COACHCARE | SERVICE LINE STRATEGY

El Paso Cardiology Associates, P.A.

An independent, physician-owned cardiology group across three El Paso sites — Clinic West and Clinic East, anchored by its own cardiac catheterization lab

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as a margin-positive, recurring professional-fee service line billed under the practice's own TIN — and as the operating layer beneath readmission defense, referral durability and procedural throughput

Purpose of this document

Prepared by CoachCare as a discussion document for the physician leadership of El Paso Cardiology Associates, P.A. It assembles the practice's public footprint, its CMS service record, its county's payer structure, the 2026 payment environment, and a financial forecast into a single argument: this independent cardiology group runs a cath lab and a busy procedural practice with no remote-care program of any kind — and the layer of care that sits between visits, the one CMS pays for separately, is neither staffed nor billed today.

The market case is unusual and specific. El Paso County is a very-high-Medicare-Advantage border market, so most of the panel is Advantage rather than traditional fee-for-service — which shapes both the sizing and the first discovery question.

Prepared by CoachCare. Contact the CoachCare account team for the underlying Value Analysis.

Table of Contents

Executive Summary

El Paso Cardiology Associates, P.A. is an independent, physician-owned professional association running a cardiovascular practice across three El Paso sites: Clinic West at 7450 Remcon Circle, recently expanded and tagged as new on the practice's own site; Clinic East at 1418 George Dieter Drive North; and the cardiac catheterization lab at 4301 North Mesa. CMS records confirm the group holds its own organizational enrollment, and about **twelve cardiologists bill under the practice's own registration** — a registry-grounded count, higher than the ten physicians the practice's own site lists.[1] No health system, foundation, management-services organization or private-equity sponsor appears in any public record, and a two-year news sweep surfaced no transaction. The reference sub-specialties are interventional cardiology, echocardiographic and nuclear imaging, peripheral vascular disease with an amputation-prevention focus, and adult and pediatric cardiology.

Two facts define this account, and both come from public records rather than from anything the practice has said.

1. **The group runs a cath lab and a procedural practice, and no remote-care program at all.** No remote physiologic monitoring, no chronic-care management, no device or monitoring vendor, no patient app and no care-coordinator or chronic-care nurse posting appears anywhere in the public record.[2] This is an absence of evidence rather than a proof of absence — the first thing to confirm directly — but nothing in this research suggests a program exists. For a practice with this procedural volume, the between-visit layer is clean whitespace.
2. **The market is a very-high-Advantage border county, and that shapes everything downstream.** El Paso County Medicare Advantage penetration is **72.0% as of CY2024**, so only about **28% of the panel is traditional fee-for-service**.[3] Medicare Advantage plans must reimburse at least 100% of the Medicare rate, but that is a floor rather than a settled rate — each Advantage contract sets its own terms for the care-management code families. The traditional-Medicare book is the addressable base priced in this report; the Advantage book is a second, contract-by-contract conversation, and it is the number-one discovery item on the account.

The central argument

1. Standalone value — and on this account it leads. RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based dollar and dependent on no reconciliation, no shared-savings determination and no hospital agreement — modeled at **$3,606,287** of net reimbursement and **$1,535,287** net to the practice over 24 months, a **42.6% practice margin** (net to the practice ÷ net reimbursement).

2. Connective tissue. One shared engine — enrollment, connected devices, 24/7 alerting and triage, nurse navigation, billing capture and analytics — produces the standalone P&L, the readmission-driven avoided cost the group's hospital partners can see, the referral durability that keeps a monitored patient attached to this practice, and the monitored post-procedure pathway that supports the cath lab. Build once, use everywhere.

---

[1] CMS National Plan and Provider Enumeration System (NPPES): El Paso Cardiology Associates, P.A., organization NPI 1235294232, taxonomy 207RC0000X (Cardiovascular Disease); authorized official carries a physician title consistent with independent physician ownership. The organization is registered at three addresses - 7450 Remcon Circle, 1418 George Dieter Drive North, and 4301 North Mesa. The billing roster of about twelve cardiologists was resolved from CMS registry organizational membership; the practice's own site lists ten physicians and no advanced-practice providers. The 4301 North Mesa building also houses two other cardiology entities, so an address-based count overstates the practice - the registry-membership method avoids that conflation.

[2] A public-source sweep across the practice's own website, reachable job boards and press, September 2026: no remote physiologic monitoring or chronic-care-management program page, no named monitoring or device vendor, no patient-app reference, and no care-coordinator or chronic-care nurse posting was found. CMS suppresses low-volume billing lines, a program launched recently would not yet appear in published data, and Advantage activity is excluded from Medicare fee-for-service files by construction. This is absence of public evidence, not proof of absence.

[3] CoachCare Value Analysis panel sizing: CMS established-patient evaluation-and-management beneficiary counts (99213/99214/99215) across the twelve billing NPIs, deduplicated to a 2,713 traditional fee-for-service established panel, then grossed up for the county's 72.0% Medicare Advantage share to an estimated 9,690-patient total in-scope base. A discovery-stage estimate to be validated against the practice's own chart counts.

The revenue base is real, and CMS confirms the practice is the right size to build on. A widely used commercial firmographic file reports Medicare allowed charges of about **$4.93 million** for this group. The CY2024 CMS Physician and Other Practitioners file, summed across the twelve billing NPIs, comes to **$5,130,307** — within about 4% of the commercial figure, which is the confirmation that the twelve-NPI roster is the correct entity rather than a conflation with the two other cardiology practices that share the North Mesa building.[4] The roster was resolved from CMS registry membership, not from a shared address, precisely to avoid that trap.

The companion CoachCare Value Analysis sizes the opportunity on an **estimated 9,690-patient in-scope base across the twelve clinicians** — *a discovery-stage estimate to validate against the practice's own chart counts* — built from an established-patient evaluation-and-management anchor of 2,713 traditional fee-for-service beneficiaries, grossed up for the county's Advantage share. It projects net reimbursement of **$884,680** in Year 1 and **$2,721,607** in Year 2 (**$3,606,287** over 24 months); **$1,535,287** net to the practice after CoachCare fees, a 42.6% margin; roughly **2,530 unique patients and 3,147 active program enrollments at month 24**; and about **187 avoided hospitalizations** over the two years. Month 1 is modeled at −$4,455 because one-time implementation lands there, and **month 2 is the first net-positive month** — a small, honest start rather than a day-one claim.

The timing is clean, and worth stating precisely because it is a positive rather than a deadline. The CY2026 Physician Fee Schedule expanded remote monitoring in ways that suit a procedural cardiology group: **99445** pays the monthly device-supply amount for 2–15 days of data where 16 or more were previously required, which makes short post-procedure windows billable for the first time, and **99470** pays for the first 10 minutes of monthly management time where the floor had been 20. And on the model side there is **no mandatory model exposure — pure-upside timing, and prepared if selection maps change**. The wedge is simple: **margin-positive well before any value-based dollar, and model-ready if the selection maps change.**

2026–2027 Priority Recommendations

1. **Charter the Remote Care Service Line as a named program with its own P&L.** TCM at discharge, then RPM, then PCM, across heart failure, uncontrolled and resistant hypertension, and post-catheterization and post-peripheral-procedure windows. Name a physician lead, pair them with the practice's administrative lead on operations, and target the first billable enrollment within 90 days.
2. **Start with the heart-failure cohort, because it drives the readmission wedge.** Heart failure is where weight and blood-pressure trend between visits changes what happens next, and it is the cohort behind the avoided-admission case in Section 5. It can be seeded from the practice's own problem lists in weeks rather than quarters.
3. **Validate the eligible panel against the practice's own chart counts.** The 9,690-patient in-scope base is a discovery-stage estimate built from CMS established-patient counts and grossed for the county's Advantage share. Confirm it against the practice's actual panel before budgeting on any figure downstream (Section 4.1).
4. **Confirm the payer mix and the Advantage contract terms before budgeting.** At 72.0% Medicare Advantage, most of the panel sits outside traditional Medicare. Advantage plans reimburse at a floor of 100% of the Medicare rate, but each contract sets its own terms for the care-management code families — so whether the county's Advantage plans pay RPM and PCM, and at what rate, is the single question that moves every number in this report (Section 3.2).
5. **Confirm the electronic health record before any integration scoping.** The record is recorded as eClinicalWorks in a commercial firmographic file; public sources do not independently confirm it.

