

Citrus Cardiology Consultants

Inverness, Lecanto, Crystal River, Homosassa, The Villages, Wildwood, Leesburg, Tavares and Ocala, Florida — a ten-site cardiology group across Citrus, Sumter, Lake and Marion counties, in practice for more than 35 years

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) built underneath the monitoring the practice already runs — sized against a CY2027 specialty-model designation, two-sided accountable care downside, and a margin-positive standalone P&L billed under the practice's own TIN

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the physician leadership of Citrus Cardiology Consultants. It starts from an unusual position for a report of this kind: the practice already bills remote monitoring at scale. Its CY2024 Medicare claims carry \$1.70 million of monitoring across three distinct code families and 47 clinicians. This is not a whitespace argument.

It is a completeness argument. The same claims show new remote-monitoring enrolments down 85% since 2021, the treatment-management add-on increments almost entirely uncaptured, and no chronic or principal care management billed at all — against a panel where two in five patients carry heart failure and the average risk score is nearly twice the national mean.

That gap stopped being only a revenue question on the day the practice was named to a CMS specialty model. From January 2027 the code families the practice does not bill are the ones that open an episode, and the family it does bill is not.

Prepared by CoachCare. Contact the CoachCare account team for the underlying model.

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Executive Summary

Citrus Cardiology Consultants is a ten-site cardiology group operating across Citrus, Sumter, Lake and Marion counties in central Florida. CMS registry data records **47 clinicians** under the practice's organisational enrolment — 22 physicians (ten interventional cardiologists, nine cardiovascular-disease physicians and three cardiac electrophysiologists) and 25 advanced practice providers.¹ In calendar year 2024 the practice billed **\$19,341,690** of Medicare fee-for-service allowed charges.²

The panel behind that number is the strongest argument on the account. Beneficiary-weighted across the practice's clinicians, the average patient is **78.4 years old** and carries a hierarchical condition category risk score of **1.91** against a national average of 1.00. Two in five carry heart failure; two thirds carry ischemic heart disease; half carry chronic kidney disease.³ This is a population for which daily physiologic data changes management, and the practice has already proved it believes that.

What is already running

The practice bills **\$1,699,486** of remote monitoring a year, across three distinct families: cardiac device remote monitoring at \$863,546, extended external electrocardiography at \$505,840, and physiologic remote patient monitoring at \$330,100.⁴ That figure excludes \$317,159 of loop-recorder and pacemaker insertion, which are procedures rather than monitoring and are counted separately here for that reason.

What stopped

New physiologic monitoring enrolments — CPT 99453, billed once per patient at setup — ran 339 in 2021, 212 in 2022, 182 in 2023, and **28 in 2024**. That is an 85% decline. The active census held near 520 across the same period and then began to drift down from its 2023 peak of 571.⁵ Enrolment is the part of remote care that requires a person doing it every week, and it is the first function a busy clinic loses. Everything downstream of it follows.

What was never billed

Against a panel with 40.5% heart-failure prevalence, the practice billed **no chronic care management, no principal care management**, and transitional care management for 31 beneficiaries from a single clinician.⁶ Separately, the treatment-management add-on increment — CPT 99458, the second and third twenty minutes in a month — was billed for 106 beneficiaries against 521 on the primary code, a ratio of roughly 0.07 add-on units per primary unit where CoachCare's own book runs near 1.45.

Why this is now a policy question as well as a revenue question

Seven heart-failure cardiologists billing under Citrus Cardiology Consultants, PLLC are named on the CMS preliminary participant list for the Ambulatory Specialty Model, heart-failure cohort, for performance year 2027.⁷ None of the seven carries the small-practice designation, so none receives small-practice treatment. Performance year 1 is calendar 2027 and is paid out in payment year 2029. The

¹ CMS Doctors and Clinicians National Downloadable File, queried 7 August 2026 on the practice's organisational PECOS identifier. Forty-seven unique national provider identifiers resolve to the organisation; the file's own organisational membership field independently records 47. Specialty splits are read from each clinician's primary specialty field.

² Medicare Physician & Other Practitioners — by Provider, calendar year 2024, released 21 May 2026. Queried per national provider identifier across all 47 clinicians and summed. Total allowed \$19,341,690; total Medicare payments \$15,068,138.

³ Same source as note 2. Risk score, average beneficiary age, dual-eligible share and chronic-condition prevalence are beneficiary-weighted across the 41 clinicians with published claims. CMS publishes chronic-condition prevalence to a ceiling of 75.0%.

⁴ Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024. Queried per national provider identifier and aggregated by procedure code. Device monitoring 93294–93298; extended external electrocardiography 93224, 93228 and 93229; physiologic monitoring 99453, 99454, 99457 and 99458. Insertion procedures 33285, 33208, 33249 and 33228 total \$317,159 and are reported separately.

⁵ Same source as note 4, extended across calendar years 2019 to 2024.

⁶ Same source as note 4. No claims appear for 99490, 99439, 99491, 99487 or 99424 through 99427. CPT 99496 appears for 31 beneficiaries from one clinician; 99495 does not appear. CMS suppresses provider and procedure lines below eleven beneficiaries.

