CARDIOVASCULAR CONSULTANTS, P.C.

Munster · Hammond · Crown Point — Northwest Indiana

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as the operating spine of the independent cardiology practice

> **Purpose of this report**
>
> This report positions a managed Remote Care Service Line — transitional care management, remote physiologic monitoring, and principal care management, delivered with CoachCare as the operating partner — as the core of Cardiovascular Consultants' 2026 growth and retention strategy. It is built from the practice's own public footprint, current Medicare billing policy, and a locality-priced 24-month Value Analysis. All modeled figures are illustrative, modeled — verify against practice data.

Prepared by CoachCare · July 2026
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Executive Summary

Cardiovascular Consultants, P.C. is an independent, physician-owned cardiology group of **seven board-certified cardiologists and three advanced-practice providers** serving Northwest Indiana from offices in Munster (headquarters), Hammond, and Crown Point/Winfield, with satellite outreach across DeMotte, Dyer, East Chicago, Lake Station, Portage, Whiting, and Winfield. The group runs a full-stack cardiovascular practice: interventional coronary and peripheral work, left-atrial-appendage closure activity and TAVR/mitral evaluation, pacemaker and defibrillator checks, Holter and mobile cardiac telemetry (MCT), nuclear and echo diagnostics, a coumadin management clinic, a lipid clinic, a vein and PAD program, and active clinical research. (Practice website, reviewed July 2026.)

What the practice does not yet operate — anywhere in its public footprint — is a **longitudinal remote care layer**: no remote physiologic monitoring (RPM) program, no principal care management (PCM) program, and no advertised telehealth offering. The patient portal (FollowMyHealth, a Veradigm product) is the only digital-care artifact published. This is the classic independent-cardiology whitespace, and in 2026 it is unusually well-timed: Medicare's CY2026 fee schedule added short-window and shorter-increment RPM codes that fit exactly the post-procedure and device-adjacent populations this group already touches every day.

> **The central argument**
>
> **Margin-positive before any value-based dollar — and model-ready if selection maps change.** A CoachCare-operated Remote Care Service Line is standalone economics first: recurring, subscription-like professional-fee revenue on the practice's own Medicare panel, margin-positive from month two of the modeled ramp, with CoachCare funding the enrollment and monitoring labor. The same infrastructure then compounds through the practice's existing clinical funnels — Holter/MCT, device checks, the coumadin clinic, structural-heart evaluation — and hardens patient retention in a market where roughly half of Medicare beneficiaries are already in Medicare Advantage.

Three facts shape the 2026 opportunity:

- **Ready-made enrollment funnels.** The practice already operates connected-monitoring workflows — Holter/MCT reads, pacemaker/ICD checks, INR management in the coumadin clinic — but has no chronic RPM or PCM layer on top of them. Every one of those workflows is a pre-qualified enrollment funnel: patients already identified, already device-tolerant, already returning for monitoring touchpoints.
- **Structural-heart activity creates longitudinal monitoring demand.** Left-atrial-appendage closure activity and TAVR/mitral evaluation generate pre- and post-procedure monitoring windows and lifelong follow-up cohorts — demand the new CY2026 short-window RPM code (99445) was built to serve.
- **A retention market, not a compliance market.** Indiana's Medicare Advantage penetration is approximately 51% (about 723,000 of 1.41 million Medicare beneficiaries, February 2026 data), and the practice currently has no mandatory model exposure — pure-upside timing, and prepared if selection maps change. The economics case stands on its own: monthly clinical touch is the strongest retention and referral-durability instrument an independent group can deploy.

The Value Analysis for this report models a 4,000-patient Medicare panel (an estimate; range 3,600–4,130 — see Section 6 for the method) at Indiana's statewide Medicare locality. 24-month practice margin: 42.6% of net reimbursement (Year 1 41.5%, Year 2 43.0%). Headline modeled results:

Modeled result	Year 1	Year 2	24-Month
Net reimbursement	$616,896	$1,661,434	$2,278,330
CoachCare fees (all-in)	$360,654	$946,192	$1,306,846
Practice margin	$256,242	$715,242	$971,484
Practice margin (% of net reimbursement)	41.5%	43.0%	42.6%

All figures illustrative, modeled — verify against practice data. Month 1 is modestly negative (−$3,559) as one-time implementation and Veradigm integration setup land ahead of the enrollment ramp; margin turns positive in month two (+$3,683) and stays positive every month thereafter — there is no negative-margin quarter — with cumulative breakeven in month three. Rows above are exact workbook reads rounded independently, so a program row and its column total can differ by a dollar.