[4] CMS Medicare Monthly Enrollment, CY2024, El Paso County, Texas: Medicare Advantage penetration 72.0%, with roughly 28% of beneficiaries in traditional fee-for-service. Medicare Advantage plans are required to reimburse at a floor of 100% of the Medicare rate; individual Advantage contracts set their own terms for the care-management code families.

Confirm the platform, version and edition directly before any integration timeline or contractual commitment (Section 7).

6. **Fund enrollment throughput as the growth lever.** The program is pace-limited, not eligibility-limited — neither the RPM nor the PCM ceiling binds inside 24 months. A second on-site enrollment specialist, funded by CoachCare, adds roughly 41% to net reimbursement — about $1.49 million over the two years — at no cost to the practice's margin (Section 8.2).

1. Footprint & Operating Model

1.1 The practice: three sites, a cath lab, no remote-care program

The legal entity is **El Paso Cardiology Associates, P.A.** — an independent, physician-owned professional association. CMS lists the organization's authorized official under a physician title, consistent with independent physician ownership rather than health-system employment, and the group holds its own organizational Medicare enrollment.[5] No hospital, health-system, management-services or private-equity parent appears in any public record, and a two-year news sweep found no transaction. Independence is the group's current position, and it is a reasonable thing to want to keep.

Site	Address	What it is
Clinic West	7450 Remcon Circle, El Paso, TX 79912	Marked new on the practice's own site — a recent expansion and the group's clearest growth signal. Also the practice's primary registered practice address
Clinic East	1418 George Dieter Drive North, El Paso, TX 79936	Second ambulatory office, on the east side of the city
Cardiac catheterization lab	4301 North Mesa, El Paso, TX 79902	The interventional site, and the organization's registered address. The building houses more than one cardiology entity, so the roster below is resolved from CMS registry membership rather than from the shared address

Roster, counted from CMS rather than from the website. About **twelve cardiologists bill under the practice's own organizational registration**, the count used as the referral bench in the financial model. The practice's own site lists ten physicians and no advanced-practice providers; the registry count is slightly higher and is the more defensible planning number. *Stated as a caveat rather than glossed over*: a commercial file reports a larger total provider count that public sources do not corroborate, and whether the practice employs any nurse practitioners or physician assistants is a discovery question. Any advanced-practice bench is upside to the referral engine and is not modeled.

Sub-specialty mix, from the practice's own published service pages

Service line	What is published	Why it matters to this program
Interventional and coronary	Cardiac catheterization and coronary intervention delivered in the practice's own cath lab	A large post-procedure population, each case opening a short recovery window that CY2026 coding now makes billable
Peripheral vascular and amputation prevention	Peripheral vascular disease management with a stated amputation-prevention focus	Additional post-procedure windows, and a population where blood-pressure and vascular surveillance between visits carries real clinical weight
Non-invasive imaging	Echocardiography and nuclear cardiology	Confirms a technical-component-heavy revenue base and an episodic, procedure-driven practice shape (Section 4.2)
Adult and pediatric cardiology	General adult cardiology, with a pediatric cardiology capability noted	A broad longitudinal cardiac panel — the population monthly management and remote monitoring were written for

[5] CMS Innovation Center specialty-model participant dataset, current preliminary vintage: the El Paso county market is not among the selected geographies, and the group's checked clinician registrations return no match on the participant dataset. Verified against a known selected market to confirm the query, so the empty result is meaningful rather than a syntax artifact. Preliminary vintage; re-run against each subsequent published list.

Service line	What is published	Why it matters to this program
Electrophysiology and structural heart	**Not advertised.** No dedicated electrophysiology physician, structural-heart program, device clinic or standalone heart-failure clinic appears on the practice's own service pages	The service line is built on what the practice actually does — cath-lab, peripheral and longitudinal cardiac work — and invents no procedural lever the practice does not offer

1.2 The operating model: independent ownership, a procedural revenue base

Two things about the operating model matter commercially. First, **adoption friction inside this practice is low** — the group controls its own profit and loss, its own record and its own billing, so a decision to build a service line does not have to pass through a health system's capital committee. Second, **the revenue base is procedural and episodic rather than cognitive**. A practice anchored on a cath lab, peripheral intervention and imaging sees a large population intensively for short episodes and then loses sight of them between visits. That is exactly the shape a monthly management service fills — recurring revenue on a population the practice already treats, with none of it dependent on a patient being in the building.

Ownership, and why it is worth protecting deliberately. No health-system, foundation, management-services or private-equity parent appears in the CMS enrollment record, and the group bills under its own organizational registration rather than a parent entity's. An infrastructure layer the practice can rent rather than build — one that leaves the practice's registration, its patient relationships, its clinical protocols and its data with the practice — is one of the few ways to add a capability of this size without giving anything up to acquire it.

1.3 Design principles for the 2026 service line

Principle	What it means at this practice
Longitudinal by default	Every heart-failure, uncontrolled-hypertension and post-procedure patient leaves the encounter enrolled in monitoring or monthly management — not merely scheduled for a return visit a quarter later
Build on what the practice actually does	The service line attaches to cath-lab, peripheral-vascular and longitudinal cardiac work — the practice's real capabilities. No electrophysiology, structural-heart or renal-denervation lever is assumed, because none is advertised
Price the whole panel; treat Advantage separately	The model prices the in-scope panel at the local rate. In a 72%-Advantage county the traditional-Medicare book is the addressable base, and Advantage reimbursement — a floor of 100% of the Medicare rate, on each plan's own terms — is a separate, additive conversation (Section 3.2)
One front door	A single enrollment, consent and device-logistics workflow; referral to the service line is one order inside the practice's existing chart, with enrollment status visible in real time (Section 7)
The partner carries the load	The practice supplies clinical direction and supervision; the partner supplies enrollment, devices, monitoring, documentation and claims — so the program adds a care-management capability without adding headcount
Single scorecard	Clinical, operational and financial metrics for the service line reviewed monthly by the physician lead and the administrative lead, with capture rate treated as the metric that quietly decides whether the modeled P&L is realized (Section 8.4)

2. The Remote Care Service Line — The Operating Spine

This section defines the service line precisely, prices its standalone economics against the practice's own base, and shows how one infrastructure serves every value lever the group faces in 2026–2027.