⁷ CMS Ambulatory Specialty Model Participants, calendar year 2027 preliminary public file, retrieved from the CMS open data portal 7 August 2026. Seven rows carry the practice's legal entity name with a heart-failure cohort designation and calendar-2027 participation recorded. Each national provider identifier was independently resolved in the NPPES registry to a cardiovascular-disease physician at a practice address.

adjustment runs **−9% to +9% for the first two performance years, rising toward −12% to +12% by the final year.**

Under the model's heart-failure cost measure, the code families that trigger an episode are principal care management, chronic care management and transitional care management. **The physiologic remote monitoring family is not among them.**⁸ Two consequences follow, and both cut against the way the practice bills today. Monitoring billed into the heart-failure population does not enlarge the attributed denominator, and it does not help a clinician clear the 30% attribution threshold — so a cardiologist whose heart-failure contact is mostly remote monitoring can fall below that threshold and not be attributed the episode at all. Meanwhile monitoring spend carried on a heart-failure diagnosis still counts against the cost measure.

The finding in one sentence

The practice has spent four years building the half of remote care that does not count toward its specialty-model position, and none of the half that does — and the same addition fixes the revenue gap and the attribution gap at once.

The two-sided risk position

The practice also carries downside on two accountable care contracts simultaneously. It joined an **ENHANCED-track** Medicare Shared Savings Program accountable care organization on 1 January 2024 — the maximum-risk track CMS offers, carrying up to 75% of shared losses — and it is recorded as a preferred provider in a **Global-risk** ACO REACH organisation.⁹ Within the shared-savings organisation the practice is **the only specialty practice among twelve participants**; six of the other eleven are primary care, family medicine or internal medicine by name. That makes cardiovascular cost performance for the entire attributed population the practice's to move, and it is a real argument for accountable-care-funded care-management infrastructure.

The forecast

The Value Analysis models a remote care service line across an in-scope cohort of 31,200 patients drawn from an estimated 39,000-patient Medicare panel, enrolled through the practice's 47 clinicians. Over 24 months it produces **\$8,575,759 of net reimbursement** to the practice, against \$4,943,190 of CoachCare fees, leaving **\$3,632,569 retained — a 42.4% practice margin**. Year 1 runs 41.9% and year 2 runs 42.5%. Month 1 is \$1,469 negative, because implementation and electronic-record integration both post against a 96-patient census; the practice clears positive in month 2.

	Year 1	Year 2	24 months
Practice net reimbursement	\$2,048,715	\$6,527,044	\$8,575,759
CoachCare fees	\$1,189,615	\$3,753,574	\$4,943,190
Net retained by the practice	\$859,100	\$2,773,470	\$3,632,569
Practice margin	41.9%	42.5%	42.4%
Unique patients under management	2,966	6,176	6,176
Hospitalizations avoided	107	346	452

Value Analysis summary. Patient counts are deduplicated across programmes; a patient enrolled in both is counted once.

⁸ CMS Proposed Operational List of Care Episode and Patient Condition Codes, June 2026, heart-failure chronic-condition tab. Trigger families and their constituent codes are read directly from that list.

⁹ CMS Medicare Shared Savings Program participants, performance year 2026 public file, and the CMS ACO REACH provider public use file for performance year 2024, both queried 7 August 2026 on the practice's exact legal names. Track, revenue classification and start date are recorded fields.

The enrolment specialist who drives that census, and the care team behind them at a 165:1 caseload, are **carried at CoachCare's expense**. They are not deducted from the margin above and they do not appear on the practice's payroll.

1. The Practice and Its Panel

1.1 Footprint and clinician bench

Citrus Cardiology Consultants, PLLC operates from ten locations across four central Florida counties: Inverness, Lecanto, Crystal River and Homosassa in Citrus County; The Villages and Wildwood in Sumter County; Leesburg and Tavares in Lake County; and Ocala in Marion County. The practice describes itself as having cared for the region for more than 35 years.

The CMS Doctors and Clinicians National Downloadable File records 47 unique clinicians under the practice's organisational enrolment.¹⁰ The file's own membership count independently reads 47.

Clinician group	Count	Note
Interventional cardiology	10	Catheterisation, stenting, peripheral intervention
Cardiovascular disease	9	Seven of these are the specialty-model cohort (§3.1)
Cardiac electrophysiology	3	Device implantation and ablation
Physicians, total	22	21 MD, 1 DO
Nurse practitioners	21	
Physician assistants	4	
Advanced practice providers, total	25	
All clinicians	47	The referral engine in the Value Analysis

Clinician bench, from CMS registry data rather than a directory count.

The published service catalogue is broad for a group of this size: transcatheter aortic valve implantation, mitral valve repair, electrophysiology and ablation, cardiac catheterisation and angioplasty, nuclear and positron-emission cardiac imaging, echocardiography, peripheral arterial disease management, an in-house laboratory, and an anticoagulation clinic that billed 4,700 services across 439 patients in 2024.¹¹

1.2 The panel: what the claims say

The practice's CY2024 Medicare claims describe an old, multi-morbid, and financially stable population. Beneficiary-weighted across the 41 clinicians with published claims, the average patient is 78.4 years old and carries a risk score of 1.91 — nearly twice the national average of 1.00. Only 5.6% are dual-eligible.