2026–2027 Priority Recommendations

1. **Stand up the Remote Care Service Line RPM-first.** Launch with the heart-failure and hypertension cohorts on cellular-connected blood pressure cuffs, weight scales, and pulse oximetry, with CoachCare providing enrollment staffing, 24/7 monitoring coverage, and billing capture.
2. **Convert the three existing funnels.** Systematically screen the Holter/MCT population, the pacemaker/ICD check population, and the coumadin-clinic population for RPM and PCM eligibility at their existing touchpoints — no new patient-acquisition cost.
3. **Wrap structural-heart activity in longitudinal monitoring.** Standard-of-care RPM windows before and after left-atrial-appendage closure and valve procedures, using the CY2026 short-window code where the monitoring period is under 16 days, then graduation into longitudinal RPM/PCM.
4. **Capture TCM at every practice-followed discharge.** A two-business-day contact protocol and timely follow-up visit for patients discharged from the group's affiliated hospitals, feeding directly into program enrollment.
5. **Integrate with the Veradigm environment.** EMR vendor is confirmed as Veradigm; run CoachCare's standard integration so enrollment, documentation, and claims flow inside existing workflow (exact product and version confirmed during contracting).
6. **Validate the panel and govern with a scorecard.** Confirm the 4,000-patient panel estimate against practice chart counts in discovery, and run the Section 7 scorecard — census, capture rate, revenue per patient per month, adherence — from the first month.

1. Practice Footprint & Operating Model

1.1 Footprint

The practice operates three primary offices and a satellite-outreach network across Lake County and adjacent Northwest Indiana communities, with hospital privileges across multiple hospitals in the region (physician biographies cite as many as seven hospital affiliations across Northwest Indiana). Hospital-partner relationships are referenced generically in this report; the practice's headquarters sits adjacent to a major regional hospital campus in Munster.

Office	Location	Role
Munster (HQ)	Munster, IN 46321	Headquarters; full diagnostics; extended Thursday and first-Saturday hours
Hammond	Hammond, IN 46324	Full weekday clinic
Crown Point / Winfield	Crown Point, IN 46307	Part-week clinic
Satellite outreach	DeMotte, Dyer, East Chicago, Lake Station, Portage, Whiting, Winfield	Rotating outreach coverage

Clinical roster: seven cardiologists — including interventional and nuclear subspecialty coverage — supported by three advanced-practice providers (two nurse practitioners and a clinical nurse specialist). The APP bench matters for this strategy: it is the natural escalation tier for a remote-monitoring program, positioned between CoachCare's monitoring staff and the physicians. (Practice website, July 2026; NPPES registry, July 2026.)

1.2 Service Mix — and What Is Missing

Capability	Status today	Remote-care relevance
Interventional (coronary, peripheral, carotid)	Active	Post-procedure monitoring windows; PAD/HTN cohorts
Structural heart (LAA closure activity; TAVR/mitral evaluation)	Active	Pre/post-procedure RPM; lifelong follow-up cohorts
Pacemaker / defibrillator checks	Active (in-office)	Device-clinic modernization; enrollment funnel
Holter / mobile cardiac telemetry	Active	Practice already consumes connected-monitoring data
Coumadin management clinic	Active	High-touch chronic cardiac cohort; PCM candidates on the principal cardiac condition
Lipid clinic, vein/PAD program, echo/nuclear diagnostics	Active	Chronic cardiac panel; PCM and RPM eligibility
Clinical research	Active	Protocol-grade data discipline transfers to RPM
RPM / PCM programs	Not advertised — whitespace	The subject of this report

Capability	Status today	Remote-care relevance
Telehealth	Not advertised	Included in program delivery
Patient portal	FollowMyHealth (Veradigm)	Confirms EMR environment for integration

Source: practice website service pages, reviewed July 2026. "Whitespace" reflects the public footprint; confirm current internal programs in discovery.

1.3 Operating-Model Design Principles

Principle	What it means here
Longitudinal by default	Every diagnostic or procedural encounter ends with a longitudinal-management decision: RPM or PCM enrollment considered at the point of care
One front door	A single enrollment workflow across all three offices and every satellite; CoachCare's enrollment specialist works the funnel lists
Digital as care, not administration	Readings, alerts, and titration touches are clinical work product — documented, billed, and visible to the treating cardiologist
Single scorecard	One monthly view: census, capture, revenue per patient, adherence, escalations (Section 7)
Top-of-license staffing	CoachCare handles enrollment, monitoring, and billing mechanics; APPs handle clinical escalation; physicians handle medicine

2. The Remote Care Service Line — The Spine

The strategy in this report is one build, not three programs. A single managed service line — enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, titration support, billing capture, analytics — delivers three Medicare care-management benefits on the practice's existing panel. Everything else in this report (funnels, structural heart, retention, the playbook) runs on this spine.

2.1 What It Is: The Specialty Billing Stack

Program	What it is	Cadence	Cardiology fit
TCM (99495/99496)	Transitional care management after discharge: contact within 2 business days; face-to-face within 14/7 days	Per qualifying discharge	Every practice-followed admission; the on-ramp into longitudinal programs
RPM (99453/54/57/58 + new 99445/99470)	Cellular-connected BP, weight, SpO2 with monthly review and management time	Monthly, recurring	HF, hypertension, post-procedure windows; the volume engine
PCM (99426/99427)	Care management focused on a single high-risk principal condition (heart failure, coronary disease, resistant hypertension) for 3+ months	Monthly, recurring	The principal cardiac condition the practice owns; the longitudinal wrapper

Why PCM, not CCM. a specialist's care management is focused on one principal condition — resistant hypertension, coronary disease, heart failure — or on cardiovascular disease as a single domain, which is precisely what Principal Care Management is written for. Chronic Care Management assumes management of all of a patient's conditions, and it is increasingly billed by the patient's primary care practice, or absorbed into a prospective payment there. PCM fits the specialist's actual scope and does not collide with the PCP's.