2.1 What it is: the cardiology clinical & billing stack

The Remote Care Service Line is not a device program and not an app. It is a managed clinical service built on Medicare's transitional-care, remote-monitoring and care-management benefits, configured for a cardiology group:

Program	Core codes	What it does	Where it lands at this practice
TCM — Transitional Care Management *(identified, not modeled)*	99495 / 99496	The 30-day post-discharge transition: interactive contact within two business days, face-to-face visit within 14 or 7 days depending on complexity	A live opportunity at every cardiac discharge from the hospital partners, deliberately excluded from every financial figure in this report so the economics rest only on RPM and PCM
RPM — Remote Physiologic Monitoring	99453; 99454 / 99445; 99457 / 99470; 99458	Cellular blood-pressure cuffs, weight scales and pulse oximeters; daily physiologic data; 24/7 review and alert triage; monthly clinical management time	The between-visit layer for heart failure (weight and blood pressure), for uncontrolled and resistant hypertension, and — via the short-window code 99445 — for the 2–15 day post-catheterization and post-peripheral-procedure windows
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Heart failure as the qualifying condition. In a cardiology panel the single dominant condition genuinely is the cardiac one — the clinical situation PCM was written for, and the monthly chassis for guideline-directed therapy titration

Chronic Care Management is not in the modeled stack, and that is a deliberate design choice. It is the multi-condition instrument of primary care, and this cardiology group has no primary-care panel to bill it against; the model therefore carries it at zero. **The stack modeled in this report is RPM plus PCM, and nothing else** — TCM is identified and described but excluded from every financial figure, so the numbers understate rather than overstate the opportunity.

Two coordination rules to write down before the first enrollment

RPM and PCM stack. They may be billed for the same patient in the same month with discrete time and discrete documentation — that pairing is the core of this program. What does not stack: only one practitioner may bill RPM for a given patient in any 30-day period, so the attribution question has to be settled before enrollment rather than after a denial.

The practice owns the cardiac condition; the referring primary-care physician owns the longitudinal wrapper. The practice bills RPM plus PCM on the cardiac condition and TCM at discharge; the referring primary-care physician owns any primary-care management of the same patient. **One shared care plan**, with explicit task ownership, so no patient is touched twice for the same purpose — which prevents duplicate-billing denials and protects the referral relationship.

2.2 Standalone value: a margin-positive service line

On this account the standalone P&L is not the supporting argument — it is *the* argument. There is no mandatory-model deadline to lean on and no shared-savings reconciliation to wait for. The service line has to pay for itself on professional fees billed under the practice's own registration, and it does. Four layers of value follow, in order of how load-bearing they are here:

1. **Direct professional-fee revenue — the lead layer.** Recurring monthly billing on a population the practice already treats, delivered at top-of-license staffing under general-supervision rules. Modeled at $3,606,287 of net reimbursement over 24 months, $1,535,287 of it net to the practice at a 42.6% margin. It depends on no reconciliation, no attribution list and no third party's agreement.
2. **Readmission-driven avoided cost, and referral-relationship defense.** Modeled at approximately 187 avoided hospitalizations over 24 months — value that accrues to the payer and to the admitting hospital partners rather than to the practice's own P&L, but visible to both, and directly relevant while hospital readmission penalties still bite those partners. The same monthly contact is what keeps a monitored patient attached to this practice (Section 5).
3. **Procedural and post-discharge throughput.** A monitored post-procedure pathway supports the cath lab and the peripheral-vascular and amputation-prevention work — the short-window code 99445 makes the 2–15 day recovery period billable for the first time (Section 6). Kept deliberately to what the practice actually does; no structural-heart or electrophysiology volume is assumed.
4. **No mandatory model exposure — pure-upside timing.** Nothing here depends on a compliance clock the practice did not choose, and the practice is prepared if the selection maps change. The value is incremental Part B revenue with no value-based offset against it.

The CY2026 billing stack

Service / code	Type	~CY2026 magnitude	Notes
TCM — 99495 / 99496 ***(not modeled)***	Per discharge	~$200 / ~$280	Moderate / high complexity. Interactive contact within two business days; face-to-face within 14 or 7 days — upside beyond every financial figure in this report
RPM — 99453	One-time setup	~$20	Device setup and patient education; requires qualifying data days
RPM — 99454 / 99445	Monthly	~$52	99454 = 16–30 days of data; 99445 = new 2026 short-window code (2–15 days) at the same magnitude — post-procedure windows now billable
RPM — 99457 / 99470	Monthly	~$52 / ~$26	First 20 minutes of management time / new 2026 first-10-minute code
RPM — 99458	Monthly	~$41	Each additional 20 minutes
PCM — 99424 / 99425	Monthly	~$79 / ~$57	Physician or qualified health professional: first 30 minutes / each additional 30
PCM — 99426 / 99427	Monthly	~$60 + ~$50 addl	Clinical staff under supervision: first 30 minutes / each additional 30 — the workhorse codes for a full-service care team

What the local rate is, and how Advantage sits on top of it

The financial model prices at the MAC-locality rate the CoachCare Value Analysis resolves for the practice's ZIP — **Novitas JH, locality 99, 'Rest of Texas'** (contractor 0441299), one of the program's lower-paying localities.[6] The margin band still lands where it should because the model is built on the local rate rather than a national magnitude.

The load-bearing point is the payer mix. **El Paso County runs at 72.0% Medicare Advantage — only about 28% of the panel is traditional fee-for-service**. Advantage plans must reimburse at a floor of 100% of the Medicare rate, but that floor is not the same as a settled rate: **each Advantage contract sets its own terms for the care-management code families**. The economics in this section are built on the traditional-Medicare channel; the Advantage book is an additive conversation, plan by plan, and it is the first thing to establish in discovery.

Modeled economics

The companion Value Analysis prices an RPM + PCM program on the practice's base.[7] The modeled population is an **estimated 9,690-patient in-scope base across the twelve clinicians**, built from an established-patient evaluation-and-management anchor of 2,713 traditional fee-for-service beneficiaries, deduplicated and then grossed up for the county's 72% Advantage share. *This is a discovery-stage estimate and should be validated against the practice's own chart counts before budgeting.*

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$884,680	$2,721,607	**$3,606,287**
CoachCare fees (incl. setup & integration)	—	—	$2,071,000
Net to the practice	**$369,038**	**$1,166,249**	**$1,535,287**
Practice margin	**41.7%**	—	**42.6%**
Net reimbursement by program	—	—	RPM $2,644,287 · PCM $962,000
Unique patients (de-duplicated) at month 24	—	—	~2,530
Active program enrollments at month 24	—	—	~3,147
Hospitalizations avoided (24-month, RPM cohort)	—	—	~187

CoachCare Value Analysis, MAC locality TX 0441299-99 (Novitas JH, Rest of Texas), RPM and PCM only. Chronic care management is carried at zero. Transitional care management is excluded entirely.

[6] CMS mandatory-model market list (FY2025 IPPS Final Rule): the El Paso core-based statistical area is not on the mandatory-market list, and the practice holds no hospital certification number that would carry mandatory-model exposure.

[7] The practice appears in a value-based Medicare Advantage network directory, which indicates a referral-and-network relationship rather than a shared-savings participant match on the practice's own registration. No Medicare Shared Savings Program participant match to the group's registration was found. Only participant registrations appear in that file, so a negative is not proof of non-participation under another entity's registration - carried to the discovery agenda.

The margin, and how the ramp behaves

24-month practice margin: 42.6% — net to the practice ÷ net reimbursement. Year 1 is **41.7%**, on $884,680 of net reimbursement, rising as the census matures into Year 2 on $2,721,607. Net reimbursement grows about 3.1× from Year 1 to Year 2 on the same referral engine, purely from census accumulation.