Condition	Prevalence	Relevance to remote care
Hypertension	75.0%	Blood-pressure monitoring; the core RPM population
Hyperlipidemia	75.0%	Titration and adherence management
Ischemic heart disease	67.0%	Post-intervention surveillance
Chronic kidney disease	49.9%	Weight and blood-pressure trend, volume status
Atrial fibrillation	45.0%	Rate control, anticoagulation management
Heart failure	40.5%	The specialty-model cohort; daily weight and symptom trend
Diabetes	38.5%	Glucose monitoring where co-managed
COPD	33.6%	Frequently co-morbid with heart failure

¹⁰ As note 1.

¹¹ The practice's own website and service pages, retrieved 7 August 2026, for the service catalogue and locations. Anticoagulation volumes are CPT 93793 from the source at note 4.

Chronic-condition prevalence, CY2024 Medicare fee-for-service, beneficiary-weighted. CMS publishes prevalence to a ceiling of 75.0%, which both hypertension and hyperlipidemia reach — the true figures for those two conditions are at or above the value shown.

The union of these conditions is what makes the in-scope estimate in §7.1 defensible. Hypertension alone reaches the published ceiling; adding heart failure, atrial fibrillation, post-intervention ischemic disease and advanced chronic kidney disease carries the remote-care-appropriate share of this panel past 80%.

2. Where the Practice Is Today

2.1 What is running, and what it bills

Three separate monitoring operations run inside this practice today, and they bill under three different code families. Distinguishing them matters, because they occupy different clinical and billing territory and only one of them overlaps with the service line proposed here.

Operation	Codes	Beneficiaries	CY2024 allowed
Cardiac device remote monitoring	93294–93298	1,513 on 93294	\$863,546
Extended external electrocardiography	93224, 93228, 93229	595 on 93229	\$505,840
Physiologic remote patient monitoring	99453, 99454, 99457, 99458	521 on 99457	\$330,100
Monitoring, total			\$1,699,486
Anticoagulation management	93793	439	\$54,150

Monitoring revenue decomposed by code family. Loop-recorder and pacemaker insertion (33285, 33208, 33249, 33228) total a further \$317,159; those are procedures and are excluded from the monitoring total above.

The device clinic is real and staffed — the practice is recruiting a device technician, one of its electrophysiologists holds a certified cardiac device specialist credential, and device remote interrogation reaches more than 1,500 patients. **None of that occupies the wedge described in this report.** Device monitoring answers a question about hardware. Physiologic monitoring and care management answer a question about the patient's condition between visits, and they bill under a different family entirely.

2.2 The enrolment engine stopped

CPT 99453 is billed once per patient, at setup. It is therefore a clean measure of how many new patients a monitoring programme takes on in a year.

Year	99453 setups	99454 device-supply beneficiaries	99457 management beneficiaries
2020	96	97	96
2021	339	443	444
2022	212	512	507
2023	182	571	567
2024	28	515	521

Physiologic remote monitoring, by year. New enrolment fell 85% from its 2021 peak while the active census held and then began to decline.

The census did not collapse, because monitored patients stay enrolled. What stopped was intake. A programme that adds 28 patients a year against roughly 1.5% monthly attrition is no longer growing; it is slowly unwinding.

This report does not speculate about the cause. It is the first question worth asking on a discovery call, and the answer determines whether this is a staffing problem, a workflow problem, a technology problem or a reimbursement problem. What the claims establish is that the clinical conviction was there — a practice does not enrol 339 patients in a year by accident — and the operational capacity to sustain it was not.

2.3 Two gaps, both quantified

Gap one: the treatment-management add-on increments

CPT 99457 pays for the first twenty minutes of treatment management in a calendar month. CPT 99458 pays for each additional twenty minutes. In CY2024 the practice billed 99457 for 521 beneficiaries and 99458 for 106 beneficiaries across 236 services — approximately **0.07 add-on units for every primary unit**. Across CoachCare's own book, measured on actual billed units from 76 practices over the first half of 2026, the same ratio runs near 1.45.

The add-on tier is where a monitored patient-year earns most of what it is worth. A programme capturing the primary code and almost none of the increments is doing the clinical work and billing a fraction of it.

Gap two: care management

Chronic care management (99490, 99439, 99491, 99487), principal care management (99424–99427) and transitional care management (99495) do not appear in the practice's CY2024 claims at all. Transitional care management appears only as 99496, for 31 beneficiaries, from a single clinician.

CMS suppresses provider and procedure lines below eleven beneficiaries, so the precise claim is that **no care-management programme operated at meaningful scale in CY2024** — not that no single claim was ever filed. The distinction does not change the conclusion. Against a panel of this size and acuity, care management is effectively absent.

3. Three Risk Contracts, One Population

The practice carries downside exposure on two CMS contracts today and a third begins on 1 January 2027. All three are settled on total cost of care for overlapping populations, and all three turn substantially on what happens in the thirty days after a discharge.

3.1 The Ambulatory Specialty Model: a CY2027 designation, verified by NPI

Seven clinicians billing under the legal entity CITRUS CARDIOLOGY CONSULTANTS, PLLC are **named on the CMS preliminary participant list for the Ambulatory Specialty Model**, heart-failure cohort, with participation recorded for calendar year 2027.¹² Each of the seven was independently resolved in the national provider registry to a cardiovascular-disease physician practising at a Citrus Cardiology address — in Lecanto, Inverness, Crystal River and The Villages.

Geography corroborates the designation rather than substituting for it. The practice's own core-based statistical area and the area covering its Villages and Wildwood sites both appear on the model's mandatory-geography file.

