COACHCARE | SERVICE LINE STRATEGY

HeartCare Associates of Arizona

Sun City West and Sun City, Arizona. An independent cardiology practice with two offices in the West Valley retirement communities: one interventional cardiologist and one physician assistant, billing Medicare under the practice's own tax ID since 2018

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) for a practice whose patients are almost all Medicare: no capital, no clinical headcount, billed under the practice's own TIN at the Arizona fee schedule, and net-positive from month 2

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the physician owner of HeartCare Associates of Arizona. The practice is an independent cardiology group of one interventional cardiologist and one physician assistant, working from two offices in Sun City West and Sun City beside the two hospitals where it admits. It has billed Medicare under its own tax ID since 2018.

In a market this old, patient supply is not the question. About 2,400 Medicare patients sit behind the practice, roughly 1,000 of them in Original Medicare, and the work that keeps them out of the hospital happens in the months between office visits. Today the practice bills nothing for those months.

The forecast in section 6 sizes what a remote care service line is worth on that panel: $1,519,280 of net reimbursement over 24 months at a 42.8% practice margin, net-positive from month 2, with the care team and the on-site enrollment specialist carried by CoachCare.

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Executive Summary

HeartCare Associates of Arizona is an independent cardiology practice in the Sun City and Sun City West retirement communities of Maricopa County. It runs two offices, one beside Banner Del E. Webb Medical Center and one beside Banner Boswell Medical Center, the two hospitals where it admits. The clinical team is **one interventional cardiologist and one physician assistant**. The practice has billed Medicare under its own tax ID since 2018.

In CY2024 the practice's cardiologist saw **1,400 unique Original Medicare beneficiaries**, average age 79, with heart failure in 25% of them, atrial fibrillation in 37%, chronic kidney disease in 44% and diabetes in 30%. Those are the patients a remote care service line is built for, and today the practice bills for the office visits and almost nothing in between.[1]

The forecast

The Value Analysis sizes a remote care service line across an in-scope cohort of 1,920 patients drawn from the roughly 2,400-patient Medicare panel, enrolled through the practice's 2 clinicians and a CoachCare-funded on-site enrollment specialist. Over 24 months it produces **$1,519,280 of net reimbursement** to the practice against $868,327 of CoachCare fees, leaving **$650,953 retained, a 42.85% practice margin** (41.13% in Year 1, 43.66% in Year 2).[2] Month 1 runs $5,414 negative, because implementation and the EHR integration setup post against a first-month census of 29 enrollments. The practice is net-positive from month 2 and stays there.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$490,279	$1,029,001	$1,519,280
CoachCare program and platform fees	$288,634	$579,693	$868,327
Net to the practice	**$201,645**	**$449,308**	**$650,953**
Practice margin	**41.13%**	**43.66%**	**42.85%**
Unique patients under management	591	651	651

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 651 unique patients carry 994 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. About half of Maricopa County's Medicare beneficiaries are in Medicare Advantage (51.5%), and the Sun City ZIP codes almost certainly run higher. 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. On a two-clinician practice with no headcount to spare, that is the point: the care team and the enrollment desk arrive with the program, not with a new hire.

The finding in one sentence

This practice sits on one of the densest Medicare panels a cardiology group can hold, and it bills nothing today for the eleven months a year its patients spend between visits; the constraint on capturing those months is not patients and not outreach, it is care-team time, and CoachCare supplies that.

[1] CMS Medicare Physician and Other Practitioners, by Provider and by Provider and Service, calendar year 2024 (released 21 May 2026), for the practice's interventional cardiologist. Beneficiary and service counts are the fee-for-service Original Medicare population only; CMS suppresses any line billed to fewer than 11 beneficiaries.

[2] 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 panel is almost entirely Medicare and almost entirely made of the chronic cardiac conditions these codes pay for, so eligibility is wide. CMS created two remote-monitoring codes for CY2026 that pay for the short post-discharge windows a cardiology practice needs, and Arizona Medicaid already lists them in its 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 a county line a patient lives on.