Month 1 is modeled at **−$4,455** because one-time implementation lands there, and **month 2 is the first net-positive month**. No practice capital is at risk while the census builds, because CoachCare funds the enrollment engine, the devices and the monitoring staff.

The program is pace-limited, not eligibility-limited, and that decides where the growth comes from. Neither the RPM nor the PCM census reaches its modeled ceiling inside the 24-month window, so **the constraint on growth is enrollment throughput rather than the size of the eligible pool**. That is the lever Section 8.2 pulls: a second on-site enrollment specialist, funded by CoachCare, moves both arms materially — roughly 41% more net reimbursement over the two years.

2.3 Connective tissue: one infrastructure, every lever

The same enrollment engine, connected-device logistics, 24/7 monitoring, nurse triage, billing-grade documentation, chart integration and analytics serve every strategic lever the practice faces. That is the argument for building the service line once, centrally, rather than assembling a separate response to each problem as it arrives.

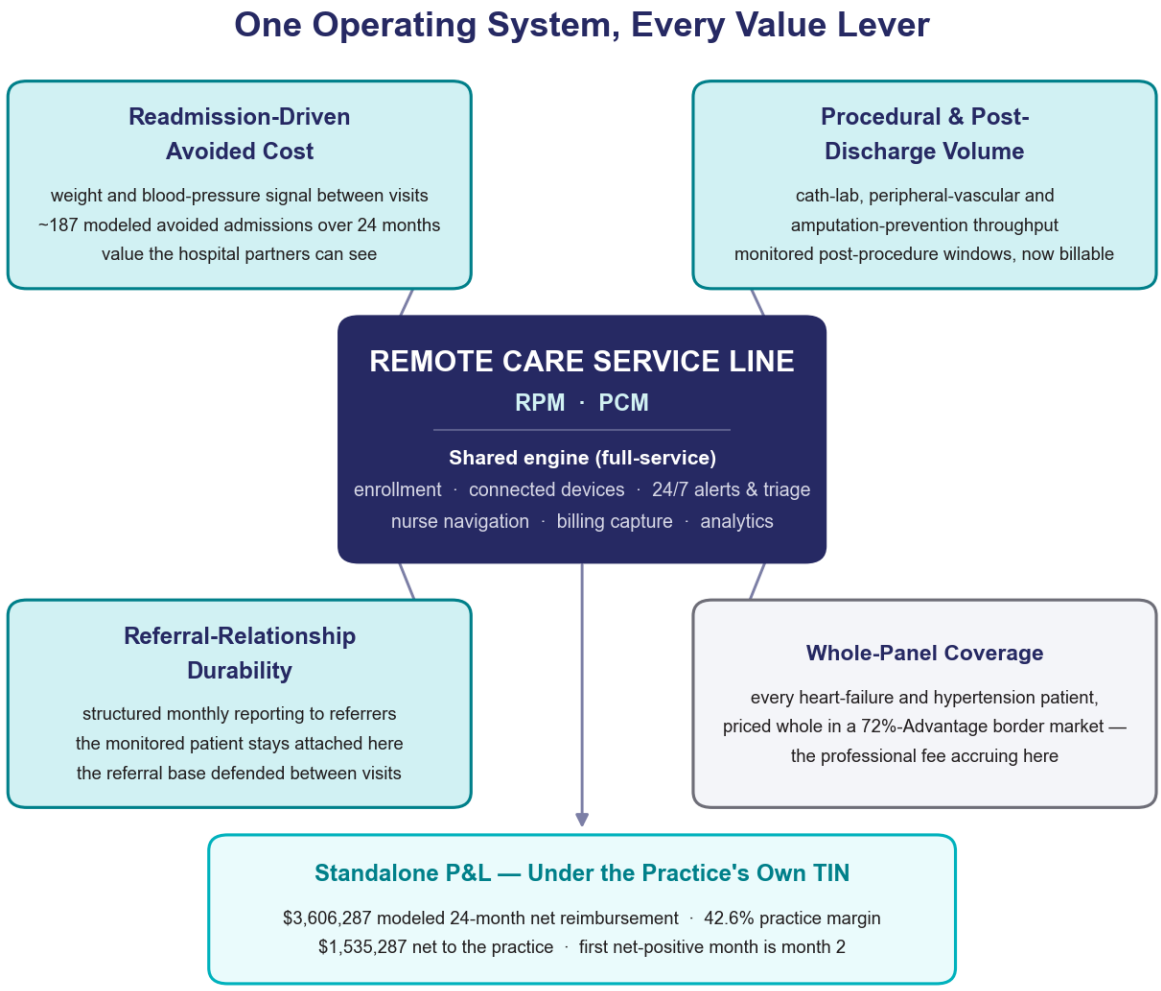

Figure 1. The Remote Care Service Line as connective tissue: one operating system producing the standalone P&L, readmission-driven avoided cost, referral-relationship durability, procedural and post-discharge throughput, and whole-panel coverage in a very-high-Advantage market.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Standalone P&L — the lead layer	No mandatory model and no shared-savings reconciliation on the practice's own registration, so the program has to pay for itself on professional fees — and CY2026 code expansion (99445, 99470) widens what is billable	**$3,606,287 of modeled 24-month net reimbursement at a 42.6% practice margin** — billed under the practice's own registration, dependent on no reconciliation and no third party's agreement
Readmission-driven avoided cost	Heart-failure patients readmit, and hospital readmission penalties still bite the group's admitting hospital partners — with no between-visit data layer in place today	Daily weight and blood-pressure signal with 24/7 triage turns deterioration into a same-week outpatient intervention instead of an emergency-department visit. Modeled at ~187 avoided admissions over 24 months (Section 5)
Referral-relationship durability	An independent group's referral base is renewed or eroded every quarter by what the referring physician hears back, and by whether the patient stays attached between visits	A monitored patient with a monthly touch stays attached to this practice, and structured monthly reporting back to the referring physician is both good practice and a referral-retention mechanism (Section 5.3)

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Procedural and post-discharge throughput	Cath-lab, peripheral-vascular and amputation-prevention work generates short, high-risk recovery windows that were clinically consequential and financially invisible before 2026	A monitored post-procedure pathway, with short-window RPM billable via 99445, covers exactly those windows — on the procedures the practice actually performs (Section 6)
Whole-panel coverage in a high-Advantage market	72% of the county's Medicare population is in Advantage, and the between-visit layer is unbuilt for all of it	The service line covers the whole panel continuously, with the professional fee accruing to the practice's own registration on the traditional-Medicare book, and the Advantage book approached contract by contract
Transitional care *(identified, not modeled)*	Every cardiac discharge from the hospital partners opens a 30-day transitional window that is unbilled today	The same enrollment and monitoring engine covers the 30-day window; short-window RPM is billable today via 99445, and TCM remains a separate decision the practice can take on its own merits

Read that table one way and it is six separate problems, each with its own project plan and its own reason to be deferred. Read it the other way and it is **one asset, built once and paid for once, that answers all six**. What the practice does not yet own is the between-visit data layer, the enrollment engine and the billing capture that turn an episodic procedural practice into a longitudinal service line.

3. 2026 Policy, Payment and Market Environment

Two things shape what is buildable here in 2026: what CMS now pays for, and how the county's payer structure supports it.