The coordination rules (set these on day of launch)

One longitudinal wrapper per patient per month. Each enrolled patient carries PCM on exactly one principal cardiac condition — the condition this practice manages. Where a patient's broader chronic burden is managed by a primary care practice, that longitudinal wrapper stays with the PCP.

RPM stacks. RPM may be billed alongside PCM for the same patient with discrete time and documentation — this stack is the core economic unit of the service line.

TCM leads, programs follow. Bill TCM at discharge, then transition the patient into RPM plus the PCM wrapper the following month.

One care plan, in the EMR. A single shared care plan inside the Veradigm environment, visible to every treating clinician, is both the compliance substrate and the referral-communication instrument back to primary care.

2.2 Standalone Value: Four Value Layers

1. **Direct professional-fee revenue (the lead layer).** Recurring monthly billings on the existing panel — modeled at $2.28M net reimbursement and $971,484 practice margin over 24 months (Section 6) — with CoachCare funding the enrollment specialist and monitoring labor as part of its service, never as a practice expense.
2. **Avoided cost and referral-relationship defense.** The model projects roughly 113 hospitalizations avoided across 24 months (approximately $1.70M in avoided facility cost at a $15,000 illustrative average). Heart-failure readmissions remain a penalty-bearing measure for the practice's hospital partners — a cardiology group that demonstrably keeps discharged patients out of the readmission window strengthens every hospital relationship it has.
3. **Procedural adjacency.** Structural-heart activity and a policy-tailwind hypertension pipeline (Section 5) both depend on exactly the monitoring infrastructure this service line builds — monitoring capacity becomes procedural-program capacity.
4. **Strategic durability.** In a roughly 51%-MA state market, monthly clinical touch is the practice's strongest retention, differentiation, and network-relevance instrument — and the program's structured outcomes data strengthens every payer conversation.

The CY2026 billing stack (Indiana pricing where modeled)

Code	Service	Frequency	Rate
99495 / 99496	TCM, moderate / high complexity	Per discharge	~$200 / ~$280*
99453	RPM setup & patient education	One-time	~$20*
99454	RPM device supply & data, 16–30 days	Monthly	$48.15
99445 (new 2026)	RPM device supply & data, 2–15 days — short transitional / post-procedure windows	Per window	~ same magnitude as 99454*
99457	RPM management, first 20 minutes	Monthly	$48.89
99470 (new 2026)	RPM management, first 10 minutes	Monthly	~$26*
99458	RPM management, each additional 20 minutes	Monthly	$39.29
99426 / 99427	PCM, first 30 min / each additional 30 min (clinical staff)	Monthly	$64.26 / $51.15

Dollar rates shown are the CY2026 Indiana statewide Medicare locality values used in the Value Analysis (ZIP 46321 resolves to the Indiana statewide locality — Munster is priced at Indiana rates, not Chicago's). Asterisked figures are illustrative national magnitudes for codes outside the modeled economics. All rates: illustrative — verify against the current CY Physician Fee Schedule and the regional MAC before financial planning. TCM and the new 2026 codes are not included in the Section 6 modeled totals; they are upside on top of it.

> **Recurring-revenue mechanics**
>
> The service line behaves like subscription revenue on the practice's own panel: each enrolled patient generates a predictable monthly billing event (RPM device + management time, plus the PCM wrapper), collections concentrate in Medicare and MA plans the practice already bills, and census — not visit volume — drives the P&L. By month 24 the program produces $153,370 of monthly net reimbursement and $66,540 of monthly practice margin, on top of undisturbed visit and procedure revenue.