The practice carries 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 to 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 two hospitals where the practice admits, outside the 24-month forecast entirely.
2. **Put the heart-failure and hypertension cohort on 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.
3. **Layer principal care management onto the same cohort from month 2.** One high-risk condition, monthly, at top-of-license staffing. Both programs reach their ceilings inside the 24-month horizon, so the earlier the start, the more of each the practice captures.
4. **Let CoachCare staff the front end.** On a two-clinician practice the enrollment desk cannot come out of existing hours. The single on-site enrollment specialist is the whole difference between the forecast and a program that never fills; section 7 puts the number on it.
5. **Bring the plan mix within the Medicare panel to the first call.** With more than half the county's beneficiaries in Medicare Advantage, the split of the practice's own 2,400 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 −5.9% on the service line. The final rule takes effect 1 January 2027.

1. Where the Practice Is Today

1.1 A Medicare panel like no other

Start with the claims. In CY2024 the practice's interventional cardiologist billed 1,400 unique Original Medicare beneficiaries for $592,753 in allowed charges, an average of $423 per beneficiary on an office-based cardiology practice. The average patient was 79 years old and carried a CMS risk score of 1.50. This is not a general panel with some cardiac patients in it; it is a cardiac panel.[3]

The CY2024 Medicare claims profile	Share of the panel
Heart failure	25%
Atrial fibrillation	37%
Ischemic heart disease	43%

[3] CMS Medicare Physician and Other Practitioners, by Provider and by Provider and Service, calendar year 2024 (released 21 May 2026), for the practice's interventional cardiologist. Beneficiary and service counts are the fee-for-service Original Medicare population only; CMS suppresses any line billed to fewer than 11 beneficiaries.

The CY2024 Medicare claims profile	Share of the panel
Chronic kidney disease	44%
Diabetes	30%
Hypertension	75%, the CMS coding ceiling

CY2024 Medicare fee-for-service condition prevalence for the practice's cardiologist. Hypertension reaches the 75% CMS top-code, a ceiling on the coded figure rather than a count, so the true share is at least that high.

Two of every five of these patients have atrial fibrillation, one in four has heart failure, and nearly half have chronic kidney disease. Every one of those conditions is a principal-care-management target and a monitoring candidate. On a general primary-care panel a remote care service line has to hunt for eligible patients; here the eligible cohort is most of the book.

What the practice looks like	Value	What it means here
Interventional cardiologists	1	Board-certified in cardiovascular disease, interventional cardiology, echocardiography and nuclear cardiology
Physician assistants	1	The clinician who sees many of the between-visit patients
Referring clinicians in the forecast	2	One interventional cardiologist and one physician assistant
Unique Medicare beneficiaries, CY2024	about 1,400	The observed fee-for-service base the panel is built out from
Medicare patients behind the panel	about 2,400	Roughly 1,000 in Original Medicare, the rest in Medicare Advantage
Offices	2	Sun City West beside Banner Del E. Webb, Sun City beside Banner Boswell
Tax ID	The practice's own, since 2018	Every claim in the forecast bills under it

Practice profile from NPPES, the CMS Doctors and Clinicians file, the practice website and CY2024 Medicare claims. The first-call agenda in section 12 confirms these against the practice's own chart and billing data.

1.2 The between-visit months are unbilled today

A cardiology patient with heart failure, atrial fibrillation or resistant hypertension is in the office perhaps two to four times a year. The 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 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 waits for 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 needs a new patient population. Both need care-team time, which on a two-clinician practice is the one thing in short supply.

Why a two-clinician practice is the case, not the obstacle

Every 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. A larger group can sometimes absorb that into existing staff. A one-cardiologist, one-PA practice cannot; there is no spare clinical hour to give it.

That is precisely why CoachCare delivers the care team and funds the on-site enrollment specialist. The practice supervises and bills; it does not staff. The forecast in section 6 is net-positive from month 2 because the labor to run it does not come off the practice's own two calendars.

1.3 The device clinic already reviews transmissions

The habit is already here. In CY2024 the practice reviewed remote cardiac device transmissions on a calendar: 101 beneficiaries on the code for implanted-device interrogation with weekly monitoring, 86 on the monthly pacemaker-and-defibrillator review, and 29 on the loop-recorder review. It also runs a warfarin-management line, 31 beneficiaries across 353 services in the year. Someone owns an incoming queue, reads it on a schedule, documents the finding and bills it.[4]

That queue-reviewed-on-a-calendar routine is the operational core of remote care, and cardiology is the one specialty where it is already normal. What it does not yet cover is the far larger group of patients with no implanted hardware: the heart-failure patient on a weight scale, the hypertensive patient on a cuff. In CY2024 the practice billed no remote physiologic monitoring, chronic care, principal care or transitional care line at meaningful scale. The habit exists; the programs do not. The service line in section 3 extends the same habit from the device panel to the rest of the practice, with CoachCare's care team owning the queue.