What the file records, and what it means

All seven rows carry a small-practice flag of "No". The practice does not receive small-practice treatment under the model and carries the full payment adjustment.

Performance year 1 is calendar year 2027, paid out in payment year 2029. The data that determines the adjustment begins accruing on 1 January 2027.

The adjustment is –9% to +9% for the first two performance years, rising toward –12% to +12% by the final year.

This is the preliminary participant list. CMS is expected to publish a final calendar-2027 file, and every designation should be re-confirmed against it.

3.2 Why remote monitoring does not open an episode and care management does

The heart-failure episode-based cost measure defines which billed services open an episode and attribute it to a clinician. The operational code list published for the measure enumerates the trigger families explicitly.¹³

Family	Codes	Opens a heart-failure episode?
Principal care management	99424, 99426	Yes
Chronic care management	99490, 99491, 99487	Yes
Transitional care management	99495, 99496	Yes
Advance care planning	99497, 99498	Yes
Physiologic remote monitoring	99453, 99454, 99457, 99458, 99091	No

Episode trigger status by code family, heart-failure cost measure.

Three consequences follow for a practice in this position.

- **Attribution.** Remote monitoring billed into the heart-failure population does not open an episode, so it does not enlarge the denominator of episodes attributed to the practice.

¹² As note 7.

¹³ As note 8.

- **The threshold.** A clinician must account for at least 30% of an episode's trigger-or-confirming codes to be attributed it. Remote monitoring does not count toward that share. A cardiologist whose heart-failure contact between visits is mostly monitoring can fall below the threshold and not be attributed the episode at all — which moves both the twenty-episode eligibility count and the resulting cost score.
- **Cost.** Monitoring spend carried on a heart-failure diagnosis is nonetheless an assigned service against the cost measure. It counts on the expense side without helping on the attribution side.

Care management inverts all three. It opens the episode, it counts toward the threshold, and it is the clinical mechanism that reduces the spend the measure is scoring. The practice already owns the monitoring infrastructure and the patient relationships; what it is missing is the billable, documented, longitudinal contact that sits on top of them.

3.3 Two-sided accountable care, already live

The practice joined a Medicare Shared Savings Program accountable care organization on 1 January 2024 on the **ENHANCED track** — the maximum-risk option CMS offers, carrying up to 75% of shared savings and up to 75% of shared losses. The organisation is classified low-revenue, the profile of a physician-led ACO.¹⁴ Separately, the practice is recorded as a **preferred provider** in an ACO REACH organisation operating in the **Global risk** track, which carries 100% of savings and losses on its aligned population.¹⁵

The structural point worth the meeting

Within the shared-savings organisation, Citrus Cardiology is the only participant whose name identifies it as a specialty practice. Six of the other eleven are explicitly primary care, family medicine or internal medicine.

That makes the practice the natural owner of cardiovascular cost and quality performance for the entire attributed population — not merely for its own patients. It is also the strongest available argument that care-management infrastructure serving that population should be funded at the organisation level rather than out of the practice's own margin.

The organisation publishes no care-management, chronic-care or remote-monitoring programme of its own. That is a gap it has to close, and the practice is the participant best positioned to close it.

3.4 The cost measure: what it actually takes to clear it

The honest way to present the cost half of the specialty-model argument is as a break-even, not as a promise. Per enrolled patient-year, the service line adds standardized allowed spend of \$2,527.51 — \$1,461.81 of remote monitoring and \$1,065.70 of principal care management. Set against that, a reduction in the annual hospitalization rate removes spend at roughly \$15,000 per avoided admission.

Line	Per enrolled patient-year
Remote monitoring added	\$1,461.81
Principal care management added	\$1,065.70
Programme spend added	\$2,527.51
20-point reduction in annual hospitalization rate, at \$15,000	−\$3,000.00
Net position	+\$472.49

Cost-measure arithmetic on a heart-failure population, assuming a 40% baseline annual hospitalization rate.

¹⁴ As note 9. The shared-savings organisation's participant roster is corroborated on its own CMS-required public reporting page, which lists twelve participant organisations.

¹⁵ As note 9.

Break-even is a 16.85-point reduction — from a 40% annual hospitalization rate to 23.15%, a 42.1% relative reduction. At a 20-point reduction the position clears at any admission cost above \$12,638.

The reason to lead with break-even rather than with a halving is that a 50% relative reduction sits at or above the top of the published effect sizes for remote monitoring in heart failure, while 42% sits inside that range. The argument does not need the larger number, and a clinical audience cannot knock over the smaller one.

Quoted per attributed episode rather than per enrolled patient, and at a 35% enrolment rate, the +\$472 per enrolled patient reads as approximately **+\$165 per episode**.

The input that settles this is the practice's own baseline heart-failure hospitalization rate. At a 25% baseline a 16.85-point reduction is unreachable; at 55% it requires only a 31% relative reduction. That figure should be established before the cost argument is carried into a negotiation.

How to order the specialty-model argument

Fee-for-service margin first. It is the largest, the most certain, and it does not depend on the model at all.

Then the quality measures — two of the five in the heart-failure set are directly moved by documented longitudinal management.

Then the thirty points of improvement-activity protection that a documented care-management programme supports.

The cost category last. It is the thinnest leg of the argument, and leading with it invites a fight about effect sizes instead of a conversation about margin.

