COACHCARE | SERVICE LINE STRATEGY

## AMS Cardiology

An independent cardiology group in Horsham, Montgomery County, Pennsylvania: four sites, 19 cardiologists and eight nurse practitioners and physician assistants, its own outpatient surgery center, and an older, high-risk Medicare panel of about 13,000 patients

# Cardiovascular Service Line Optimization Report

### 2026 Strategy Report

A scalable, profitable remote care service line for AMS Cardiology: remote monitoring and principal care management for the Medicare cardiology panel AMS's physicians already manage, billed under AMS's own NPIs at metropolitan Philadelphia's CY2026 Medicare rates, staffed by CoachCare and run inside eClinicalWorks

**Purpose of this document**

Prepared by CoachCare, October 2026, as a discussion document for the leadership of AMS Cardiology. It is the companion to AMS's remote care strategy page and makes the same case at report length: why Medicare's payment rules make this the year, what AMS's own Medicare claims show, how the service line runs inside eClinicalWorks, what it returns over 24 months at metropolitan Philadelphia's rates, and why CoachCare is the partner to run it.

AMS already follows about 1,700 patients' implanted devices remotely, runs a nurse-led Coumadin clinic and its own intensive cardiac rehab program, and opened its own surgery center in 2024. What its claims do not show is home blood pressure and weight for the third of the panel with heart failure, monthly care management for anyone, or a call in the 30 days after discharge. This report shows what that program returns, who does the work, and how fast it can be enrolled.

**Prepared by CoachCare for discussion with AMS Cardiology. © 2026 CoachCare.**

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# Executive Summary

**AMS Cardiology** is an independent cardiology group in Horsham, Montgomery County, with 19 cardiologists and eight nurse practitioners and physician assistants across four sites: offices on Welsh Road and in North Wales, an imaging, stress-testing and cardiac rehab suite on Prudential Road, and the AMS Surgery Center, the practice's own outpatient center for catheterization and stents. eClinicalWorks runs at every site.[1]

AMS's own CY2024 Medicare claims describe the panel. Its clinicians billed for traditional-Medicare patients **averaging 77 years old, with a weighted risk score of 1.79** against a national 1.00. Hypertension and high cholesterol both sit at CMS's 75% reporting cap, ischemic heart disease runs at 47%, atrial fibrillation 39%, chronic kidney disease 37%, diabetes 35% and heart failure 33%. AMS already reads remote device transmissions for about 1,700 patients and billed about 2,260 initial hospital visits. **No remote physiologic monitoring, principal care management or transitional care management program appears at meaningful scale**.[2]

### The observation this report is built on

**A remote care service line that is margin-positive before any value-based dollar.**

AMS has the panel, the conditions, the record system and the between-visit habits: device follow-up, a Coumadin clinic and cardiac rehab. What it does not have is daily blood pressure and weight between visits, a care manager assigned to each heart-failure care plan every month, or a call in the 30 days after discharge. This service line fills that gap. CoachCare staffs it, AMS's cardiologists govern it, and it bills under AMS's NPIs from inside eClinicalWorks. Fee-for-service reimbursement alone pays for it.

AMS also carries no mandatory Medicare payment-model exposure today, so the timing is pure upside, and the practice is ready if CMS selection maps change.

## What the Value Analysis returns

| Full service line | Year 1 | Year 2 | 24 months |
|---|---|---|---|
| **Unique patients, end of period** | 960 | 2,191 | 2,191 |
| **Contribution margin** | **$247,684** | **$1,055,324** | **$1,303,008** |

*CoachCare Value Analysis: 13,000 Medicare patients, all 13,000 in scope, remote monitoring and principal care management, 27 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 Pennsylvania locality 01 amounts. Contribution margin is what AMS keeps from the service line.*

AMS can take this two ways, and both are net-positive. CoachCare can run remote monitoring on its own, with care-plan work between visits left with AMS's nurses as it runs today: **$942,725 of contribution margin over 24 months**, for 1,969 patients. Or CoachCare can run both programs across the panel, the forecast of record above, for 2,191 unique patients.

1. **Positive from month 2, with nobody hired.** Contribution margin runs slightly negative in month 1 while the program ramps; every month after is positive, and the monthly contribution margin climbs with the census to $115,560 by month 24. CoachCare delivers 24,604 care-team hours over 24 months, about 11.8 full-time-equivalent years, with 6 care managers at month 12 and 13 at month 24, at 165 patients each.