2. The Sun City Medicare Market

The practice sits in the oldest large Medicare geography in the state. Its two offices draw from two ZIP Code Tabulation Areas, Sun City (85351) and Sun City West (85375), that were built as retirement communities and remain so. In one, 76.0% of residents are 65 or older; in the other, 84.2%. The median resident is in their seventies, and more than four in five are on public coverage. Together the two ZIP codes hold about 44,286 seniors.[5]

	Sun City (85351)	Sun City West (85375)
Residents 65 and older	76.0%	84.2%
Median age	72.6	74.7
On public health coverage	83.6%	86.6%
Uninsured	2.2%	1.9%

American Community Survey five-year data, 2020 to 2024, tables DP05 and DP03.

For a cardiology practice this means the panel is almost entirely Medicare, and the constraint on a remote care service line is never finding eligible patients. It is having the hands to enroll and manage them. That is the argument, made once here and carried through the rest of this report, for CoachCare staffing the care team and funding the on-site enrollment desk.

[4] CMS Medicare Physician and Other Practitioners, by Provider and by Provider and Service, calendar year 2024 (released 21 May 2026), for the practice's interventional cardiologist. Beneficiary and service counts are the fee-for-service Original Medicare population only; CMS suppresses any line billed to fewer than 11 beneficiaries.

[5] U.S. Census Bureau American Community Survey five-year data, 2020 to 2024, tables DP05 and DP03, for ZIP Code Tabulation Areas 85351 (Sun City) and 85375 (Sun City West).

The payer split

Maricopa County carried 801,802 Medicare beneficiaries in 2025, split between Original Medicare (394,208) and Medicare Advantage (407,595). Medicare Advantage penetration stood at 51.5% in September 2026. There is no CMS file below the county level, and age-restricted communities like these almost always run above the county figure, so the practice's own Advantage share is very likely higher still. 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]

- **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, in either office.[7]
- **Arizona Medicaid covers 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. The practice's dual-eligible share is small, 2.4% of its CY2024 patients, so this is upside rather than a load-bearing part of the forecast; section 9 takes it up.[8]

The two hospitals, and the thirty days after discharge

The practice admits to Banner Del E. Webb Medical Center in Sun City West and Banner Boswell Medical Center in Sun City. Both are CMS-rated hospitals, and their heart-failure figures point the same way transitional care and monitoring do. Over the two-year measure window the two hospitals discharged about 2,590 heart-failure patients between them.[9]

Hospital	CCN	HRRP heart-failure ratio	Excess days after HF discharge, per 100
Banner Del E. Webb Medical Center	030093	0.9646	−19.8, better than the national rate
Banner Boswell Medical Center	030061	1.0647	+4.6

CMS Hospital Readmissions Reduction Program FY2026 file and the Unplanned Hospital Visits file. A readmission ratio above 1.0 means more 30-day readmissions than the national benchmark predicts for the hospital's case mix.

Del Webb runs 19.8 fewer excess days in acute care per 100 heart-failure discharges than the national rate. Boswell carries a heart-failure readmission ratio of 1.0647 and a heart-attack ratio of 1.0917, both above 1.0. Neither figure is a statement about the care inside the hospital. The gap is the thirty days after discharge, not the care, and those thirty days are where a cardiology practice with a post-discharge cadence does its work. A practice that runs that cadence for its own patients is worth more to both hospitals than one that does not.

[6] CMS Medicare Advantage State/County Penetration file, September 2026, Maricopa County; CMS Medicare Monthly Enrollment, calendar year 2025 county row.

[7] CY2026 Medicare physician fee schedule, Arizona statewide locality (carrier 03102, locality 00), non-facility amounts against the national non-facility amount for the remote-care codes. Geographic practice cost indices: work 1.000, practice expense 0.969, malpractice 0.856; conversion factor $33.4009.