4. The Post-Discharge Window

4.1 Reading the hospital measures precisely

The hospital that receives approximately 47% of the practice's admissions holds a CMS overall star rating of **2 out of 5** — the lowest of the practice's three named admitting partners, the other two rating 3 and 4 stars.¹⁶ The detail underneath that rating matters more than the rating itself, and it points somewhere different from where a standard readmissions pitch would aim.

CMS measure	Score	Versus national
Hybrid hospital-wide readmission	16.8	Worse than the national rate
Hybrid hospital-wide mortality	5.3	Worse than the national rate
30-day heart-failure readmission	20.2	No different than the national rate
30-day heart-attack readmission	13.7	No different than the national rate
Heart-failure return days per 100 discharges	-5.3	Average, and better than expected
Excess readmission ratio, heart failure	1.0244	Above 1.0
Excess readmission ratio, heart attack	1.0128	Above 1.0

Largest admitting partner, CMS Care Compare and Hospital Readmissions Reduction Program. Hybrid measures cover July 2023 to June 2024; condition-specific measures and excess readmission ratios cover July 2021 to June 2024.

What not to say, and what to say

The condition-specific cardiac readmission rates are at par. CMS classifies both the heart-failure and heart-attack 30-day readmission rates as no different than the national rate, and the heart-failure return-days measure is better than average. An argument built on "your heart-failure readmissions are a problem" is wrong on the published measure.

The hospital-wide picture is not at par. The all-cause hybrid readmission measure and the hybrid mortality measure are both classified worse than the national rate, on the most recent measurement window.

Four of the six reported penalty measures carry an excess readmission ratio above 1.0, including both cardiac conditions. One ratio is an anecdote; four out of six is a pattern.

The opportunity is the gap between par-level cardiac performance and worse-than-national all-cause performance. That gap sits in the chronically ill medical population — the patients with heart failure plus chronic kidney disease plus COPD who are readmitted for something other than the condition that brought them in. It is exactly the population an accountable-care-participating cardiology group is answerable for, and exactly the population longitudinal management reaches.

4.2 What a three-touch cadence does about it

The service line's answer to that gap is a defined post-discharge cadence triggered by any emergency-room visit or hospitalization in the previous 60 days: a first contact on day 1 to 2 for medication reconciliation and a red-flag screen, a second on day 5 to 8 for adherence and trend review, and a third on day 12 to 14 to confirm the follow-up visit happened and hand off to the longitudinal cadence. Section 6 describes the governance that sits around it.

In the Value Analysis this cadence, applied across the enrolled census, produces **452 avoided hospitalizations over 24 months** — 107 in year 1 and 346 in year 2. That figure is calculated on the

¹⁶ CMS Care Compare — Hospital General Information, Complications and Deaths, Unplanned Hospital Visits, and the Hospital Readmissions Reduction Program supplemental file, all retrieved 7 August 2026 and queried by CMS certification number. Admission-share percentages are from a commercial healthcare database and are not independently verified.

model's generic 20% annual admission rate. A real heart-failure cohort runs materially higher, and the sensitivity is set out in §7.3.

5. The Service Line

5.1 The clinical and billing stack

The device clinic, the anticoagulation clinic and the rhythm-monitoring operation continue unchanged. What the service line adds is the longitudinal layer underneath them.

Stage	Codes	What happens
Discharge hand-off	99495, 99496	Structured transitional care at every discharge — the entry point the cost measure recognises and the window in which readmission risk is highest
Short-window monitoring	99445, 99470	Two-to-fifteen-day monitoring for post-discharge and post-procedure patients, where a full 30-day cycle does not fit
Longitudinal monitoring	99453, 99454, 99457, 99458	The programme already running, enrolled continuously rather than in bursts, with the treatment-management increments actually captured
Principal care management	99424, 99426	Monthly management of the single dominant condition. Opens the heart-failure episode and counts toward the attribution threshold

The cardiology billing stack. Chronic care management is not part of this service line; principal care management is the appropriate family for a specialty practice managing a dominant condition.

5.2 CY2026 rates at the practice's locality

Rates below are the CY2026 Medicare physician fee schedule at Florida locality 09102-99, resolved from the practice's headquarters ZIP code.

Code	Service	Rate
99453	Remote monitoring setup and patient education, one time	\$21.12
99454	Device supply with daily recordings, per 30 days	\$50.00
99445	Device supply, 2–15 days of readings	\$50.00
99457	Treatment management, first 20 minutes	\$51.12
99458	Treatment management, each additional 20 minutes	\$41.22
99470	Short-window monitoring, 2–15 days	\$25.73
99426	Principal care management, first 30 minutes	\$67.57
99427	Principal care management, each additional 30 minutes	\$53.69

CY2026 physician fee schedule, Florida locality 09102-99.

Two of these codes did not exist two years ago. CPT 99445 and 99470 pay for monitoring windows shorter than a full calendar month, which is what a post-discharge or post-procedure patient actually needs. They make the transitional window billable in a way it previously was not, and they are the reason the discharge hand-off in §5.1 is an economic proposition rather than only a clinical one.

One term is worth establishing early in scoping. Roughly **three in five** Medicare beneficiaries across the practice's four counties are enrolled in a Medicare Advantage plan. Plans are required to reimburse at no less than the Medicare rate, and the terms on which each individual contract pays these specific care-management code families should be confirmed as the programme is scoped. The forecast in §7 prices the whole in-scope cohort at the fee-schedule rate above.

