A practice whose billing is run by one administrator cannot absorb 647 or more new claim lines a month by hand. The integration means the monthly claim for every

[12] Practice website, Patient Portal link, retrieved 14 September 2026; the portal URL resolves to an eClinicalWorks cloud instance and returned HTTP 200.

enrolled patient is created from captured time and attached documentation, and the administrator reviews rather than keys.

Integration economics carried in the model 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.[13]

5.1 The escalation engine

- **Reading received.** Values are evaluated against the patient's own thresholds, not a generic band.
- **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 four-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 with four physicians who also run hospital procedure days, that distinction is the difference between a program that gets adopted and one that gets ignored.

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

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-verified
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 82 avoided hospitalizations in the forecast come from. It runs inside the same 30-day window transitional care management pays for and the admitting hospitals' heart-failure ratio is calculated over. One cadence, three separate 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.

6. The Value Analysis

6.1 Model inputs and how the panel was sized

Input	Value
Medicare panel	3,130 patients
In-scope for year 1	2,500, 80% of the panel
Referring clinicians	5
On-site enrollment specialists	1, funded by CoachCare
Programs modeled	Remote physiologic monitoring and principal care management
MAC and locality	WPS (J8), Michigan locality 99, Rest of Michigan, resolved from ZIP 48532
Electronic health record	eClinicalWorks, native integration
Medicare Advantage penetration	69.8% Genesee County, 62.9% Lapeer County, 66.0% site-weighted. Advantage plans must reimburse at least the Medicare rate. That is a floor; individual contracts set their own terms for the care-management code families.
Forecast horizon	24 months

The panel figure is built from the established-visit population rather than from total beneficiary counts. CMS reports beneficiaries per rendering physician, and in a four-physician cardiology practice the same patient is routinely seen by more than one of them, so the 2,613 beneficiaries in the file overstate the unique panel. The 1,520 established-visit beneficiaries are deduplicated across physicians and then grossed up for the Medicare Advantage share of the two counties, because the claims file covers fee-for-service only and the practice's Advantage patients are not in it. The result is a 3,130-patient Medicare panel, of which 80% is treated as condition-eligible for a cardiology service line in year 1.[14]

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 model bills it on the clinical-staff codes. The 5 referring clinicians are the four physicians and the nurse practitioner who resolves to the practice in CMS data; the two further nurse practitioners on the website roster are an open item, and section 7 shows what they would add.

[14] Panel derivation: 1,520 established-visit beneficiaries across the four physicians, deduplicated at 70% to account for patients seen by more than one physician, then divided by the fee-for-service share of the two counties (1 less 65.98% site-weighted Advantage penetration, July 2026 CMS file) to restore the Advantage patients the claims file does not contain. In-scope is 80% of the resulting panel.

6.2 The 24-month forecast

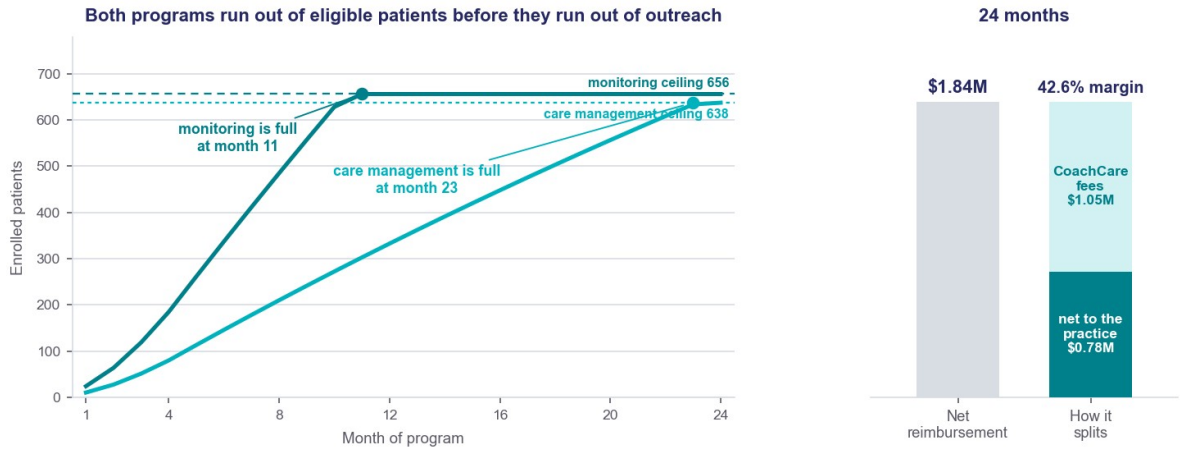

Figure 1. Enrollment against the modeled ceilings, and how 24 months of net reimbursement splits between the practice and CoachCare.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$582,589	$1,253,696	$1,836,285
CoachCare program and platform fees	$343,925	$710,374	$1,054,299
Net to the practice	**$238,664**	**$543,322**	**$781,986**
Practice margin	**41.0%**	**43.3%**	**42.6% (42.59%)**