[8] AHCCCS Medical Policy Manual, Policy 320-I Telehealth, section D Remote Patient Monitoring; AHCCCS Telehealth Code Set, 2026 Final sheet, effective 1 June 2026; AHCCCS Medical Policy Manual, Policy 310-P Medical Equipment and Supplies.

[9] CMS Hospital Readmissions Reduction Program FY2026 supplemental file, excess readmission ratios for the 1 July 2021 to 30 June 2024 window; CMS Unplanned Hospital Visits file, excess days in acute care per 100 discharges; CMS Hospital General Information. Reported for the two hospitals where the practice admits.

3. The Service Line: TCM, RPM, PCM

3.1 Transitional care: the fastest first dollar

Transitional care management is the entry point, for reasons that have nothing to do with the forecast. It needs no device, no new patient population, no consent conversation and no enrollment funnel. It needs 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 two hospitals where the practice admits.

Code	Service	CY2026 rate, Arizona
99495	Transitional care management, moderate medical decision complexity, face-to-face within 14 days	$215.45
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 85375.

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, and it is the window Boswell's readmission ratio is measured on.

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 to 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 to 30 days	$50.45
99445	**Device supply with daily recording, 2 to 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
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 85375. 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 **$168,688** of gross remote-monitoring reimbursement, 17% of the monitoring arm's gross and about 10.3% of the whole service line's net reimbursement.[10]

Every rate above is the Original Medicare amount. More than half the county's beneficiaries are in Medicare Advantage, and the Sun City ZIP codes likely run higher. 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 share of the panel is where these rates apply exactly as printed.

3.4 Who does the work

The practice's interventional cardiologist orders, reviews escalations that need a cardiologist, and sees 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	The cardiologist 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

[10] As the Value Analysis source. 99445 carries $144,373 and 99470 carries $24,315 of gross remote-monitoring reimbursement across the 24-month horizon, against $979,163 of gross for the monitoring arm, read from the per-code rows on 22 September 2026.

Function	Practice	CoachCare
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 the practice's own TIN	Captures time, attaches monthly documents, creates the claim in the practice's EHR

CoachCare runs this division of labour at scale: more than 500,000 patients across over 400 managed conditions, 10,000 or more clinicians running remote care programs day to day, 1,000 or more programs stood up and running in market, care-plan coding and billing behind more than 5 million claims, and over 100 million vitals recorded.[11]

The pattern is proven in this exact market. In the same corner of the West Valley, a physician-owned cardiology group runs CoachCare remote monitoring on 2,738 patients, with an average systolic blood-pressure reduction of 6.42 mmHg and a 29.1-point drop in the share of readings in Stage 2 hypertension.[12]

4. Working Inside the Practice's EHR

CoachCare's integration is direct and bi-directional: the program lives inside the practice's own electronic health record rather than in a second system the clinicians have to open. CoachCare integrates with the major certified ambulatory EHR platforms. One item is settled in contracting before the interface work is scheduled: the practice's EHR and the interface options it supports. That sets the sequencing of the integration in 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 the chart 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 either clinician 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 EHR integration overview. The named platform, scope and interface owner are confirmed in contracting.

The last row matters most for a two-clinician practice. By month 24 the service line carries about 994 active enrollments, each generating a monthly claim. The integration means each of those claims is created from captured time and attached documentation, so nobody on the practice's small staff keys a claim by hand every month.

[11] CoachCare company figures, coachcare.com, as approved for external use in July 2026.
[12] CoachCare published cardiology case study, April 2026, for a physician-owned cardiology group in Arizona's West Valley.

Integration economics carried in the forecast are $4,000 of one-time setup, $150 per month, and $1.50 per enrolled patient per month, priced as a custom interface and 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 practice asks first. Every reading the program generates 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 two-clinician 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 need 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 the cardiologist is the volume that requires the cardiologist. In a practice whose physician also runs interventional 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, 6, 7, 11 and 13.

5.4 The post-discharge cadence

Touch	Timing	Content
First	Day 1 to 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 to 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 to 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 64 avoided hospitalizations in the forecast come from. It runs inside the same 30-day window transitional care management pays for, and inside the window the two hospitals are measured on. 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. 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 the highest-priority qualifying diagnosis calls for.