[1] amscardiology.com, locations, physicians and advanced practice pages, retrieved October 23, 2026. CMS Doctors and Clinicians, October 2026 refresh: 19 cardiologists and eight nurse practitioners and physician assistants at the practice's group enrollment; a vascular surgeon at the practice's vein clinic is not counted.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, the 25 clinicians who billed from the practice's address: average age 77; HCC risk 1.79; hypertension and high cholesterol 75% (cap); ischemic heart disease 46.7%; atrial fibrillation 38.6%; CKD 37.4%; diabetes 34.8%; heart failure 33.1%. Device patients counted once across 93296, 93297 and 93298.

2. **The binding constraint is enrollment capacity, not the size of the panel.** With one on-site enrollment specialist and 27 clinicians referring, neither program reaches its ceiling in 24 months: remote monitoring has 1,969 of its 2,438 ceiling enrolled at month 24 and principal care management 742 of 2,210. Across every panel size AMS's claims support, 11,000 to 13,800, 24-month contribution margin moves only from $1,287,590 to $1,309,176.
3. **A second on-site enrollment specialist is the largest lever.** It cannot raise the ceilings, but reaches them sooner: remote monitoring fills in month 22, and 24-month contribution margin rises from $1,303,008 to $1,831,286 (+$528,278, +41%). We recommend scoping it; the forecast of record keeps one (Section 6.5).
4. **The program lives in eClinicalWorks.** CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically, and a flagged patient reaches the first day of service in under five days (Section 4).
5. **The month after discharge is where AMS's referral relationships are measured.** In FY2026 Medicare's Hospital Readmissions Reduction Program penalized heart-failure readmissions at 8 of the 11 hospitals where AMS physicians hold privileges, including the one where most of them admit. The care team can make the two-business-day call after each cardiac discharge, so the follow-up visit AMS already schedules can qualify as transitional care, 99495 ($227.97) or 99496 ($309.15). The forecast carries no transitional care dollars.
6. **The CY2027 proposed rule takes $219,223 off the 24-month contribution margin.** A 20.6% cut to device supply leaves $1,083,786 of contribution margin over 24 months instead of $1,303,008, with enrollment held constant. Section 8 draws the cascade.

**The ask is a working session:** confirm AMS's Medicare chart count by payer, agree on the heart-failure and hypertension flag criteria, scope the eClinicalWorks integration, and set enrollment staffing for the Welsh Road and North Wales offices before the first patient enrolls.

# 1. Why Now: Medicare Pays for the Months Between Cardiology Visits

Cardiology is managed in the months between appointments. Four changes in how Medicare pays for and measures that care are arriving together, and each lands in the same place: the heart-failure patient whose weight climbs in week three, the hypertensive patient whose new agent needs a second dose change, the patient sent home from the hospital on a Friday.

| The shift | What it means for AMS |
|---|---|
| **1. From visits to panels** | Most AMS patients see their cardiologist two to four times a year, and two follow-ups leave 363 days a year with no data. Between visits a heart-failure patient's weight creeps up, a new agent leaves blood pressure above goal, and atrial fibrillation speeds up after a missed dose; the office hears at the next visit or from the emergency department. Managing a panel of about 13,000 Medicare patients means knowing which of them are trending the wrong way this week. |
| **2. The 30 days after discharge** | AMS cardiologists billed about 2,260 initial hospital visits for traditional-Medicare patients in CY2024. In FY2026 Medicare's Hospital Readmissions Reduction Program penalized heart-failure readmissions at 8 of the 11 hospitals where AMS physicians hold privileges, including the one where most of them admit[3]. A cardiology group that brings the month after discharge under control is worth more to every one of those hospitals. |
| **3. Guideline therapy as a titration process** | Therapy for heart failure with reduced ejection fraction spans four drug classes, each started low and stepped toward a target dose over several adjustments a few weeks apart, more than a visit schedule usually allows. Home blood pressure, heart rate and weight tell the cardiologist when the next step is safe, and the monthly care-management call catches the patient who stopped a drug because of dizziness or fatigue. The same loop works for resistant hypertension and for rate control in atrial fibrillation. |

[3] CMS FY2026 Hospital Readmissions Reduction Program supplemental data file (discharges July 2021 to June 2024), matched to the 11 local hospitals in the Care Compare facility-affiliation file for AMS's clinicians (October 2026).

| The shift | What it means for AMS |
|---|---|
| **4. Codes for the work between visits** | Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for shorter months such as the first weeks after an enrollment or a discharge; in this forecast they carry 17% of remote-monitoring Medicare payments.[4] Principal care management pays for care-team time with a patient whose single high-risk condition, such as heart failure, needs a disease-specific care plan. At metropolitan Philadelphia's CY2026 rates one heart-failure patient on both (99454, 99457 and 99426) is worth **$178.09 a month** in Medicare allowed charges. |

Each shift pays for, or measures, what happens between visits. A remote care service line is how AMS covers that time for every eligible patient, and remote monitoring and principal care management bill for it under Medicare fee-for-service today.