2.3 Connective Tissue: One Infrastructure, Every Lever

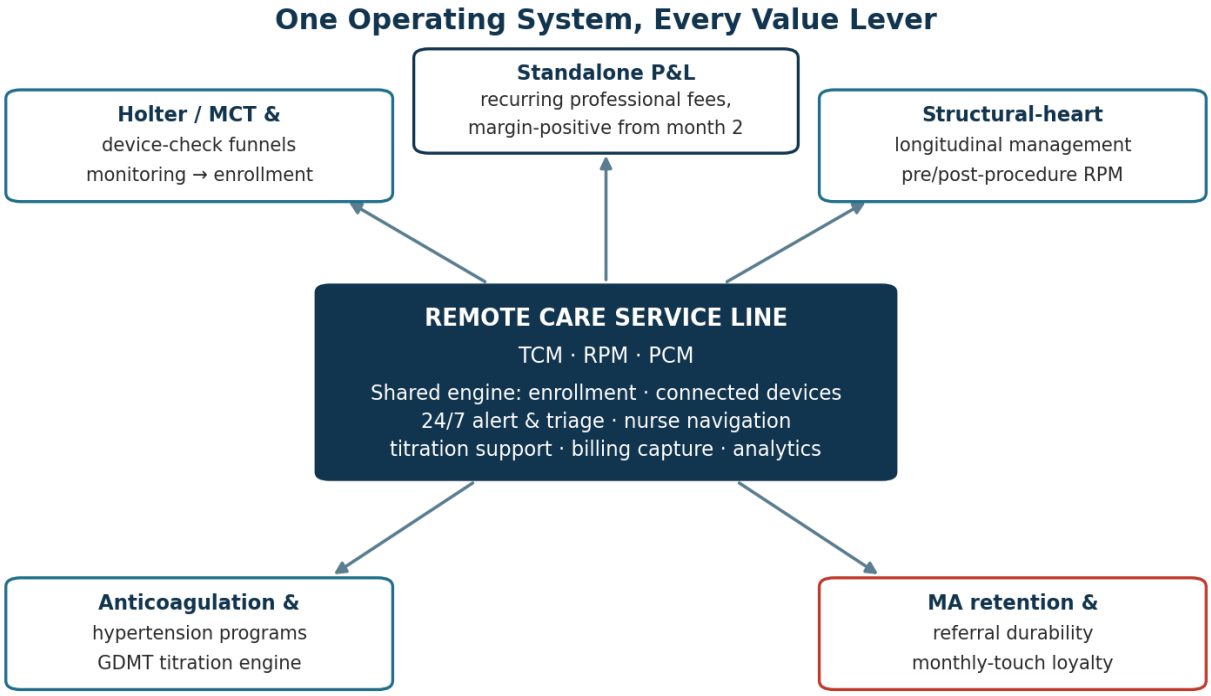

Figure 1. One operating system, every value lever — the Remote Care Service Line as shared infrastructure.

Value lever	What the shared infrastructure contributes
Holter/MCT & device-check funnels (Section 3)	Enrollment screening at existing monitoring touchpoints; device logistics; a remote layer on the in-office device clinic
Anticoagulation & hypertension programs (Section 3)	Structured home BP/weight data for titration decisions; monthly care-management touch for the coumadin cohort; GDMT titration run as a production process
Structural-heart longitudinal management (Section 5)	Pre-procedure optimization data; short-window post-procedure RPM; lifelong valve/LAA follow-up cohorts
MA retention & referral durability (Section 4)	Monthly clinical touch between visits; documented outcomes; readmission-window vigilance that hospital partners can see
Standalone P&L (Section 6)	Recurring professional fees — 24-month practice margin: 42.6% of net reimbursement (Year 1 41.5%, Year 2 43.0%); margin turns positive in month two, with no negative-margin quarter

3. Ready-Made Enrollment Funnels

The most expensive part of any remote-care program is finding, convincing, and connecting the first thousand patients. Cardiovascular Consultants has already done the hard part three times over: it operates three clinical workflows whose entire population is pre-identified, monitoring-tolerant, and already returning to the practice on a schedule. The service line converts these workflows from episodic diagnostics into longitudinal management.

3.1 Holter / MCT: From Episodic Reads to Longitudinal Monitoring

The practice already prescribes, applies, and interprets ambulatory cardiac monitoring — meaning it already runs device logistics, patient education, and data-review workflows. Every Holter or MCT patient is, by definition, a patient whose physician wanted more physiologic data than an office visit provides. The natural next question at every read: does this patient need thirty days of data, or continuous management? AFib, post-ablation follow-up, syncope workups, and rate-control titration cohorts graduate directly into RPM with a BP cuff (and weight, where HF overlaps) — the monitoring instinct is already in the practice's DNA; the service line adds the chronic layer and the billing capture.

3.2 Pacemaker / ICD Checks: Device-Clinic Modernization

The group advertises in-office pacemaker and defibrillator checks but no dedicated remote layer around that population. Device patients are the highest-yield enrollment cohort in cardiology: they are chronic by definition, device-adjacent by temperament, and scheduled — every check is an enrollment conversation that costs nothing to create. Wrapping the device population in RPM (BP/weight) plus the PCM wrapper modernizes the device clinic into a longitudinal-management program, and the monthly care-management touch catches the decompensation the device interrogation alone does not measure.

3.3 The Coumadin Clinic: High-Touch Chronic Care, Already Staffed

An anticoagulation clinic is a longitudinal management program that has not billed itself as one. These patients already accept frequent monitoring, already interact with practice staff between physician visits, and nearly all carry a dominant cardiac condition the practice owns — atrial fibrillation, heart failure, or valve disease. Layering PCM on that principal condition — and RPM where BP/weight monitoring is clinically indicated — converts an existing cost center into a revenue-bearing longitudinal program, while the structured monthly touch improves time-in-therapeutic-range vigilance.

3.4 GDMT Titration as a Production Process

For the heart-failure cohort specifically, the service line turns guideline-directed medical therapy titration from an opportunistic, visit-bound activity into a production process: home BP, heart rate, and weight arrive daily; titration-eligible patients surface on a worklist; protocolized adjustments happen between visits under physician direction, with APP escalation. Practices that run titration this way reach target dosing faster and catch decompensation earlier — and every titration touch is billable management time inside the RPM/PCM structure.