6. The Value Analysis

6.1 Inputs and how the panel was sized

The practice's cardiologist billed 1,417 established office-visit rows to 1,400 unique Original Medicare beneficiaries in CY2024. Original Medicare is a little under half of Maricopa County's Medicare, so the full Medicare panel behind that fee-for-service base is about 2,400 patients, roughly 1,000 of them in Original Medicare. The forecast treats 1,920 of the panel, 80%, as condition-eligible for a cardiology service line, the same scope-down used on comparable cardiology groups.[14]

Input	Value
Medicare panel	about 2,400 patients (range 2,000 to 2,900)
In scope	1,920, 80% of the panel
Program eligibility within the in-scope cohort	Remote monitoring 75%; principal care management 85%
Acceptance	Remote monitoring 35%; principal care management 30%
Enrollment ceilings	Remote monitoring 504; principal care management 490
Referring clinicians	2 (one interventional cardiologist and one physician assistant), 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

[14] CMS Medicare Physician and Other Practitioners, by Provider and by Provider and Service, calendar year 2024 (released 21 May 2026), for the practice's interventional cardiologist. Beneficiary and service counts are the fee-for-service Original Medicare population only; CMS suppresses any line billed to fewer than 11 beneficiaries. The full-panel figure carries the fee-for-service base through the county Original-Medicare share; the credible range runs from 2,000 to 2,900 patients, and a chart count from the practice replaces it (section 12).

Input	Value
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 85375
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

Within the in-scope cohort, 75% are eligible for remote monitoring and 85% for principal care management, and the forecast enrolls 35% and 30% of those. That produces a monitoring ceiling of 504 enrollments and a care-management ceiling of 490. Both are reached inside the horizon, which is the defining fact of this account and the subject of section 7.[15]

6.2 The 24-month forecast

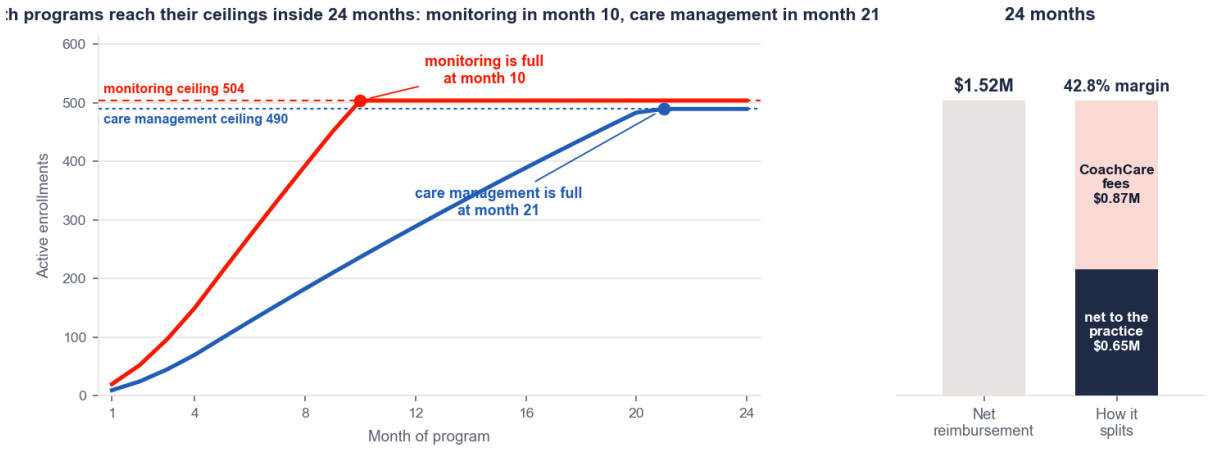

Figure 1. Active enrollments against the forecast ceilings, both reached inside 24 months, and how 24 months of net reimbursement splits between the practice and CoachCare.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$490,279	$1,029,001	$1,519,280
CoachCare program and platform fees	$288,634	$579,693	$868,327
Net to the practice	**$201,645**	**$449,308**	**$650,953**
Practice margin	**41.13%**	**43.66%**	**42.85%**

[15] Ceilings: 1,920 in scope x 75% eligible x 35% acceptance = 504 for remote monitoring; 1,920 x 85% x 30% = 490 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.