By program	Year 1 net	Year 2 net	24-month net	24-month fees	Ceiling	Ceiling reached
Remote physiologic monitoring	$410,575	$715,791	$1,126,366	$638,053	656	Month 11
Principal care management	$172,014	$537,905	$709,919	$368,304	638	Month 23

Per-program year splits are read from the workbook's summary, not allocated from the ramp, and reconcile to the annual totals above.

Both programs fill inside the horizon. Monitoring reaches its ceiling of 656 patients in month 11 and care management reaches 638 in month 23. After that the census is flat because the model has run out of patients it counts as eligible, not because it has run out of outreach. The binding constraint on this account is the eligibility definition, which is why the chart count and the in-scope share are the first two items on the discovery agenda.

6.3 Month by month

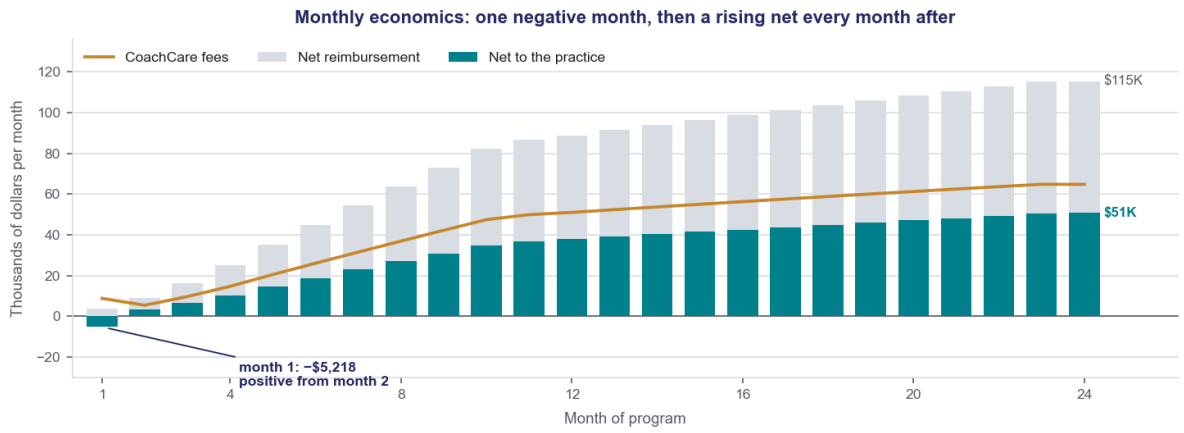

Figure 2. Net reimbursement, CoachCare fees and net to the practice by month. Month 1 is the only negative month.

Month 1 runs **$5,218 negative**. Implementation and the eClinicalWorks integration setup both post in the first month against a 35-patient census. The practice is positive from **month 2** onward and stays there. By month 12 the practice nets $37,773 a month; by month 24, $50,682.

6.4 Patients, readings and avoided admissions

What the service line produces over 24 months	Value
Unique patients under management at month 12	756
Unique patients under management at month 24	848
Active program enrollments at month 24	1,294
Physiologic readings reviewed	128,735
Claims generated	35,374
Hospitalizations avoided	82
Care-team hours delivered	17,256, about 8.3 full-time equivalents

Unique patients are deduplicated across programs. A patient enrolled in both monitoring and care management is one person and two enrollments, which is why 848 unique patients carry 1,294 active enrollments at month 24. Care-team hours describe labor supplied by CoachCare, not headcount the practice hires.

The avoided-admission figure is built on a generic 20% annual admission rate. A cohort with heart failure at 47–53% of the panel runs well above that. The table below shows what the same enrolled population avoids at higher baselines, and 40% is the realistic figure for a heart-failure-heavy cardiology cohort.

Annual admission rate in the enrolled cohort	Hospitalizations avoided, 24 months
20%, the modeled base	**82**
30%	123
40%, realistic for this cohort	163
50%	204

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

Those hours are the number to hold against the practice's own staffing. About 8.3 full-time equivalents of care-management labor, supplied by CoachCare, against a practice with three nurse practitioners and four 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 modeled base.