Why this matters economically

The Value Analysis (Section 6) assumes acceptance rates of 35% (RPM) and 30% (PCM) against eligible patients. Those rates are achievable precisely because these three funnels exist: the practice is not cold-calling a panel — it is offering a monitoring upgrade to patients already in monitoring relationships. CoachCare's enrollment specialist (funded by CoachCare, modeled at 80 enrollments per month) works these lists at existing touchpoints.

4. Market Context: Medicare Advantage & Referral Durability

4.1 A 51%-MA Market Rewards Monthly Touch

Indiana's Medicare Advantage penetration stands at approximately **51% — about 723,000 of 1.41 million Medicare beneficiaries** (February 2026 data), and Lake County seniors chose among dozens of MA plans in the most recent landscape (55 plans in the 2025 plan year). County-level penetration was not separately obtained; confirm in discovery. Two consequences follow for an independent cardiology group:

- **Patients move more easily.** MA members re-shop annually, plans steer to network partners, and a patient whose only contact with the practice is a semi-annual visit is a patient another group — or an employed network — can take. A patient transmitting readings to the practice every morning, with a care manager who calls when the numbers drift, is not.
- **Plans reward exactly what this service line produces.** Documented chronic-care engagement, medication adherence support, and readmission-window vigilance are the currencies of MA plan relationships. A practice that can show structured outcomes data enters network and payer conversations with evidence rather than assertions.

4.2 Referral Durability with Hospital Partners

The practice's cardiologists hold privileges across multiple Northwest Indiana hospitals, in a market that also contains employed cardiology networks. Heart-failure readmissions remain penalty-bearing for those hospital partners under Medicare's readmission-reduction policy. An independent group that runs a visible post-discharge program — TCM contact within two business days, RPM through the vulnerable 30-day window, escalation before the emergency department becomes the only option — makes itself structurally valuable to every hospital it rounds at. That is referral defense built on clinical function rather than on relationships alone.

The same program logic protects the practice's referral inflow from primary care: the shared care plan and monthly management documentation give referring physicians continuous visibility into their patients' cardiovascular management — the strongest possible answer to “what happened after I referred?”

5. Structural Heart & Hypertension: Where Monitoring Demand Grows

5.1 Structural-Heart Activity Creates Longitudinal Cohorts

The practice's service list includes left-atrial-appendage closure activity and evaluation for TAVR and mitral repair — the front end of the fastest-growing procedural franchise in cardiology. Every structural-heart patient is a longitudinal-monitoring patient three times over:

- **Before the procedure:** optimization windows where home BP, weight, and symptom data sharpen candidacy decisions and document medical management.
- **Immediately after:** the highest-risk 2–15 days, which the new CY2026 short-window RPM code (99445) was created to make billable — monitoring windows too short for the legacy 16-day requirement.
- **For life:** valve and LAA-closure patients carry permanent follow-up needs (anticoagulation decisions, HF surveillance, rhythm vigilance) that map directly onto RPM plus the PCM wrapper.

A practice that evaluates and co-manages structural-heart patients with monitoring infrastructure in place captures more of the longitudinal value of each procedure it touches — and presents a stronger co-management proposition to the hospital programs performing the implants.

5.2 Hypertension: A Policy-Aligned Growth Pipeline

Medicare's national coverage decision on renal denervation for uncontrolled hypertension (NCD 20.40, effective October 28, 2025, under coverage with evidence development; FDA approvals P220023/P220026) formalizes something useful to this practice regardless of whether it ever refers a single denervation case: **structured home blood-pressure monitoring is now the connective tissue of serious hypertension care**. Candidacy determination, medication-optimization documentation, and the evidence-development follow-up all run on exactly the BP-RPM infrastructure this service line builds. For a group already running PAD, vein, and interventional programs, a monitored resistant-hypertension cohort is both a clinical program and a referral magnet — and every patient in it is an RPM patient by definition.

> **The compounding point**
>
> Sections 3 and 5 describe the same asset from two directions: monitoring infrastructure converts existing diagnostic workflows into recurring revenue (Section 3), and it positions the practice for the procedural and policy growth arriving in cardiology now (Section 5). One build serves both.

6. Value Analysis: Modeled 24-Month Economics

CoachCare's Value Analysis models the service line on the practice's estimated Medicare panel at CY2026 Indiana-locality Medicare rates. **All figures in this section are illustrative, modeled — verify against practice data.** The model was built July 2026.