By program	Year 1	Year 2	24 months	24-month fees	24-month net to the practice
Remote physiologic monitoring	$338,031	$568,919	$906,950	$508,991	$397,959
Principal care management	$152,248	$460,082	$612,330	$319,588	$292,742
Implementation, EHR integration and telephonic outreach				$39,747	−$39,747
Total	**$490,279**	**$1,029,001**	**$1,519,280**	**$868,327**	**$650,953**

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	504	504	504	At ceiling since month 10
Principal care management	490	289	490	At ceiling since month 21

Both programs reach their ceilings inside the horizon. Monitoring is full at month 10 and flat afterward; care management is full at month 21. When a program is at its ceiling, more enrollment capacity cannot add to it, because the forecast has enrolled every patient it counts as eligible. The constraint on this account is the size of the eligible population, not outreach. Section 7 shows what that means for the one input that still moves the number.

6.3 Month by month

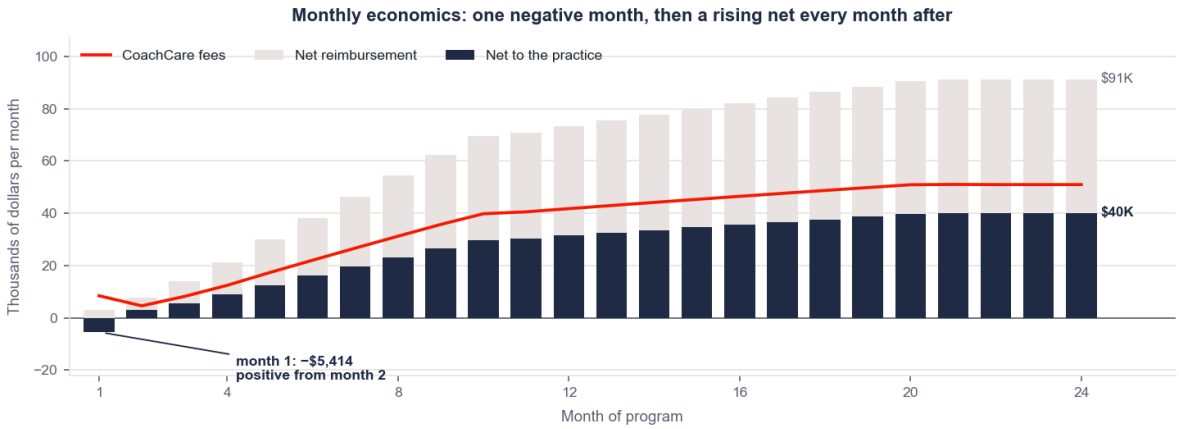

Figure 2. Net reimbursement, CoachCare fees and net to the practice by month. Month 1 is the only negative month.

Month 1 runs **$5,414 negative**. Implementation and the EHR integration setup both post in the first month against a census of 29 enrollments. The practice is net-positive from **month 2** onward and stays there. Enrollments stand at 29 after month 1, 76 after month 2 and 141 after month 3, and net-new enrollment peaks at about 73 a month once every pathway is at full productivity. By month 12 the practice nets $31,421 a month; by month 24, $40,111.

6.4 Patients, readings and avoided admissions

What the service line produces over 24 months	Value
Unique patients under management at month 12	591
Unique patients under management at month 24	651
Active program enrollments at month 12	793
Active program enrollments at month 24	994
Physiologic readings reviewed	100,160
Claims generated	28,388
Hospitalizations avoided	64
Care-team hours delivered	14,008, about 6.7 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 651 unique patients carry 994 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 6.7 full-time-equivalent years of care-management labor over the horizon, supplied by CoachCare, on a practice of one cardiologist and one physician assistant who also run interventional procedure days. Any version of this program that assumes existing staff absorb the work is a proposal that the two of them stop seeing patients.