3.1 The CY2026 fee schedule: remote care gets more billable

The CY2026 Physician Fee Schedule expanded the remote-monitoring toolkit in ways that suit a cardiology group whose highest-value windows are short.[8] **99445** pays the monthly device-supply amount for 2–15 days of data, where 16 or more days were previously required — which had made short post-procedure windows effectively unbillable. **99470** pays for the first 10 minutes of monthly management time, where the floor had been 20. Together they convert the days after a catheterization or a peripheral procedure from unfunded care into billable events. PCM (99424–99427) remains the monthly chassis for single-condition specialty management, and RPM and PCM stack in the same month with discrete documentation.

Why the short-window codes matter more here than at most cardiology groups. This practice's revenue is dominated by procedures and imaging rather than by office visits, so the population it sees is episodic by construction: a patient arrives, is imaged or treated, and leaves. Before 2026 the days immediately after those episodes were clinically the most consequential and financially invisible. A code that pays for two to fifteen days of data is a code written for exactly this practice's shape.

3.2 The market: a very-high-Advantage border county

> **The load-bearing market fact**
>
> El Paso County Medicare Advantage penetration is **72.0% as of CY2024** — only about 28% of the county's Medicare beneficiaries are in traditional fee-for-service.[9] This is the opposite of most independent-cardiology sizing assumptions, and it is the single most important number on the account.
>
> Medicare Advantage plans are required to reimburse at a floor of 100% of the Medicare rate. That floor is not a settled rate: **each Advantage contract sets its own terms for the care-management code families** — whether a plan pays 99453, 99454, 99457, 99458 and 99424–99427 at all, and at what rate, is a contract question, not a fee-schedule one. Everything modeled in Section 2.2 is built on the traditional-Medicare channel; the Advantage book is a second, additive conversation, plan by plan.
>
> **This is the number-one discovery item, and no public source can supply it.** Establish the practice's traditional-Medicare-versus-Advantage split as a share of patients, and whether any Advantage volume is capitated or paid fee-for-service — every number downstream moves with the answer.

The high-Advantage structure has a second implication worth stating plainly. A practice this embedded in Advantage almost certainly sits inside one or more Advantage networks, which is a referral-and-network relationship rather than a shared-savings obligation on the practice's own registration. It does not change the standalone economics, which are billed on the traditional-Medicare book; it does mean the managed-care contact is a required call point, because that is where the answer to the code-coverage question lives.

3.3 No mandatory model exposure

no mandatory model exposure — pure-upside timing, and prepared if selection maps change. The verification was run to conclusion against the current published participant files: the county is not on the

[8] CMS Medicare Physician & Other Practitioners - by Provider, CY2024, summed across the twelve NPIs billing under the practice's own registration: Medicare allowed of $5,130,307, within about 4% of the approximately $4,933,426 reported by a commercial firmographic file. Figures are traditional Medicare Part B fee-for-service only; Advantage encounters are excluded by construction.

[9] The CoachCare Value Analysis resolves the practice's ZIP to Medicare Administrative Contractor 0441299 (Novitas JH), locality 99, 'Rest of Texas' - one of the program's lower-paying localities. Locality-adjusted payment should be confirmed against the current CY2026 Physician Fee Schedule and the applicable Texas locality files.

mandatory-market list, and none of the group's clinician registrations appears on the participant datasets.[10][11] Nothing in this report depends on a compliance deadline, and the practice is under no clock it did not choose. A referral-network signal in a value-based Advantage network is present but is not participation on the practice's own registration.[12] The verification is vintage-specific and should be re-run against each subsequent published file — which is what 'prepared if selection maps change' means in practice.

Why that is a selling point rather than a footnote. The standard objection to adding billable services inside a value-based structure is that incremental Part B spending shows up against a total-cost-of-care benchmark and is clawed back at reconciliation. **On this practice's own registration, that mechanism does not appear to exist** — which means every dollar of RPM and PCM reimbursement is incremental Part B revenue with no offset against it.

[10] The electronic health record is recorded as eClinicalWorks in a commercial firmographic file. No patient-portal link is exposed on the practice's website, and the one third-party technology profile that names eClinicalWorks conflates the practice with a differently named El Paso cardiology group, so it cannot be relied on for this practice specifically. eClinicalWorks is in CoachCare's integration catalog and prices correctly as a standard integration; the platform, version and edition should be confirmed directly in discovery.

[11] CMS CY2026 Medicare Physician Fee Schedule: the new short-window remote-monitoring code 99445 pays the monthly device-supply amount for 2-15 days of data (where 99454 requires 16-30), and 99470 pays for the first 10 minutes of monthly management time (where 99457 requires 20). PCM codes 99424-99427 and the RPM-plus-PCM concurrency rules apply as described. CY2027 rulemaking is in progress.

[12] CoachCare Value Analysis companion model: RPM and PCM only, chronic care management at zero and transitional care management excluded; estimated 9,690-patient in-scope base; twelve referring clinicians; one on-site enrollment specialist funded by CoachCare, with a second modeled as a roughly 41% net-reimbursement lever (about $1,492,602 and $646,712 of additional net to the practice over 24 months); pace-limited RPM and PCM arms, neither reaching its modeled ceiling inside 24 months; RPM and PCM 24-month net reimbursement of $2,644,287 and $962,000; and MAC-locality rates resolved for the practice's ZIP (Novitas JH, locality 0441299-99).

4. Performance Snapshot: The Starting Position

4.1 The panel, and the whitespace beside it

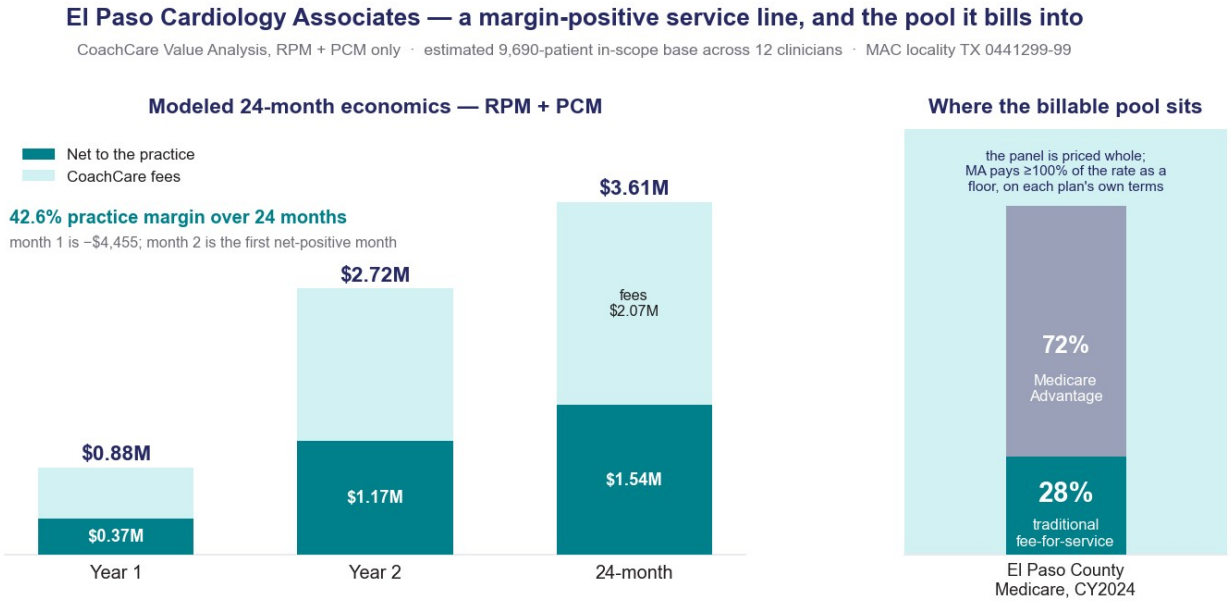

Figure 2. The modeled 24-month economics — Year 1, Year 2 and the total, each split into net-to-practice and CoachCare fees — beside the county payer split that sets how deep the fee-for-service pool is. CoachCare Value Analysis, RPM + PCM only; CMS Medicare Monthly Enrollment, El Paso County, CY2024.