6.1 Inputs and Method

Input	Value	Basis
Medicare panel	4,000 (estimate)	Claims-derived: $5.37M practice Medicare allowed ÷ ~$1,300 per cardiology beneficiary-year ≈ 4,128; provider-based cross-check: 7 MDs × 800 panel × 0.7 dedup ≈ 3,920. Range 3,600–4,130. Validate against chart counts in discovery.
Programs modeled	RPM + PCM	Specialty stack (see “Why PCM, not CCM” in Section 2.1); TCM and the new 2026 codes excluded from totals (upside)
Eligibility (of panel)	RPM 75% (3,000) · PCM 85% (3,400)	Cardiology eligibility profile
Acceptance (of eligible)	RPM 35% · PCM 30%	Yielding ceilings of 1,050 (RPM, reached month 16) and 1,020 (PCM, not reached in 24 months — ~677 active at month 24)
Medicare locality	Indiana statewide (ZIP 46321)	Munster priced at Indiana rates, not Chicago's; all CPT rates verified populated
Enrollment staffing	1 enrollment specialist, 80 enrollments/mo	CoachCare's expense — embedded value, never subtracted from practice margin
EMR integration	Veradigm (confirmed)	One-time integration setup reflected in month-1 economics

About the panel estimate

The 4,000-patient Medicare panel is an **estimate, not a count**: it triangulates a claims-based method (practice Medicare allowed dollars calibrated to cardiology revenue per beneficiary) against a provider-based method (panel norms per cardiologist, deduplicated), which land within 5% of each other (range 3,600–4,130). The claims data vintage lists nine physicians against seven on the current roster — a mild upward bias risk. Treat panel validation as the first discovery workstream; every downstream figure scales roughly linearly with it.

6.2 Headline Results

Modeled result	Year 1	Year 2	24-Month
Net reimbursement	$616,896	$1,661,434	$2,278,330
CoachCare fees (all-in)	$360,654	$946,192	$1,306,846
Practice margin	$256,242	$715,242	$971,484

Modeled result	Year 1	Year 2	24-Month
Practice margin (% of net reimbursement)	41.5%	43.0%	42.6%

Program (24-month)	Net reimbursement	Practice margin
RPM	$1,557,755	$684,270
PCM	$720,575	$345,792
Implementation & ancillary	—	−$58,578
Total, 24 months	$2,278,330	$971,484

6.3 The Ramp: Census and Ceilings

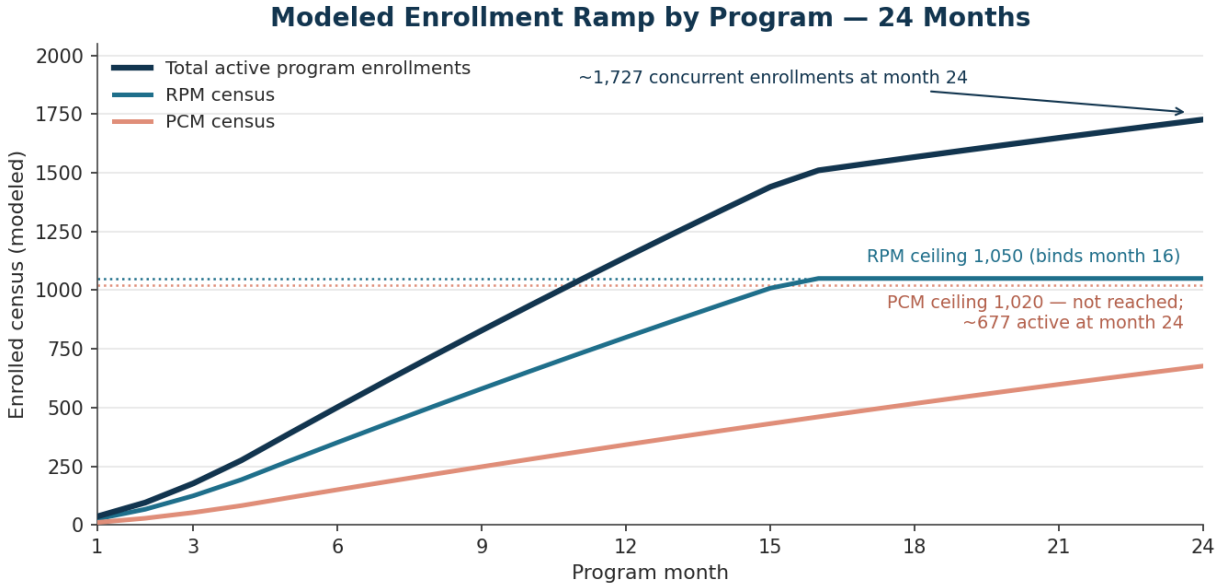

Figure 2. Modeled enrollment ramp by program. RPM reaches its 1,050-patient ceiling at month 16; PCM (ceiling 1,020) is still ramping at month 24 (~677). Illustrative, modeled — verify against practice data.

Program ceilings are structural — panel × eligibility × acceptance: RPM 1,050 and PCM 1,020. RPM saturates inside the 24-month window and PCM does not, which means the modeled steady state is conservative in one specific way: remaining PCM headroom (~343 patients) and any panel growth extend the ramp beyond what is shown. Total active program enrollments reach ~1,141 by month 12 and ~1,727 by month 24 — enrolled services, not unique patients, since a patient carrying both RPM and PCM is counted in each. Deduplicated, the model carries 1,253 unique patients in active remote care at month 24.