Input	Setting	24-month net	Net to the practice	Unique patients, month 24
Modeled base	**1 enrollment specialist, 80% in scope, 5 clinicians**	**$1,836,285**	**$781,986**	**848**
Enrollment specialists	0	$734,037	$299,844	546
	2	$2,209,851	$952,069	848
	3	$2,355,971	$1,018,252	848
In-scope share of the panel	60%	$1,545,075	$660,165	637
	100%	$2,040,345	$865,703	1,020
Referring clinicians	4	$1,790,346	$761,391	845
	7	$1,915,808	$817,759	848
Upside roster	7 clinicians, panel resized to the larger roster	$2,302,035	$976,447	1,170

Sensitivities recalculated from the same workbook, one input at a time. The upside roster adds the two co-located clinicians whose billing entity is an open item, and rebuilds the panel from their combined established-visit beneficiaries.

Read the enrollment rows carefully

Going from zero enrollment specialists to one is worth $1,102,248 over 24 months. That is the single largest lever in the model, and it is the answer to the staffing objection: the enrollment function is the program, and CoachCare funds it.

A second or third specialist cannot raise the ceiling. The month-24 census is 848 unique patients at one, two and three, because both programs are already pinned at their ceilings. What extra capacity buys is reaching those ceilings sooner, and the additional patient-months in between are real revenue: $373,567 more over 24 months with two specialists, $519,686 more with three.

The in-scope share and the roster move the ceiling. The enrollment specialist count moves the speed. Both matter, and they are different conversations.

8. The Shared Savings Layer

Cardiology Consultants of East Michigan PLLC is a participant in **McLaren High Performance Network, LLC** (ACO A3317) in the Medicare Shared Savings Program, in the Enhanced track, in agreement period 3.[15] The Enhanced track is two-sided. Spending below the benchmark on assigned beneficiaries is shared savings; spending above it is shared losses. Heart-failure admissions are among the largest single drivers of total cost of care in a cardiology panel, and every one of them lands on that benchmark.

The forecast in section 6 claims none of that. **No shared-savings dollars are in the forecast.** The service line is margin-positive on Part B professional fees billed under the practice's own TIN before any value-based dollar is counted. What the ACO position adds is a second reason to run the post-discharge cadence, and an organization that is measured on exactly the outcome the cadence produces.

What the service line produces	Where it lands
Net reimbursement on remote monitoring and care management	The practice's own P&L, section 6
Transitional care management on every discharge	The practice's own P&L, outside the forecast
Avoided heart-failure admissions among assigned beneficiaries	The ACO benchmark; shared savings or shared losses under the Enhanced track
Lower heart-failure readmission ratios at the admitting hospitals	The hospitals' Medicare inpatient payment adjustment
Documented between-visit management of heart-failure patients	The evidence base a specialty model scores on, if selection ever changes

One number belongs on the discovery agenda rather than in this report: the count of Medicare beneficiaries assigned to the ACO through this practice. It sets how much of the avoided-admission value in section 6 lands under the benchmark, and the ACO can supply it.

[15] CMS Medicare Shared Savings Program ACO Participants file, performance year 2026, matched on the practice's exact legal name; the ACO record shows the Enhanced track, high-revenue status, retrospective assignment and 83 participant entities. The CMS Quality Payment Program eligibility interface confirms an advanced alternative payment model flag for the practice's clinicians in 2025.

9. Medicare Advantage in This Market

County	Medicare eligibles	Advantage penetration	Fee-for-service beneficiaries	Population 65 and over	Median household income
Genesee	96,610	69.8%	31,292	75,735 (18.8%)	$62,281
Lapeer	22,978	62.9%	8,307	17,916 (20.2%)	$77,306

CMS State and County Medicare Advantage penetration file, July 2026; CMS Medicare Monthly Enrollment, calendar year 2025; American Community Survey 2020–2024 five-year estimates.

This is one of the most Advantage-heavy markets in the country. 69.8% of Genesee County's Medicare eligibles and 62.9% of Lapeer County's are in Advantage plans, which leaves about 31,292 fee-for-service beneficiaries in Genesee and 8,307 in Lapeer.[16] The practice's claims profile in section 1 describes only the fee-for-service third of its panel. The Value Analysis grosses the panel up to include the Advantage patients, because they are enrolled in the same programs and consented the same way. Advantage plans must reimburse at least the Medicare rate. That is a floor; individual contracts set their own terms for the care-management code families.