7. What Moves the Forecast

The 24-month answer turns on a short list of inputs, 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, 1,920 in scope, 2 clinicians**	**$1,519,280**	**$650,953**	**42.8%**	**651**
On-site enrollment specialists	0	$320,187	$126,408	39.5%	231
	2	$1,806,421	$781,038	43.2%	651
In-scope share of the panel	60%	$1,254,896	$537,986	42.9%	488
	100%	$1,702,569	$727,494	42.7%	802
Medicare panel	2,000 (range low)	$1,351,599	$579,546	42.9%	542
	2,900 (range high)	$1,676,440	$716,603	42.7%	781
	3,500, if the Advantage share is 60%	$1,821,214	$776,970	42.7%	908
Referring clinicians	1, physician only	$1,479,559	$633,207	42.8%	651
	3	$1,553,472	$666,273	42.9%	651

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

Read the enrollment-specialist rows first

The clinician count barely moves the number: one physician alone or a third clinician both land within about 3% of the base case, because both programs are already at their ceilings. The panel moves it more, roughly 10% across the credible range. The on-site enrollment specialist is the forecast.

Take the on-site specialist away and the 24-month net reimbursement falls to $320,187, a 79% fall, with net to the practice of $126,408. Add a second specialist and net reimbursement rises +$287,141 and net to the practice +$130,085; the second specialist cannot raise either ceiling, it only reaches them sooner.

On a practice with two clinical calendars and no room to add a third task to either, that is the whole argument for CoachCare staffing the enrollment desk. The eligible population sets the ceiling; the on-site specialist is what reaches 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, this practice's patients.

Section 2 gave the two hospitals' numbers: Banner Boswell carries a heart-failure readmission ratio of 1.0647 and a heart-attack ratio of 1.0917, both above 1.0. 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 an independent practice defending its hospital relationships, 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	64
Avoided inpatient cost at $15,000 per admission	$0.95 million
At a 40% annual admission rate, closer to a heart-failure-heavy cardiology cohort	about 127

Avoided admissions scale with the cohort's baseline admission rate, holding the enrolled census and the forecast's reduction rate constant. The practice's CY2024 heart-failure prevalence is 25%, so the 20% rate is conservative for a targeted cohort.

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 either hospital counts what the practice's post-discharge cadence did for its readmission ratio.

9. Medicare Advantage and AHCCCS

The forecast bills Original Medicare. Two other payer families sit around it, and both work in the practice's favour rather than against it.

- **Medicare Advantage is the majority payer, and it is a floor.** More than half of Maricopa County's beneficiaries are in Medicare Advantage, and the Sun City ZIP codes almost certainly run higher. 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 split of the practice's own panel decides how much of this forecast is fee-schedule-set, which is why it is the first number to confirm on the first call.

- **Arizona Medicaid covers remote patient monitoring.** AHCCCS covers both synchronous and asynchronous remote patient monitoring under its telehealth policy, with no originating-site restriction, and its 2026 telehealth code set lists 99091, 99445, 99453, 99454, 99457, 99458 and 99470. The professional service is billed by the AHCCCS-registered provider; the device is covered as a medical supply when medically necessary. The practice's dual-eligible share is small, 2.4% of its CY2024 patients, so this is upside rather than a load-bearing part of the case.[16]
- **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.[17]

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. Given the panel's small dual share, none of it changes the forecast; it is a second phase on the same devices and the same care team.

[16] AHCCCS Medical Policy Manual, Policy 320-I Telehealth, section D Remote Patient Monitoring; 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.

[17] Arizona Revised Statutes section 20-841.09, telehealth coverage, whose definition of telehealth includes remote patient monitoring technologies.

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 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.

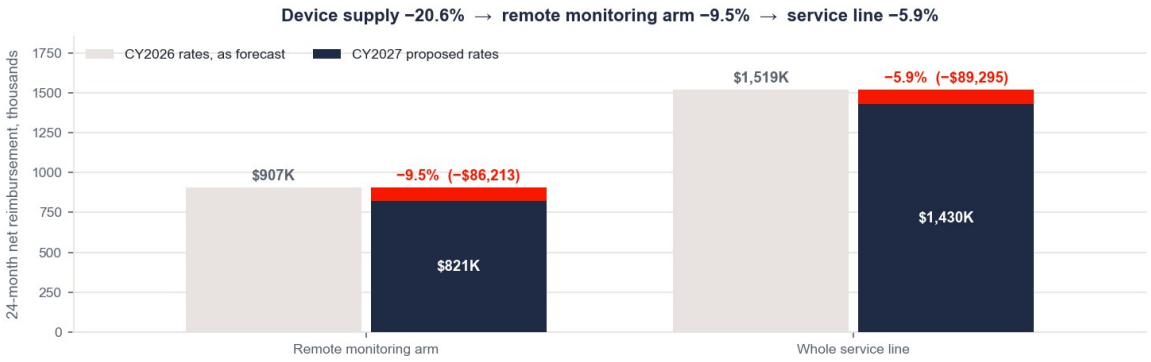

Figure 3. The CY2027 cascade on one dollar scale: the device-supply cut flows through the remote-monitoring arm to the whole service line, each percentage smaller only because its base is larger.