The whitespace is the finding the report turns on. No remote physiologic monitoring, no chronic-care management, no device or monitoring vendor, no patient app and no care-coordinator or chronic-care nurse role appears anywhere in the public record — not on the practice's own website, not in reachable job postings, not in press.[13] *Stated at its true limits, this is absence of evidence rather than proof of absence*: a program launched recently would not yet be visible, and a cath-lab practice may run passive device follow-up that is not advertised. It is the single most important question to ask in discovery, and the answer shapes the proposal either way — but nothing found here suggests a physiologic monitoring or care-management program exists.

The panel that program would serve, sized as an estimate. The in-scope base modeled in this report is **9,690 patients across the twelve clinicians**, built bottom-up: CMS established-patient evaluation-and-management counts across the twelve billing NPIs give an anchor of **2,713 traditional fee-for-service beneficiaries** after deduplication, grossed up for the county's 72% Advantage share to reach the whole addressable panel.[14] *This is a discovery-stage estimate, not a chart-verified count*, and validating it against the practice's own panel is the first discovery item after payer mix. In a cardiology panel of this size and procedural intensity, essentially every in-scope patient carries two or more chronic conditions and a dominant cardiac one — the eligibility bar for monthly management and the textbook indication for remote physiologic monitoring, met by the existing panel without recruiting a single new patient.

4.2 The revenue and procedural base

The CY2024 CMS Medicare Physician and Other Practitioners file was summed across the twelve billing NPIs.[15] These figures are traditional Medicare Part B fee-for-service only — Advantage encounters are excluded by construction — so **every dollar below sits in the channel that RPM and PCM bill into**.

13

14

15

Measure	Value	What it means
CY2024 Medicare allowed, twelve billing NPIs	**$5,130,307**	Sum across the twelve NPIs that bill under the practice's own registration
Commercial firmographic file's reported figure	~$4,933,426	Within about 4% of the CMS sum — the confirmation that the twelve-NPI roster is the right entity, not a conflation with the co-located cardiology practices at the same building
Procedural base	Cath lab · peripheral vascular · imaging	An interventional and imaging-heavy revenue base with a large episodic population — the shape a monthly management service is built to complement
Advertised advanced programs	None beyond the above	No electrophysiology, structural-heart, device-clinic or standalone heart-failure program is published, so the report assumes none

The read is straightforward. This is a real, mid-sized independent cardiology group with a genuine procedural base and no recurring, non-procedural revenue line. It sees a large cardiac population intensively and episodically, and it currently has no way to bill for the care that happens between those episodes. That is precisely the gap the service line fills.

4.3 Position in the market

The group's admissions and cardiac referrals flow to El Paso's dominant hospital systems — **The Hospitals of Providence (Tenet) and Las Palmas Del Sol Healthcare (HCA)**, with University Medical Center of El Paso as the county's public safety-net hospital. The practice is independent of all of them: it owns its own cath lab and refers into these systems rather than being employed by any.

The competitive and strategic dynamic worth understanding is the referral base. An independent cardiology group in a dense border market holds its position through its hospital relationships and the primary-care physicians who send it patients. The first is structural; the second is renewed or eroded every quarter. **A patient's attachment to a practice is renewed between visits, not during them** — and a group whose patients have two touchpoints a year with it, and many more with everyone else, is more exposed on referral durability than its procedural strength suggests. A monitored patient with a monthly contact and a device this practice supplied has twelve. That is the retention argument, and it is at least as strong as the revenue one (Section 5.3).

5. Readmission Defense and Referral Durability

The second value layer is the one the practice does not bill for directly and should still care about, because it is what makes the service line defensible to everyone around it — the admitting hospitals and the referring physicians.

5.1 The clinical mechanism, stated without exaggeration

A heart-failure patient decompensates over days, not minutes, and the earliest reliable signals are weight gain and blood-pressure change. In the current state those signals exist and nobody sees them: the patient is weighed at a visit a quarter away, and the intervening trajectory is invisible. **Daily weight and blood-pressure data with 24/7 triage converts that trajectory into an actionable alert, and converts what would have been an emergency-department presentation into a same-week outpatient intervention** — a medication change, a diuretic adjustment, a nurse call, a brought-forward visit. The practice's hospital partners still carry Medicare readmission penalties, so an outpatient capability that measurably reduces avoidable heart-failure readmissions is worth something specific to them.

5.2 Avoided cost, across a range of assumptions

The Value Analysis models the mechanism on the RPM cohort. The honest way to present it is as a range, because the avoided-admission share is the assumption that moves the result. Valuing each avoided admission at an illustrative $15,000, and holding the modeled expected admissions in the enrolled cohort fixed:

Share of avoidable admissions prevented	Avoided admissions (24-month)	Avoided cost
20%	~94	~$1.40M
30%	~140	~$2.10M
40% — the planning case	**~187**	**~$2.80M**
50%	~234	~$3.51M

The 40% case — about 187 avoided admissions and roughly $2.8 million — is the realistic planning figure, consistent with the effect sizes remote heart-failure monitoring programs report. Two qualifications, both important: this value accrues to the payer and to the admitting hospital partners, not to the practice's own P&L, and it is not double-counted anywhere in Section 2.2; and it is a model output driven by the enrolled census and the assumed clinical effect, not a measured local readmission rate. This report quotes no local readmission benchmark, because the argument does not need one — the practice's own panel composition justifies it.

5.3 Referral durability, which is the quieter half

- **A structured monthly report is a referral instrument.** Enrolled patients generate a monthly summary — readings, trend, interventions, medication changes, escalations — that goes back to the referring primary-care physician as a by-product of the program rather than as a separate administrative effort. A referring physician who receives twelve structured updates a year from this practice, and two from another, is not making a close decision.
- **Attachment is renewed between visits, not during them.** A patient with a monthly contact, a device in the home that this practice supplied, and a care team they can reach is attached to this practice in a way a twice-yearly office visit does not achieve — which matters in a dense market with two large hospital systems touching the same patients.
- **It gives the practice its own data.** Enrollment counts, adherence, alert-to-contact times, blood-pressure control rates and readmission deltas against the unenrolled panel are the practice's own

measurements, on its own patients, in its own system. Whatever conversation comes next — with a hospital, a referring group, or an Advantage plan — is better with that data than without it.

6. Powering Procedural and Post-Discharge Throughput

Remote care is usually sold as a chronic-disease program. In a group with this procedural profile it is also a throughput and follow-up instrument, and the mechanism is specific: **the CY2026 short-window codes now pay for exactly the days after a procedure that were clinically the most consequential and financially invisible**. This section is deliberately scoped to what the practice actually performs — no structural-heart, electrophysiology or renal-denervation volume is assumed, because none is advertised.