# 2. AMS Today: A Cardiology Group Built Around Its Patients

## 2.1 Four sites, 27 clinicians

| Site | What happens there | What it means for this program |
|---|---|---|
| **Welsh Road office 118 Welsh Road, Horsham** | The main office, open every weekday. Blood pressure, heart rate and weight are checked at the visit, then go unseen until the next one | A launch site. Patients flagged at the visit go home with cellular devices, and home averages are in the chart before the next appointment |
| **North Wales office Monday to Thursday** | A second office that brings AMS cardiologists closer to patients in the western part of the county | The second launch site: the same flags, devices and care team as Welsh Road, with enrollment status visible at the front desk |
| **Prudential Road 507 Prudential Road, Horsham** | Echocardiography, stress testing, nuclear imaging, PET/CT and calcium scoring, and the intensive cardiac rehab program | A reduced ejection fraction or a new valve finding becomes an enrollment flag the same day |
| **AMS Surgery Center 507 Prudential Road, Horsham** | Outpatient catheterization and stents since its first case in fall 2024, with more than 1,000 cardiac procedures by March 2026 | Patients go home after a stent with a cuff, and the care team watches blood pressure and heart rate through recovery |

*amscardiology.com, location and service pages, retrieved October 23, 2026.*

The clinical bench is 19 cardiologists and eight nurse practitioners and physician assistants. Between them they cover electrophysiology, interventional and structural cardiology, peripheral vascular disease, imaging, heart failure, preventive cardiology and lipids, and cardio-obstetrics. The advanced practice team has grown since 2021, and several of its members came from cardiac critical care.[5]

## 2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician who billed from AMS's address, 25 in all. The profile below is the traditional-Medicare panel those clinicians saw.[6]

| Panel | CY2024 | Condition | Share |
|---|---|---|---|
| **Medicare allowed** | $9,703,373 | **Hypertension** | **75% (at the cap)** |

[4] CoachCare Value Analysis for AMS Cardiology, 2026: 99445 and 99470 together, 17.2% of 24-month remote-monitoring Medicare payments.

[5] amscardiology.com physician and advanced practice biographies, retrieved October 23, 2026; CMS Doctors and Clinicians, October 2026; NPPES taxonomies.

[6] CMS by Provider (8889d81e) and by Provider and Service (92396110), CY2024, queried by NPI: 31,043 beneficiary-clinician pairs, 11,747 established-visit pairs, $9,703,373 allowed; prevalence weighted by beneficiaries.

| Panel | CY2024 | Condition | Share |
|---|---|---|---|
| **Average age** | **77** | High cholesterol | 75% (at the cap) |
| **Weighted HCC risk score** | **1.79** | Ischemic heart disease | 47% |
| **Dual-eligible share** | About 10% | **Atrial fibrillation** | **39%** |
| **Remote interrogation of implanted devices** | **About 1,700 patients** | Chronic kidney disease | 37% |
| **Echocardiograms** | About 5,930 | Diabetes | 35% |
| **Holter and mobile cardiac telemetry** | About 510 patients | **Heart failure** | **33%** |
| **Initial hospital visits** | **About 2,260** | Depression | 28% |
| **Remote physiologic monitoring, principal care management, transitional care** | No program at meaningful scale | COPD · dementia | 21% · 14% |

*CMS Medicare Physician & Other Practitioners, CY2024, 25 clinicians billing from AMS's address. Device patients are counted once across the remote-interrogation codes; echocardiograms and hospital visits are services. CMS caps published prevalence at 75%, so hypertension and high cholesterol are floors, and suppresses lines under 11 beneficiaries.*