Genesee County's poverty rate is 16.4% and its median household income $62,281; Lapeer is better off at $77,306. The practice's own dual-eligible share runs 16% to 18% per physician, which is moderate for the market. Cost-sharing on a monthly care-management program is an ordinary conversation on this panel, and the enrollment specialist has it in person.[17]

What this means for the business case

Two-thirds of the panel's reimbursement is contract-dependent rather than fee-schedule-set. The practice's own Advantage plan mix, plan by plan, is therefore the single most useful piece of information it can bring to the first call.

The fee-for-service third is where the rates in section 3 apply exactly as printed. The Advantage two-thirds is where the practice's existing plan contracts decide the answer, and those contracts already exist.

[16] CMS State and County Penetration, Medicare Advantage, July 2026 file: Genesee County 96,610 eligibles and 67,465 enrolled; Lapeer County 22,978 eligibles and 14,457 enrolled. Fee-for-service counts from CMS Medicare Monthly Enrollment, calendar year 2025 county rows.

[17] American Community Survey 2020–2024 five-year estimates, tables DP03 and DP05, Genesee and Lapeer counties. Dual-eligible share per physician from the by-Provider source.

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.[18] 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 Michigan locality 99.

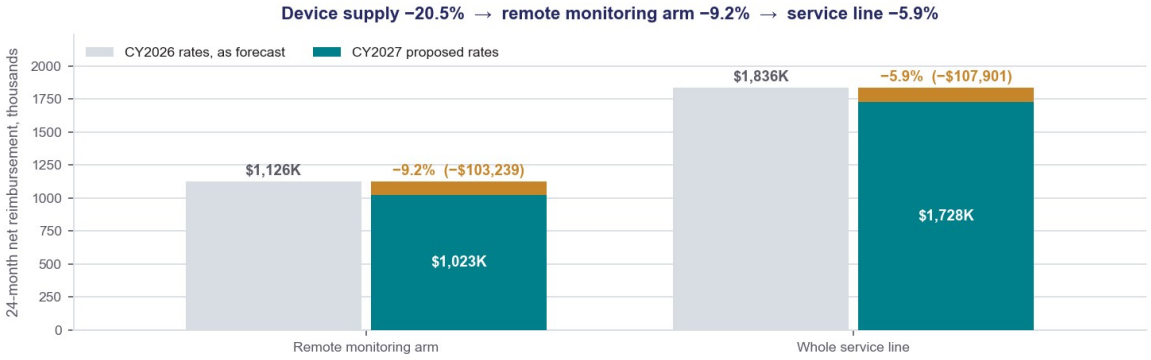

Figure 3. The CY2027 cascade on one dollar scale: the device-supply cut flows through the remote-monitoring arm to the whole service line, each percentage smaller only because its base is larger.

Device supply (99454 and 99445) falls −20.5% at this locality, from $47.64 to $37.85 per patient-month. Device supply is 31% of the remote-monitoring basket on the practice's mix, so the monitoring arm falls −9.2%, or −$103,239 over 24 months. The monitoring arm is 61% of the service line, so the whole line falls −5.9%, or −$107,901 of $1,836,285. Principal care management moves −0.7%, through the conversion factor and practice-expense churn rather than any targeted change.

Code	Service	Locality 99, CY2026	Locality 99, CY2027 proposed	Change	National, CY2026	National, CY2027 proposed
99453	Remote monitoring setup	$19.97	$18.36	−8.1%	$21.71	$20.03
99454	Device supply, 16–30 days	$47.64	$37.85	−20.5%	$52.11	$41.38
99445	Device supply, 2–15 days	$47.64	$37.85	−20.5%	$52.11	$41.38
99457	Treatment management, first 20 min	$49.33	$47.37	−4.0%	$51.77	$49.59
99470	Treatment management, first 10 min	$24.83	$19.92	−19.8%	$26.05	$20.69
99458	Treatment management, additional 20 min	$39.87	$38.98	−2.2%	$41.42	$40.39
99426	Principal care management, staff, first 30 min	$65.32	$64.45	−1.3%	$67.80	$67.00
99427	Principal care management, staff, additional 30 min	$51.83	$52.16	+0.6%	$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.