Procedural line	What the practice publishes	What the service line adds
Interventional and coronary	Cardiac catheterization and coronary intervention in the practice's own cath lab	Post-procedure blood-pressure and weight monitoring in the 2–15 day window, now billable via 99445; structured recovery follow-up on the highest-risk and least-supervised days
Peripheral vascular and amputation prevention	Peripheral vascular disease management with a stated amputation-prevention focus	Short-window post-procedure monitoring, and a natural feeder into the hypertension pathway — peripheral disease and uncontrolled blood pressure travel together, and surveillance between visits is where amputation prevention actually happens
Longitudinal cardiac and imaging	Echocardiography, nuclear cardiology and general adult cardiology	The imaging and follow-up population feeds a monitored longitudinal panel — the recurring layer beneath an otherwise episodic, technical-component-heavy revenue base

The point is narrow and useful. The service line does not require the practice to add a procedure or a program it does not have. It attaches to the cath-lab and peripheral work already being done, makes the recovery windows billable, and turns the imaging and longitudinal population into a monitored panel. Every lever in this section is grounded in a capability the practice publishes today.

7. eClinicalWorks Integration & Technology Architecture

What is recorded, and what to confirm

The practice's electronic health record is recorded as eClinicalWorks in a commercial firmographic file. **Public sources do not independently confirm it** — no patient-portal link is exposed on the practice's website, and the one third-party corroboration conflates the practice with a differently named El Paso cardiology group.[16] The platform prices correctly as a standard integration regardless, because eClinicalWorks is in CoachCare's integration catalog; the figure does not move if the vendor turns out to be another catalog record.

Confirm the record — platform, version and edition — directly in discovery before any integration scoping, timeline or contractual commitment.

7.1 What the integration does

Modeled and presented as a standard eClinicalWorks integration, the pattern is well-trodden. What it delivers:

- **Enrollment inside the chart.** Referral to the service line is one order in the existing record, not a separate system, a separate login or a paper form.
- **Bidirectional orders and results.** Orders flow out and results flow back into the chart, so the record the practice is audited on is the record it already keeps.
- **Documentation write-back.** Vitals, evidence of care and care plans write back into the chart on a monthly cadence, with enrollment status and device assignment visible to the clinician at the point of the next decision.
- **Automated claim generation.** The monthly per-patient claim is generated by the billing engine rather than assembled by hand — which is what makes a recurring, high-volume monthly claim stream capturable at all.

Scope note: integration capabilities are CoachCare-provided; confirm the connector, the product version and the delivery timeline in contracting.

7.2 Why automated claim generation matters here specifically

This practice's billing operation is currently optimized for high-value, low-frequency events — procedures and imaging studies, concentrated in a small number of code families. **A recurring, low-value, high-frequency monthly claim stream is a different operational problem**, and it is the one most likely to be under-captured if it is bolted onto an existing workflow rather than generated automatically. At a modeled census approaching 3,147 active enrollments at month 24, the monthly billing task is thousands of per-patient, per-code, time-documented claims — each dependent on evidence that the monitoring days and management minutes were met. Automated generation from the monitoring record is what makes the capture rate in Section 8.4 a real operating metric rather than an aspiration.

16

8. Implementation Playbook: Building the Remote Care Service Line

8.1 Goals, scope, and the modeled funnel

The goal for the first twelve months is a named service line with its own P&L, its own physician lead, a defined target population, and a first billable enrollment inside 90 days. The modeled funnel is deliberately conservative and bottom-up:

Model input	Value	Note
In-scope base	9,690	Discovery-stage estimate — validate against chart counts. Established-E/M anchor of 2,713 FFS beneficiaries, grossed up for the county's Advantage share
Referring clinicians	12	Registry-grounded count billing under the practice's own registration
Medicare Advantage penetration	**72.0%**	El Paso County, CMS CY2024. Only ~28% of the panel is traditional FFS; Advantage pays a floor of 100% of the rate on each plan's own terms — confirm code coverage in discovery
Programs modeled	RPM + PCM	Chronic care management off; transitional care management identified but excluded from every figure
On-site enrollment specialist	1 (a second adds ~41%)	**CoachCare's expense — embedded value, never deducted from practice margin**
Program regime	Pace-limited	Neither the RPM nor the PCM census reaches its modeled ceiling inside 24 months — throughput, not eligibility, is the lever
MAC locality	TX 0441299-99	Novitas JH, 'Rest of Texas'; auto-resolved for the practice's ZIP

Target populations and clinical pathways

Population	Why it is first	Pathway
Heart failure	The population in which weight and blood-pressure trend between visits changes what happens next, and the cohort behind the readmission wedge (Section 5)	Weight and blood-pressure RPM with 24/7 triage; PCM as the monthly chassis; titration against measured response
Uncontrolled and resistant hypertension	A near-universal condition in a cardiology panel, and the population where between-visit blood-pressure data changes titration	Blood-pressure RPM; protocolized titration; a natural feeder from the peripheral-vascular and amputation-prevention population
Post-catheterization and post-peripheral-procedure	Every case in the practice's own cath lab and peripheral service opens a short recovery window that is now billable	Short-window RPM via 99445 / 99470, kept distinct from any device follow-up
Post-discharge cardiac	Every cardiac discharge from the hospital partners opens a 30-day transitional window that is unbilled today	TCM 99495 / 99496 (not modeled) plus short-window RPM via 99445

8.2 Staffing: nobody has to be hired — and the growth lever

What the practice supplies is clinical direction, general supervision, and the physician lead who owns the escalation protocol. What it does not supply is headcount. **The on-site enrollment specialist is funded by CoachCare — embedded value that is never deducted from the practice's margin, and never a**

practice cost line. The partner supplies enrollment, devices, monitoring, documentation and claims under the practice's protocols and supervision.

> **The growth lever: a second enrollment specialist**
>
> The program is pace-limited on both arms — neither the RPM nor the PCM census reaches its modeled ceiling inside 24 months — so the constraint is enrollment throughput, not the size of the eligible pool. **Adding a second on-site enrollment specialist, also funded by CoachCare, raises modeled net reimbursement by about 41% — roughly $1,492,602 over 24 months — and adds about $646,712 of net to the practice**, lifting the census materially above the single-specialist ramp.
>
> Because the specialist is CoachCare-funded, the practice captures the upside without a corresponding cost line. This is the single highest-leverage decision in the build, and it is a scaling decision rather than a clinical one.

8.3 Clinical workflow

1. **Identify.** Heart failure, uncontrolled hypertension, post-catheterization and post-peripheral-procedure, post-discharge. Built from the practice's own record and the cath lab and discharge lists.
2. **Enroll.** One order in the chart. Consent, device selection and logistics handled by the partner; the on-site enrollment specialist covers the sites, with a telephonic pathway behind it. Given the market, plan bilingual English/Spanish enrollment scripting from day one.
3. **Monitor.** Daily physiologic data with 24/7 review and alert triage against thresholds the physician lead sets — not vendor defaults.
4. **Escalate.** A defined path from alert to nurse contact to same-week outpatient intervention, with the emergency department as the exception rather than the default. This is where the ~187 modeled avoided admissions come from.
5. **Titrate.** Guideline-directed therapy adjusted against measured response on a schedule rather than at the next quarterly visit, with PCM as the monthly billing chassis.
6. **Document and bill.** Time, readings and interventions captured as a by-product of care; claims generated automatically from the monitoring record (Section 7.2).
7. **Report back.** Structured monthly reporting to the referring primary-care physician — the referral-retention mechanism in Section 5.3.