This is the panel remote care is built for: hypertension in nearly every chart, heart failure in one patient of three, atrial fibrillation in more than a third. The forecast treats 85% of the panel as eligible for principal care management and 75% for remote monitoring. AMS sees these patients often and tests them thoroughly, but **no remote physiologic monitoring, principal care management or transitional care management program appears at meaningful scale under any AMS clinician**.[7]

## 2.3 From the 1970s to the AMS Surgery Center

| Year | What happened |
|---|---|
| **1970s** | AMS traces its cardiology practice in eastern Montgomery County back to the 1970s, and has grown with the community it serves[8] |
| **2021** | AMS begins building a team of nurse practitioners and physician assistants alongside its cardiologists; by 2026 it numbers eight |
| **2023** | AMS enrolls its own intensive cardiac rehab program with Medicare on Prudential Road, with exercise physiologists and an onsite nutrition program, so patients recover with the practice that treated them |
| **2024** | The AMS Surgery Center performs its first procedure in the fall, among the first outpatient centers in Pennsylvania to place coronary stents |
| **Today** | Four sites and 27 clinicians: more than 1,000 cardiac procedures at the surgery center, imaging and stress testing on Prudential Road, remote follow-up for about 1,700 patients with implanted devices, and offices on Welsh Road and in North Wales, all on one eClinicalWorks system |
| **Next** | **Daily readings and monthly care management for every eligible Medicare patient, run by a CoachCare care team inside eClinicalWorks and billed under AMS's NPIs** |

## 2.4 What AMS already runs, and the gap

| What exists | Status | What it means for this program |
|---|---|---|
| **eClinicalWorks, with the healow portal and app** | **Live at every site** | The program's host: flags, orders, readings, care documents and claims (Section 4) |
| **Remote follow-up of implanted devices** | **About 1,700 patients in CY2024** | Credited and kept. The transmissions report rhythm and device function; device patients with heart failure add a cuff and a scale |

[7] CMS by Provider and Service, CY2024: no remote physiologic monitoring (99453 to 99458, 99445, 99470), principal care management (99424 to 99427) or transitional care (99495, 99496) line at or above CMS's 11-beneficiary reporting floor for any AMS clinician.

[8] amscardiology.com, our-mission page, retrieved October 23, 2026.

| What exists | Status | What it means for this program |
|---|---|---|
| **Nurse-led Coumadin clinic** | More than 1,000 patients, with home INR testing[9] | The same nurse-led, between-visit model, extended to blood pressure and weight; the monthly call also confirms anticoagulant adherence |
| **Intensive cardiac rehab** | Enrolled with Medicare since 2023 | The post-discharge calls confirm the referral was made and the patient has started |
| **Imaging, stress and ambulatory rhythm monitoring** | About 5,930 echos; about 510 Holter and telemetry patients | Findings become enrollment flags; rhythm patients stay on home heart rate after the monitor comes off |
| **Remote physiologic monitoring, principal care management, transitional care** | No program at meaningful scale | Devices, daily readings, monthly care management, the post-discharge call and business-hours alert triage come from CoachCare |

The gap is specific. Device transmissions report rhythm and device function, not blood pressure or daily weight. Nothing tracks home blood pressure or weight for the third of the panel with heart failure, and nobody is assigned to the 30 days after a discharge.

### 2.5 The market, and the rate basis

Montgomery County had 194,307 Medicare-eligible residents in October 2026, and 36.72% of them were in a Medicare Advantage plan, well below the state share; 122,311 were in Original Medicare in July 2026. Most of AMS's Medicare base is fee-for-service. In the county, 18.8% of residents are 65 or older, and 27.0% of those report a disability. Among adults, 30.8% have high blood pressure and 6.7% coronary heart disease.[10]

All four sites sit in Pennsylvania locality 01, Metropolitan Philadelphia, under Novitas, the Medicare administrative contractor. Every dollar in this report is priced at those CY2026 amounts.[11]

## 3. The Service Line: Remote Monitoring and Principal Care Management

### 3.1 The clinical and billing stack

One discharge code and two monthly programs, with one enrollment conversation, one care team and one billing pipeline into AMS's own billing through eClinicalWorks. The forecast carries the two monthly programs; transitional care stays on the stack and carries no dollars.