5.3 eClinicalWorks: one integration, ten sites

The practice runs eClinicalWorks, confirmed from three independent directions: its patient portal resolves to eClinicalWorks' hosted cloud platform, its own employment page states a preference for eClinicalWorks experience, and regional clinical postings for the practice list the system by name.¹⁷

Layer	What integration delivers
Bi-directional record flow	Demographics, problem list and encounter data flow to the monitoring platform; readings, escalations and documented time flow back into the patient's chart as discrete data rather than a scanned attachment
Billing	Time thresholds are tracked against each patient-month, so the primary treatment-management code and its add-on increments post when the work has been done — which is where the capture gap in §2.3 closes
Workflow	Escalations route into the task queue the practice already works, so a cardiologist reviewing a heart-failure patient sees the same trend the care manager saw that morning

eClinicalWorks integration.

Because the practice's instance is cloud-hosted, the integration is configured once and reaches all ten sites without a per-site build. Integration setup posts in month 1 of the forecast, alongside implementation, and is the reason month 1 runs slightly negative.

¹⁷ The practice's patient portal host, its own employment page, and regional clinical job postings naming the practice, all retrieved 7 August 2026.

6. Clinical Governance and Escalation

The economics establish that the service line pays. This section establishes that it is safe and disciplined, which is the question a physician group asks second and a risk-bearing physician group asks first. Every reading generated by the programme routes through one escalation engine before it reaches the practice.

6.1 The escalation engine

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

6.2 The emergent pathway

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

The guarantee that makes delegation possible

CoachCare's urgent and emergent policy supersedes any practice-specific escalation preference. That is not a configurable setting. It is the reason a practice can delegate the overnight and weekend watch without inheriting the risk of having done so.

6.3 Routing, so the practice sees signal rather than noise

Escalations route three ways. Emergencies go to emergency services. Non-critical findings that require a clinical decision go to a named member of the practice's team, defined per site during protocol design. Stable, resolved events post to the record as a notification and no one is paged. The volume that reaches a cardiologist is the volume that requires a cardiologist — which is the difference between a monitoring programme that is adopted and one that is quietly ignored.

6.4 The post-discharge cadence

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

Post-discharge cadence, triggered by any emergency-room visit or hospitalization in the previous 60 days.

Continuity is governed the same way. A patient who cannot be reached is re-escalated on a fixed cadence rather than dropped, and the practice is notified at every decision point.

7. The Value Analysis

7.1 Model inputs and how the panel was sized

The panel was sized from the practice's own claims rather than from a directory. Established outpatient evaluation-and-management beneficiaries across all 47 clinicians total 23,285 patient relationships in CY2024. Because a patient seen by three clinicians appears three times, a cross-clinician deduplication factor of 0.70 gives approximately 16,300 fee-for-service patients. Dividing by the fee-for-service share of the county's Medicare population gives a total Medicare panel of approximately 39,000.

The in-scope cohort is set at 31,200 — 80% of that panel — derived bottom-up from the condition prevalence in §1.2 rather than assumed. A chart count from the practice replaces this estimate, and it is the first item on the discovery agenda in §9.

Input	Value
Total Medicare panel	39,000
Year-1 in-scope cohort	31,200
Referring clinicians	47
Programmes modelled	Remote patient monitoring and principal care management
Electronic record	eClinicalWorks, integrated
Fee-schedule locality	Florida 09102-99
On-site enrolment specialists	1, at CoachCare's expense
Monthly attrition	1.5%

Value Analysis inputs.

7.2 The 24-month forecast

	Year 1	Year 2	24 months
Practice net reimbursement	\$2,048,715	\$6,527,044	\$8,575,759
CoachCare fees	\$1,189,615	\$3,753,574	\$4,943,190
Net retained by the practice	\$859,100	\$2,773,470	\$3,632,569
Practice margin	41.9%	42.5%	42.4%

Practice economics. The 24-month practice margin is 42.4%.

Programme, 24 months	Net reimbursement	Net retained
Remote patient monitoring	\$6,518,006	\$2,854,909
Principal care management	\$2,057,754	\$987,067
Total	\$8,575,759	\$3,632,569

By programme.

Month 1 runs **\$1,469 negative**, because implementation and electronic-record integration both post in that month against a 96-patient census. The practice clears positive in **month 2** and remains positive thereafter.

A growth curve, not a plateau — and a margin-positive P&L behind it

CoachCare Value Analysis, RPM + PCM only · in-scope base 31,200 across 47 referring clinicians · MAC locality FL 09102-99