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 −$86,213 over 24 months. The monitoring arm is 60% of the service line, so the whole line falls −5.9%, or −$89,295 of $1,519,280. 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 to 30 days	$50.45	$40.06	−20.6%	$52.11	$41.38
99445	Device supply, 2 to 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.

[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 $1,429,984 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 EHR interface.

Phase	Window	What happens
Charter	Days 1 to 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 EHR and interface owner identified and the integration scheduled; plan mix within the Medicare panel reviewed
First enrollments	Days 31 to 45	On-site enrollment specialist starts; transitional care management goes live on current discharges from the two hospitals; the first monitoring cohort is set up from the heart-failure list; telephonic outreach begins
Ramp	Days 46 to 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 141 by the end of month 3
Beyond 90 days	Months 4 to 21	Monitoring census climbs to its ceiling of 504 by month 10; care management builds alongside it to its ceiling of 490 by month 21; first read of readmissions in the post-discharge cohort
Steady state	Month 22 onward	Both programs at ceiling; the conversation turns to widening the in-scope definition and to the commercial and AHCCCS phase

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

A short list of questions decides how much of this report's forecast survives contact with the practice's own data, and each can be answered on the first call.

1. **The chart count.** A unique-patient count from the practice's EHR, by diagnosis, replaces the roughly 2,400 panel and the 1,920 in-scope figure outright, and section 7 shows what it moves.
2. **The plan mix within the Medicare panel.** The split of the panel 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.
3. **The EHR and interface options.** Which electronic health record the practice runs, and the interface options it supports. This sets the sequencing of the integration in the roadmap and the fee tier.
4. **Who bills today.** In-house or outsourced revenue-cycle management. It sets the claims workflow for the monthly codes.
5. **How the physician assistant bills.** Under her own NPI reassigned to the practice or incident-to. It decides who the ordering clinician is on each enrollment and how the 2 referring clinicians are counted.
6. **Device-clinic volume under the practice today.** How many patients the practice follows on remote device transmissions now. It is the existing remote-review habit the service line extends.
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, and the small dual share keeps it immaterial to the forecast.

> **The case in three sentences**
>
> A remote care service line built on the panel this practice already manages produces $1,519,280 of net reimbursement and $650,953 of retained margin over 24 months, at a 42.8% practice margin, billed under the practice's own TIN.
>
> It does that with no capital and no clinical headcount, net-positive from month 2, because CoachCare delivers the care team and funds the on-site enrollment specialist.
>
> **On a panel this old and this cardiac, the constraint was never the patients. It was the hands to reach them, and this is how the practice gets them.**

The next step is a working session with the practice to walk the chart count, the plan mix and the EHR 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.

Source	Used for	Vintage
CMS Medicare Physician and Other Practitioners, by Provider and by Provider and Service	The practice's CY2024 claims profile, established-visit counts, device-clinic and warfarin-management lines, and the panel base	CY2024, released 21 May 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	CY2025 annual county row
U.S. Census Bureau American Community Survey five-year data, ZCTAs 85351 and 85375	Sun City and Sun City West demographics in section 2	2020 to 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
CMS Hospital Readmissions Reduction Program and Unplanned Hospital Visits files	Banner Del E. Webb and Banner Boswell heart-failure figures in sections 2 and 8	FY2026 program, 2021 to 2024 window
AHCCCS Medical Policy Manual 320-I (Telehealth) and 310-P; 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	Code set 2026 Final, effective 1 June 2026
Arizona Revised Statutes section 20-841.09	Commercial telehealth parity including remote patient monitoring	As amended 2021
CoachCare EHR 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 and published April 2026 cardiology case study	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