| Program | What it does clinically | Who it fits on this panel |
|---|---|---|
| **Transitional care management (TCM)** | Contact within two business days of discharge, medication reconciliation, a visit within 14 days (99495) or 7 days at high complexity (99496) | Every cardiac patient discharged home from a hospital or observation stay. Named at $0; not in the forecast |
| **Remote physiologic monitoring (RPM)** | Cellular cuffs and scales send readings between visits against thresholds AMS's cardiologists set; 99453, 99454 or 99445, 99457, 99458, 99470 | Heart failure and uncontrolled hypertension first, then atrial fibrillation, coronary disease after a stent, and kidney disease |
| **Principal care management (PCM)** | A disease-specific care plan and at least 30 minutes of clinical staff time a month for a patient with one high-risk condition; 99426, 99427 | Heart failure, resistant hypertension, atrial fibrillation on anticoagulation |

[9] amscardiology.com, Coumadin clinic and intensive cardiac rehab pages, retrieved October 23, 2026.

[10] CMS Medicare Advantage State/County Penetration, October 2026: Montgomery County 36.72% (71,353 of 194,307). CMS Medicare Monthly Enrollment, July 2026: 122,311 in Original Medicare. American Community Survey 2020–2024 (DP02, DP05). CDC PLACES 2024 release, Montgomery County, crude prevalence.

[11] CY2026 Physician Fee Schedule, Novitas carrier 12502, Pennsylvania locality 01: geographic indices work 1.018, practice expense 1.041, malpractice 1.193; conversion factor $33.4009.

| Codes | What they pay for | CY2026 Pennsylvania locality 01 |
|---|---|---|
| **99495 · 99496** | Transitional care, visit within 14 days · within 7 days | $227.97 · $309.15 |
| **99453** | Remote monitoring setup and education, once | $22.70 |
| **99454 · 99445** | **Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)** | **$54.29 · $54.29** |
| **99457 · 99458** | Treatment management, first 20 minutes · each additional 20 | $53.63 · $42.85 |
| **99470** | **Treatment management, 10 to 19 minutes (new in CY2026)** | **$26.98** |
| **99426 · 99427** | Principal care management, clinical staff, first 30 minutes · each additional 30 | $70.17 · $56.04 |

### How the rates apply

CY2026 non-facility amounts, Pennsylvania locality 01, Metropolitan Philadelphia (Novitas, carrier 12502), ZIP 19044. One device code (99454 or 99445), one first-tier management code (99457 or 99470) and one care-management program bill for a patient in a given month; transitional care bills once per discharge alongside them. One heart-failure patient on 99454, 99457 and 99426 is $178.09 a month in Medicare allowed charges.

Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient at the Medicare amount.

## 3.2 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 6 care managers for the 960 unique patients at month 12, and 13 for the 2,191 at month 24. An on-site enrollment specialist on CoachCare's payroll works AMS's schedules beside the front desk and clinical staff and enrolls patients during the visit, telephonic outreach reaches the rest, and the cardiologists and advanced practice clinicians order from the chart. Devices are cellular, with no Wi-Fi, smartphone or pairing needed. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. in the patient's time zone, inside the hours AMS's offices keep. Patients are told at consent to call 911 for an emergency and AMS for anything urgent.

## 3.3 Transitional care after a cardiac discharge

AMS cardiologists billed about 2,260 initial hospital visits for traditional-Medicare patients in CY2024, and claims show no transitional care management at meaningful scale. The CoachCare care team can make the two-business-day contact and the medication reconciliation after each cardiac discharge AMS learns of, so the follow-up visit AMS already schedules can qualify as transitional care, furnished and billed by AMS at $227.97 (99495, visit within 14 days) or $309.15 (99496, high complexity, within 7 days). Remote monitoring and principal care management then carry the patient past day 30. The forecast carries no transitional care dollars. Where discharge notices come from, and who runs the workflow today, is item four on the confirmation list in Section 9.5.[12]

The same work is the value AMS brings to the hospitals where its physicians hold privileges, most of which Medicare penalized for heart-failure readmissions in FY2026. Each enrolled patient's referring primary-care physician can also receive a monthly summary of home readings and care-plan changes, so the practices that send patients to AMS see the work done between visits.

[12] CMS by Provider and Service, CY2024: 99221 to 99223, 2,256 services across AMS's clinicians; 99495 and 99496 below CMS's 11-beneficiary reporting floor for every AMS clinician.

### 3.4 Around procedures, and beside the device clinic

**Around a procedure.** Patients scheduled for a catheterization, a stent, an ablation or a device implant can go on blood pressure, heart rate and weight before the procedure and stay on them through recovery, with the same care team and the same chart. After a stent at the AMS Surgery Center the patient goes home with a cuff, and the care team checks blood pressure, heart rate and symptoms until the follow-up visit. The short-month codes, 99445 and 99470, cover a partial first month.