[18] 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 $1,728,384 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

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, eClinicalWorks integration scheduled, Advantage plan mix reviewed
First enrollments	Days 31–45	On-site enrollment specialist starts, transitional care management goes live on current discharges from all four hospitals, the first monitoring cohort is set up from the heart-failure list
Ramp	Months 2–11	Monitoring census climbs to its ceiling of 656; monthly billing cadence established; first read of readmissions in the post-discharge cohort
Depth	Months 12–23	Principal care management builds to its ceiling of 638 on the heart-failure, atrial fibrillation and kidney-disease cohort; treatment-management time capture matures
Steady state	Month 24 onward	Both programs at ceiling; the conversation turns to the in-scope definition, the two further nurse practitioners and the roster

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
Shared savings	Assigned-beneficiary admissions in the enrolled cohort against the prior year, reported to the ACO on its own cadence

12. Open Items for the First Call

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

1. **The chart count.** The 3,130-patient Medicare panel is built from established-visit beneficiaries in the CMS file, grossed up for the Advantage share. A unique-patient count from eClinicalWorks replaces the estimate outright, and section 7 shows what it moves.
2. **The two co-located clinicians.** CMS data show a cardiologist and a physician assistant at the Lapeer office who bill through a separate entity as well as through the practice. Whether they are in the practice's roster decides between the base case and the upside roster in section 7.
3. **The two further nurse practitioners.** Three nurse practitioners are on the website; one resolves to the practice in CMS data. Enrollment status of the other two decides whether the referring-clinician count is 5 or 7.
4. **The Medicare Advantage plan mix.** About two seniors in three across the two counties are in Advantage, and the panel is priced at the fee schedule. Advantage plans must reimburse at least the Medicare rate. That is a floor; individual contracts set their own terms for the care-management code families. Which plans, and in what proportion, is the question.
5. **Physician-organization membership.** Whether the practice participates in a Blue Cross Blue Shield of Michigan physician organization or incentive program, and through which organization, is not publicly registered and would add a payer-side reason to run the program.
6. **Any remote monitoring pilot under the practice's own TIN.** Confirm whether any remote physiologic monitoring has been billed under the practice's own tax identifier, and by whom, so the program starts from the right baseline.
7. **The ACO's assigned-beneficiary count for the practice.** It sets how much of the avoided-admission value lands under the Enhanced-track benchmark, and the ACO can supply it.

> **The case in three sentences**
>
> A remote care service line built on the panel this practice already manages produces $1,836,285 of net reimbursement and $781,986 of retained margin over 24 months, at a 42.6% practice margin, billed under the practice's own TIN.
>
> It does that while producing the post-discharge cadence that moves four admitting hospitals' heart-failure ratios and an Enhanced-track ACO's benchmark, on a panel where roughly half the patients have heart failure.
>
> **The operating model is already running in the device clinic. What is missing is its reach.**

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 roster and the plan mix against this model. Connor Knapp · Head of Sales · CoachCare · connor.k@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.

Source	Used for	Vintage
Medicare Physician & Other Practitioners — by Provider	Allowed charges, beneficiary counts, risk score, age, dual-eligible share, chronic-condition prevalence for the four physicians	CY2024, queried 14 September 2026
Medicare Physician & Other Practitioners — by Provider and Service	Procedure-level claims: device-monitoring codes, established and new office visits, and the absent remote-care and care-management families	CY2024, queried 14 September 2026
CMS Doctors & Clinicians national file; NPPES registry; Quality Payment Program eligibility interface	Clinician roster, group identifier, billing-entity attribution, alternative payment model status	Current file / PY2025, retrieved 14 September 2026
CMS Medicare Shared Savings Program ACO Participants	ACO participation, track, agreement period	PY2026, 1 January 2026 file
FY2026 Hospital Readmissions Reduction Program supplemental data file and Table 15	Excess readmission ratios, eligible discharges, payment adjustment factors for the four admitting hospitals	FY2026, performance period July 2021 to June 2024
CMS Care Compare, Complications and Deaths; Hospital General Information	30-day heart-failure mortality; hospital CCNs	July 2022 to June 2025 / current
CMS State and County Medicare Advantage penetration file	County Advantage penetration	July 2026
CMS Medicare Monthly Enrollment	County fee-for-service beneficiary counts	CY2025
American Community Survey five-year estimates, Genesee and Lapeer counties, Michigan	Population 65 and over, income, poverty	2020–2024
CY2026 physician fee schedule, WPS Michigan locality 99	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
CoachCare eClinicalWorks integration overview	Section 4	Current
CoachCare Care Management Standard Operating Procedures and SOP process maps	Section 5: escalation engine, emergent pathway, routing, post-discharge cadence, discharge flow	Version March 2026
CoachCare Value Analysis for this account	The 24-month forecast, per-program detail, sensitivities and clinical outputs	Recalculated 14 September 2026