8.4 KPI dashboard and expected impact

Domain	Metric	Why it is on the dashboard
Clinical	Blood-pressure control rate; weight-alert response time; heart-failure admissions and 30-day readmissions among the enrolled census	The measures that make the avoided-cost argument in Section 5 measurable rather than modeled — the practice's own data on its own patients
Operational	Enrolled census by program; enrollment conversion rate; device compliance (days with data); alert-to-contact time	Census is revenue. Days-with-data is what makes 99454 and 99445 billable in the first place. Throughput is the growth lever, so conversion rate is watched closely
Financial	Time to first billable enrollment; capture rate (billed ÷ eligible); net reimbursement per patient per month; net to practice; coinsurance collection rate	Capture rate is the metric that quietly decides whether the modeled 42.6% margin is realized; coinsurance collection decides whether patients stay enrolled

Domain	Metric	Why it is on the dashboard
Strategic	Readmission delta versus the unenrolled panel; referral retention by referring physician; Advantage code-coverage confirmed by plan	The numbers that make the group's contribution measurable rather than asserted — in a hospital conversation, a referral conversation, and an Advantage-plan conversation

Expected impact over 24 months, as modeled: $3,606,287 of net reimbursement and $1,535,287 net to the practice at a 42.6% margin; about 2,530 unique patients and 3,147 active program enrollments at month 24; and approximately 187 avoided hospitalizations. Month 1 is −$4,455 and month 2 is the first net-positive month.

8.5 Twelve-month roadmap

Phase	Months	What happens
Charter	0–1	Physician lead named; service line chartered with its own P&L; target populations agreed; payer mix and Advantage code coverage confirmed (Section 3.2); the eligible panel validated against chart counts; the attribution and coordination policy written before the first enrollment
Stand up	1–3	eClinicalWorks integration built once the record is confirmed; alert thresholds and escalation protocol set by the physician lead; on-site enrollment specialist placed; bilingual enrollment scripting in place before the first patient is approached
First census	2–6	Heart-failure and hypertension cohorts enrolled first, seeded from the practice's own record; first billable enrollment inside 90 days; month 2 is the first net-positive month in the model
Extend	6–9	Post-catheterization, post-peripheral-procedure and post-discharge pathways added; the second enrollment specialist opened to move both pace-limited arms (Section 8.2)
Institutionalize	9–12	Monthly scorecard running; capture rate, coinsurance collection and readmission delta reported; the TCM decision taken on its own merits; the hospital and Advantage-plan conversations opened from a position of measured data

References & Data Sources

- **CMS National Plan and Provider Enumeration System (NPPES)** for the organizational registration of El Paso Cardiology Associates, P.A. (organization NPI 1235294232), the authorized-official physician title consistent with independent physician ownership, and the three registered practice addresses. The billing roster of about twelve cardiologists was resolved from CMS registry organizational membership rather than from the shared North Mesa address, because that building houses more than one cardiology entity.
- **The practice's own website** (elpasocardio.com — home, providers, services and location pages): the three sites, the Clinic West expansion, the published sub-specialty range (interventional and coronary, echocardiographic and nuclear imaging, peripheral vascular and amputation prevention, adult and pediatric cardiology), and the absence of any published electrophysiology, structural-heart, device-clinic or standalone heart-failure program.
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024,** summed across the twelve billing NPIs: Medicare allowed of $5,130,307, within about 4% of the ~$4,933,426 reported by a commercial firmographic file — the confirmation that the twelve-NPI roster is the correct entity. Also the established-patient evaluation-and-management counts underlying the 2,713 traditional fee-for-service anchor. These figures are traditional Medicare Part B only; Advantage encounters are excluded by construction.
- **CMS Medicare Monthly Enrollment, CY2024,** El Paso County, Texas: total, traditional fee-for-service and Medicare Advantage beneficiary counts, from which the 72.0% Advantage penetration and the roughly 28% traditional fee-for-service share are drawn. This is the load-bearing market fact in Sections 3.2 and 4.1 and the model-inputs table in Section 8.1.
- **CMS Innovation Center model participant files** were retrieved and searched to conclusion for the verification in Section 3.3 — by county market, by organization legal name and by the group's clinician registrations, with no filter applied that could mask a match. El Paso is not on the mandatory-market list, and no clinician registration appears on the participant datasets. The verification is vintage-specific and should be re-run against each subsequent published file.
- **CMS Medicare Shared Savings Program and Advantage-network references:** the practice's presence in a value-based Advantage network directory is a referral-and-network relationship, not participation on the practice's own registration; no participant match to the group's registration was found. This report makes no claim of accountable care organization participation.
- **CMS — CY2026 Medicare Physician Fee Schedule:** TCM 99495 and 99496; RPM 99453, 99454, 99445, 99457, 99470 and 99458; PCM 99424–99427; and the concurrency rules under which RPM and PCM stack. Locality-adjusted payment for this practice is set by the Novitas Medicare Administrative Contractor; the model resolves the practice's ZIP to locality 0441299-99 ('Rest of Texas'). CY2027 rulemaking is in progress.
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts, including the estimated 9,690-patient in-scope base, the 2,713 established-E/M anchor grossed for Advantage, the twelve-clinician referral engine, one on-site enrollment specialist at CoachCare's expense (with a second modeled as a ~41% net-reimbursement lever), the RPM and PCM pace-limited regime, and MAC-locality rates resolved for the practice's ZIP (Novitas JH, locality 0441299-99).

Items not independently verified

The following were searched for and could not be confirmed from public sources. They are listed so that nothing in this report is mistaken for a verified fact, and together they are the right discovery agenda for a first conversation.

- **Payer mix, and whether any Medicare Advantage volume is capitated.** The county runs at 72.0% Advantage, so most of the panel sits outside traditional Medicare. Establish the practice's traditional-Medicare-versus-Advantage split as a share of patients, and whether any Advantage volume is capitated or paid fee-for-service. *This is the number-one discovery item and it blocks the value model.*
- **Which plans pay the codes.** Whether the county's Advantage and commercial plans reimburse 99453, 99454, 99457, 99458 and 99424–99427 at all, and at what rate. Advantage plans pay a floor of 100% of the Medicare rate, but each contract sets its own terms for the care-management code families — nothing public answers this, and it is where the high-Advantage market actually bites.
- **Whether any remote monitoring or care-management program exists today.** No public evidence of one was found from any direction, but a program launched recently would not yet be visible, and a cath-lab practice may run passive device follow-up that is not advertised. *Ask directly.*
- **The eligible-panel size.** The 9,690 in-scope base is a discovery-stage estimate built from CMS established-patient counts and grossed for the Advantage share; the practice's own chart-verified panel count is required before budgeting.
- **The electronic health record.** Recorded as eClinicalWorks in a commercial firmographic file and priced as a standard integration; not independently confirmed from public sources. Confirm the platform, version and edition before any integration scoping (Section 7).
- **The advanced-practice bench.** The practice's own site lists no advanced-practice providers; a commercial file reports a larger total provider count that public sources do not corroborate. Any nurse practitioners or physician assistants are upside to the referral engine and are not modeled.
- **The administrative buying center.** Confirm who owns operations and who signs before any assumption is made about the buying process; individual names are held internally and are not used in this document.

Global verification note

Facts in this report reflect public sources current to September 2026 and are cited above. Reimbursement is set by the Novitas Medicare Administrative Contractor at the practice's locality, and CY2027 rulemaking is in progress. CMS model verification is vintage-specific and should be re-run against each subsequent published participant file. This report makes no claim of accountable care organization participation. The electronic health record is recorded but not independently confirmed. Medicare Advantage penetration of 72.0% means the traditional-Medicare book is the addressable base priced here, and the Advantage book is an additive, contract-by-contract conversation.

Prepared by CoachCare for discussion.