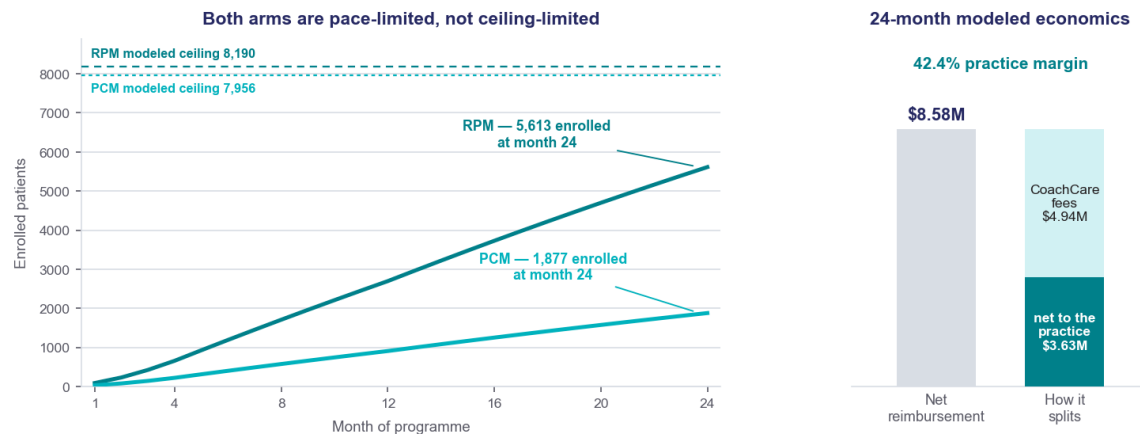


Figure 1. Enrolment ramp and monthly economics across the 24-month horizon.

Neither programme reaches its enrolment ceiling inside 24 months — the remote monitoring ceiling is 8,190 patients and the principal care management ceiling is 7,956, against a month-24 census of 5,613 and 1,877 respectively. **The constraint on this account is enrolment throughput, not eligibility.** That has a direct consequence for what moves the forecast, set out in §7.3.

What the service line produces besides revenue	24 months
Unique patients under management at month 24	6,176
Unique patients under management at month 12	2,966
Hospitalizations avoided	452
Physiologic readings captured	712,038
Care-team hours delivered	72,181
Full-time-equivalent clinical staff, without a hire	34.7

Clinical and operational output.

7.3 What moves the answer

Because the account is throughput-limited, the levers are not the ones that matter on a ceiling-limited practice.

- **Enrolment capacity is the strongest lever.** Additional enrolment specialists cannot raise a programme ceiling, but they reach the ceiling sooner, and the additional patient-months in between are real revenue. This is the direct remedy for the pattern in §2.2.
- **Cohort size matters less than it would appear.** Because neither ceiling binds inside the horizon, a larger in-scope cohort mostly extends runway beyond month 24 rather than raising the 24-month total.
- **Acceptance rates move both programmes together.** The model assumes 35% acceptance for monitoring and 30% for principal care management, applied to the eligible share of the in-scope cohort.

The avoided-hospitalization figure deserves its own sensitivity, because the model's generic 20% annual admission rate understates a targeted heart-failure cohort.

Baseline annual hospitalization rate assumed	Hospitalizations avoided, 24 months
20% — the model's generic rate, used in §7.2	452
30%	678
40% — realistic for a heart-failure cohort	904
50%	1,130

Avoided-hospitalization sensitivity. The figure carried through this report is the most conservative of the four.

8. Market Context

The practice operates in one of the oldest markets in the United States. Its four counties hold approximately 419,561 Medicare beneficiaries between them.¹⁸ Sumter County, which contains The Villages and two of the practice's sites, is 57.7% aged 65 or over; Citrus County, the practice's home county, is 36.5%.

County	Medicare beneficiaries	Medicare Advantage penetration	Practice sites
Citrus	67,210	58.25%	Inverness, Lecanto, Crystal River, Homosassa
Sumter	89,796	56.85%	The Villages, Wildwood
Lake	127,351	57.32%	Leesburg, Tavares
Marion	135,204	60.90%	Ocala

Medicare population and Medicare Advantage penetration across the practice's operating counties, April 2026.

Two implications follow from that penetration level, and both belong in the scoping conversation rather than at the end of it.

- **Contract terms.** The forecast prices the entire in-scope cohort at the fee-schedule locality rate, while roughly three in five of these beneficiaries sit inside a Medicare Advantage contract. Plans must reimburse at no less than the Medicare rate; the terms on which a given contract pays the care-management families specifically should be confirmed in contracting.
- **Attribution.** The specialty model and the shared-savings organisation both attribute traditional Medicare beneficiaries only. The fee-for-service share of the panel is what carries the model exposure, even though the fee forecast treats both populations alike.

The practice's position in this market is unusually strong. Its three named admitting partners span three counties, its ten sites cover the four-county catchment, and its 47 clinicians make it the dominant cardiology group in its home county. The Villages alone represents one of the densest concentrations of Medicare beneficiaries in the country, and the practice already has three cardiologists and two sites inside it.

¹⁸ CMS Medicare Monthly Enrollment, April 2026, filtered by state and county. American Community Survey 2024 five-year estimates for the age-65-and-over share.

9. Implementation and Roadmap

Performance year 1 of the specialty model begins on 1 January 2027. A programme that starts this quarter has a full year of documented care management behind it before the first episode is scored.

Phase	Timing	What happens
Scoping	Weeks 1–2	Chart count to replace the modelled 39,000-patient panel; the practice's own heart-failure hospitalization baseline; Medicare Advantage contract terms for the care-management families. Three answers, after which the forecast stops being a model
Configuration	Weeks 3–4	eClinicalWorks integration configured once against the practice's cloud instance; escalation thresholds, routing rules and the named clinical contact per site agreed and documented
Launch	Day 45	Enrolment specialist on site; first patients enrolled, starting with the heart-failure cohort and post-discharge patients — the population where the evidence is strongest and the specialty-model relevance is direct
Scale	Months 2–12	Roll out across the ten sites to 2,966 patients under management by month 12, and a full year of care-management documentation on the population the specialty-model episodes are built from

Implementation sequence.