6.4 Monthly Economics

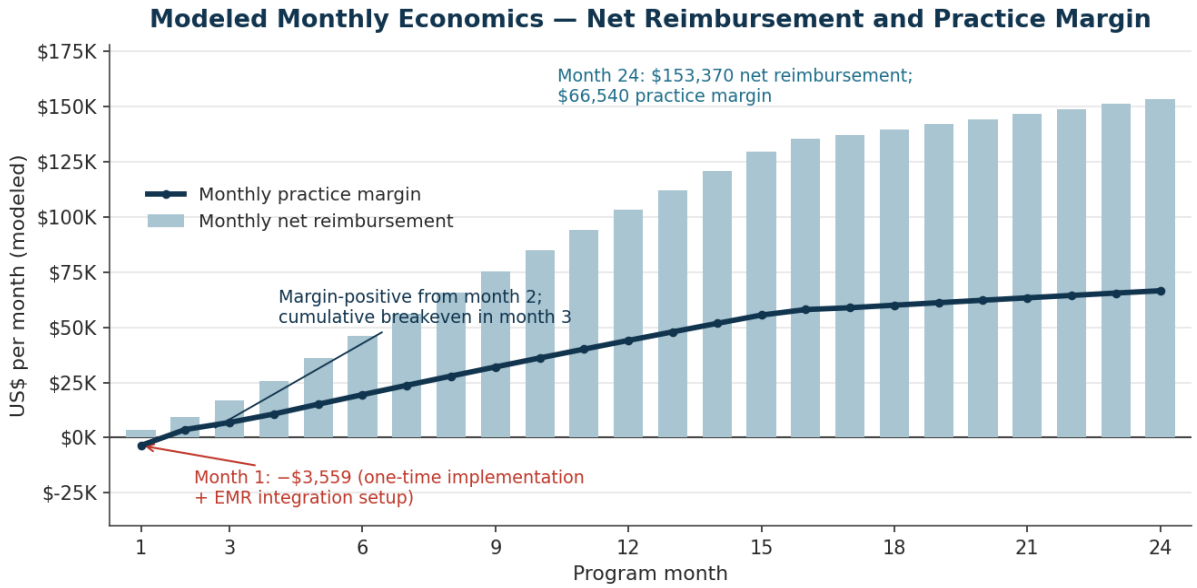

Figure 3. Modeled monthly net reimbursement (bars) and practice margin (line). Month 1 absorbs one-time implementation and EMR integration setup; margin turns positive in month two and there is no negative-margin quarter.

Month-1 economics, plainly

Month 1 is modeled at −$3,559: one-time implementation and Veradigm integration setup land ahead of the enrollment ramp. Month 2 turns positive (+$3,683), cumulative breakeven arrives in month 3, and monthly margin compounds every month thereafter — reaching $66,540/month at month 24. There is no negative-margin quarter. The honest framing is “margin turns positive in month two,” not faster.

6.5 Clinical and Operational Value (Modeled, 24 Months)

Measure	24-month modeled value
Billable claims / units generated	44,636
Physiologic readings captured	178,496
Hospitalizations avoided	~113 (≈ $1.70M avoided facility cost at $15,000/admission, illustrative)
Care-team hours saved	20,894 (≈ 10.0 FTE-years of clinical capacity)

Care-team hours saved reflect monitoring, outreach, and documentation work performed by CoachCare's clinical staff that would otherwise consume practice staff time. CoachCare's staffing is CoachCare's expense — it is embedded value in the fee, not a cost line for the practice.

7. Operating System: Scorecard & Governance

A service line is only as good as its monthly review. One scorecard, reviewed by a physician champion and the practice manager with CoachCare's account team, keeps the program honest:

Domain	Metric	What good looks like
Growth	Enrolled census by program (RPM / PCM)	Tracks the Section 6 ramp; gaps trigger funnel review
Growth	Time-to-first-billable-enrollment	Days from launch to first billed month; short and falling
Capture	Billing capture rate	Share of eligible enrolled-patient-months actually billed; target >95%
Capture	Revenue per enrolled patient per month	Stacked-code economics holding at modeled levels
Clinical	16-day adherence rate (RPM)	Share of RPM patients meeting the device-supply threshold
Clinical	Alert response time; escalations to APP/physician	Alerts triaged same-day; escalation volume within staffing plan
Clinical	30-day post-discharge contact rate (TCM)	Two-business-day contact on every practice-followed discharge
Outcomes	Readmission-window events among enrolled patients	Trending below the unenrolled baseline
Experience	Patient retention in program; practice retention overall	Program attrition low; panel attrition falling

Governance cadence: weekly operational huddle (CoachCare + practice manager) for the first 90 days, then monthly scorecard review with the physician champion; quarterly economics review against the Value Analysis, with the panel-size validation from discovery folded into a model refresh at month 6.

8. Implementation Playbook

8.1 Goals and Scope

- Stand up a margin-positive Remote Care Service Line on the existing Medicare panel across all three primary offices, without adding practice headcount.
- Convert the Holter/MCT, device-check, and coumadin-clinic funnels into longitudinal program census.
- Reach the modeled ramp: ~1,141 enrolled services by month 12; RPM ceiling (1,050) by month 16.