One Operating System, Every Value Lever

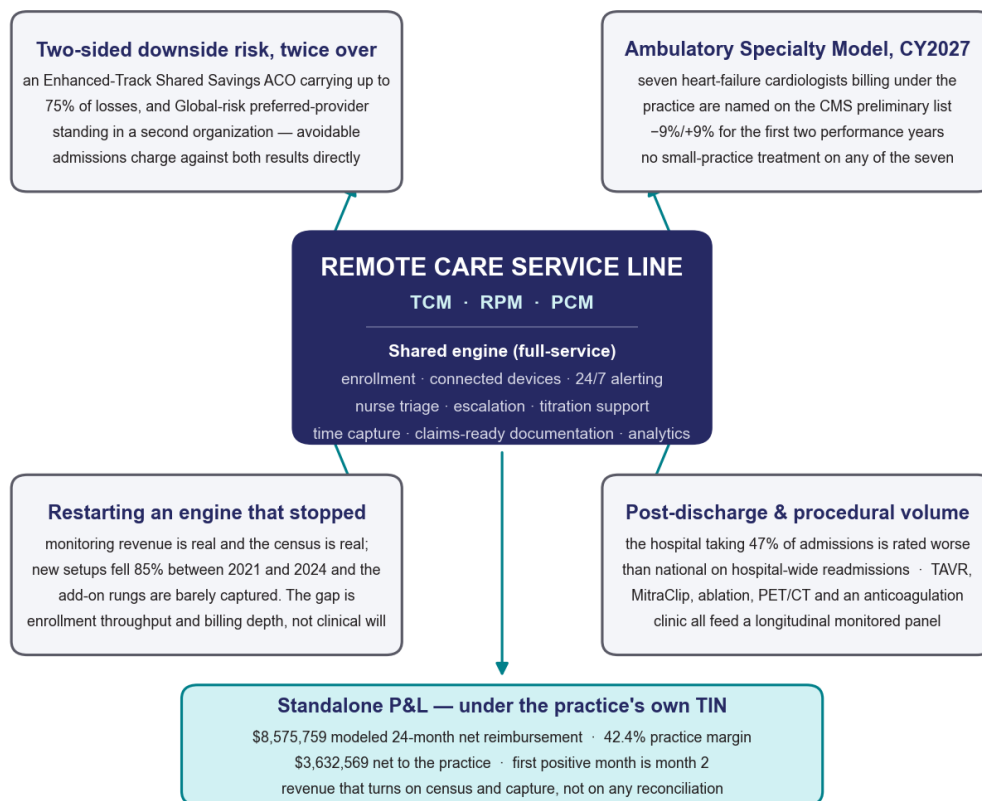


Figure 2. One service line, serving the fee-for-service P&L, the specialty-model position and the accountable-care contracts from a single infrastructure.

9.1 Discovery agenda

Four questions determine the shape of the programme, and none of them can be answered from public data.

- **What stopped the enrolment programme?** New setups fell 85% between 2021 and 2024. The answer determines whether the remedy is staffing, workflow, technology or reimbursement.
- **What is the practice's own heart-failure hospitalization baseline?** The entire cost-measure argument in §3.4 pivots on it.
- **What is the chart count?** It replaces the modelled panel and in-scope cohort.
- **Would the accountable care organisation fund care-management staffing?** The practice is its only specialist participant and the organisation publishes no care-management programme of its own.

10. Recommendations

Five recommendations follow from the analysis, in the order they should be acted on.

10.1 Restart enrolment before anything else changes

The monitoring infrastructure, the clinical conviction and the eligible population are all already in place. What is missing is the weekly function that puts patients into the programme. A CoachCare-funded on-site enrolment specialist is the direct remedy, and because the account is throughput-limited it is also the single largest lever on the forecast.

10.2 Add principal care management to the heart-failure cohort first

This is the addition that closes the revenue gap and the specialty-model attribution gap simultaneously. Starting with the heart-failure cohort concentrates the clinical benefit where admissions actually are, and it puts trigger-code volume on exactly the population the cost measure scores.

10.3 Capture the treatment-management increments already being earned

The add-on ratio in §2.3 represents work the practice's clinicians are plausibly already doing and not billing. Time tracking against each patient-month, posted through the electronic record integration, closes it without changing clinical practice.

10.4 Establish the baseline hospitalization rate and the chart count in the first fortnight

Both are inputs the practice holds and the model does not. Both materially change the argument. Neither takes long to produce.

10.5 Take the accountable-care funding question to the organisation

As the only specialty participant among twelve, and with no care-management programme published at the organisation level, the practice has a defensible claim that infrastructure serving the whole attributed population should be funded above the practice. That conversation is worth having in parallel with the practice-level decision, not after it.

The decision in front of the practice

A remote care service line built on the panel Citrus Cardiology already manages produces \$8,575,759 of net reimbursement and \$3,632,569 of retained margin over 24 months, at a 42.4% practice margin, billed under the practice's own TIN.

It does that while closing the attribution gap that would otherwise sit underneath a specialty-model designation that begins scoring on 1 January 2027, and while giving two risk-bearing organisations the post-discharge mechanism neither of them currently publishes.

The infrastructure is already half-built. The half that is missing is the half that counts.

References & Data Sources

Every figure in this report traces to one of the sources below. CMS files were queried directly rather than through an aggregator, and each query date is recorded.