8.2 Target Populations

Cohort	Source funnel	Primary program stack
Heart failure	HF panel; hospital discharges; echo findings	RPM (BP/weight) + PCM; TCM at discharge
Hypertension incl. resistant HTN	Office BP readings; lipid/PAD clinics	RPM (BP) + PCM where resistant HTN is the principal condition
AFib / anticoagulated	Coumadin clinic; Holter/MCT reads	PCM + RPM where indicated
Device patients (PPM/ICD)	Device-check schedule	RPM + PCM wrapper
Post-procedure (structural, PCI, peripheral)	Procedure schedule	Short-window RPM (99445) → longitudinal RPM/PCM
Coronary artery disease	Lipid clinic; general panel	PCM + RPM

8.3 Staffing Model

Role	Who provides it	Function
Enrollment specialist (80 enrollments/mo)	CoachCare (CoachCare's expense)	Works funnel lists at existing touchpoints; consent, device shipment, onboarding
24/7 monitoring & telephonic clinical staff	CoachCare	Reading review, alert triage, monthly management time, documentation
Billing capture & claims support	CoachCare	Code assignment, time aggregation, claim-ready output into practice billing
Clinical escalation tier	Practice APPs (3)	Protocolized titration and symptom escalation between visits
Physician champion	Practice (1 cardiologist)	Protocol sign-off, scorecard review, clinical governance

8.4 Technology, Data, and Billing Architecture

The practice's EMR vendor is confirmed as **Veradigm** (the FollowMyHealth patient portal corroborates the environment); the exact product and version are confirmed during contracting. CoachCare runs its standard Veradigm integration — enrollment status, care plans, encounter documentation, and claim-ready billing output flow inside the practice's existing workflow, with the

one-time integration setup already reflected in the month-1 economics of Section 6. Devices are cellular-connected (no patient Wi-Fi dependency): blood pressure cuffs, weight scales, and pulse oximeters shipped pre-paired to the patient's home.

8.5 Clinical Workflow (Steady State)

1. Identification: eligible patients surface from funnel lists and point-of-care flags in the EMR.
2. Enrollment: CoachCare's specialist obtains consent at (or between) existing touchpoints; devices ship same week.
3. Monitoring: readings arrive daily; CoachCare clinical staff triage alerts against practice-approved thresholds.
4. Management: monthly care-management time delivered telephonically; titration-eligible patients surface to the APP worklist.
5. Escalation: protocol-defined events route to APPs same-day, physicians as needed — before the emergency department becomes the default.
6. Billing: time and data thresholds aggregate automatically into claim-ready output each month.

8.6 Twelve-Month Roadmap

Phase	Months	Milestones
Launch	1–2	Contracting; Veradigm integration; protocol & threshold sign-off; enrollment begins with HF/HTN cohorts (margin-positive from month two in the modeled ramp)
Funnel conversion	3–6	Holter/MCT, device-check, and coumadin lists worked systematically; TCM discharge protocol live; ~502 enrolled services by month 6
Scale	7–12	Satellite-site enrollment; structural-heart monitoring windows standard; ~1,141 enrolled services by month 12; month-6 model refresh with validated panel
Steady state	13+	RPM ceiling (1,050) by month 16; PCM still ramping at month 24 (~677 of a 1,020 ceiling); quarterly economics review against the Value Analysis

About CoachCare

CoachCare operates remote care programs for more than 400 managed conditions across 500,000+ patients, with 10,000+ providers on platform, 1,000+ successful implementations, over 5 million claims generated through care-plan coding and billing support, and more than 100 million vitals recorded. The enrollment, monitoring, and billing infrastructure described in this report is in production at scale today.

References & Data Sources

- Cardiovascular Consultants, P.C. — practice website: services, provider, locations, satellite-office, and patient-portal pages (cardioconsultantspc.com), reviewed July 2026.
- NPPES National Provider Registry (npiregistry.cms.hhs.gov) — organizational and provider records, queried July 2026.
- CMS CY2026 Medicare Physician Fee Schedule; Indiana statewide locality pricing via the regional MAC fee schedule (ZIP 46321), as loaded in the CoachCare Value Analysis, July 2026.
- Medicare Advantage enrollment, Indiana: approximately 723,196 of 1,412,712 Medicare beneficiaries (~51%), February 2026 data (healthinsurance.org state Medicare profile, retrieved July 2026); Lake County 2025 MA plan landscape (55 plans; helpadvisor.com).
- CMS National Coverage Determination 20.40, Renal Denervation for Uncontrolled Hypertension (effective October 28, 2025, coverage with evidence development); FDA PMAs P220023 and P220026.
- CoachCare Value Analysis workbook for Cardiovascular Consultants, P.C. (July 2026): panel estimate, program ramp, locality-priced economics, and clinical-operations projections.
- CoachCare platform statistics: coachcare.com, July 2026.

Global caveat

This report was prepared from public sources and modeled assumptions in July 2026. All economic figures are illustrative, modeled — verify against practice data. Billing rates are CY2026 values subject to locality adjustment and annual rulemaking; verify against the current Physician Fee Schedule and regional MAC before financial planning. The Medicare panel size is an estimate to be validated in discovery. Nothing in this report constitutes billing, coding, legal, or compliance advice; program design should be reviewed with the practice's billing counsel.

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