**Beside the device clinic.** AMS already follows about 1,700 patients' pacemakers, defibrillators and loop recorders remotely. Those transmissions report rhythm and device function, not blood pressure or daily weight. Adding a cuff and a scale for device patients with heart failure puts both data streams in the same eClinicalWorks chart, and the device team keeps reading the device. Who reads transmissions today, and how device patients with heart failure are co-managed, is item three on the confirmation list.

### 3.5 Two deployments, and build versus partner

AMS has already built part of the answer to build-versus-partner. It reads device transmissions for about 1,700 patients, runs a nurse-led Coumadin clinic with home INR testing, and brings patients back through its own cardiac rehab program. None of it supplies daily blood pressure and weight, monthly billable care management for the heart-failure care plan, or an assigned call after discharge across the whole eligible panel. CoachCare adds those.

| Deployment | What CoachCare runs | What stays with AMS |
|---|---|---|
| **Remote monitoring on its own** | Remote monitoring for the heart-failure, hypertension and rhythm patients | Care-plan work between visits, as AMS's nurses run it today, with home readings in the chart |
| **Full service line, RPM + PCM (the forecast of record)** | Both programs, enrolling every eligible high-risk patient into principal care management as well as monitoring | Clinical governance, the visits, transitional care billing and the patients |

- **AMS keeps clinical governance, the patients and the revenue.** Its cardiologists set thresholds, routing and discharge criteria and sign the care plans; claims go out under AMS's NPIs, and in the full service line AMS keeps $1,303,008 of contribution margin over 24 months.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims. None of it is AMS's headcount, inventory or software.
- **The device clinic and the Coumadin clinic stay as they are.** The program sits beside them and shares their chart.

## 4. eClinicalWorks: The Program Lives in the Chart

eClinicalWorks already runs at every AMS site, and patients reach the practice through its healow portal and app. CoachCare works inside eClinicalWorks' own workflows, so AMS's cardiologists, advanced practice clinicians and staff do not learn a second system. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible at every office, and a flagged patient reaches the first day of service in under five days.[13] CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically.

[13] CoachCare eClinicalWorks integration overview, 2026: the six integration pillars; patients begin remote monitoring and care management in less than five days.

## 4.1 The six integration pillars

| Integration pillar | What happens in eClinicalWorks at AMS |
|---|---|
| **Integrated enrollment** | Flags in the chart prompt the order for patients who meet criteria AMS's cardiologists set, such as heart failure on a loop diuretic, two office readings at or above 140/90, atrial fibrillation with a rate above goal, or a recent cardiac discharge |
| **Enrollment by services and devices** | The clinician orders by service and by device (cuff, scale), the way a test is ordered; the enrollment specialist can complete enrollment before checkout |
| **Exchange of health history** | Diagnoses, ejection fraction, medications, vitals and labs pass to the care team at intake; the care plan comes back to the chart |
| **Integrated vital reports** | Home readings land in the chart, so the cardiologist sees home averages and weight trends at the next visit or in the inbox |
| **Compliance documentation and care summary** | Evidence of care, vitals and the care plan attached monthly for every enrolled patient |
| **Automated claim generation** | Claims built for every patient, every month, once a code's requirements are met; AMS's billing team reconciles and files them under AMS's NPIs |

## 4.2 From a flag in the chart to a claim

1. **Flag.** A patient who meets AMS's criteria is flagged in the chart and on a worklist: at a follow-up visit, after an echo, on an outreach list, or when a discharge notice arrives.
2. **Order.** The cardiologist or advanced practice clinician orders remote care by service and device in eClinicalWorks, or the on-site enrollment specialist enrolls the patient during the visit.
3. **Device and welcome call, within five days.** Cellular devices ship ready to use. The assigned care manager calls to walk through the device and set a routine that fits the patient's day, and setup (99453) is earned.
4. **The monthly loop.** Readings land in the chart. The care manager works the care plan, logs time and routes escalations, and 99454 or 99445, 99457 or 99470, and 99426 accrue as their requirements are met.
5. **The claim.** At month end the claim is built in eClinicalWorks once a code's requirements are met: 16 reading days, 20 minutes of treatment management, 30 minutes of care management. AMS's billing team reconciles the batch in its own work queue and submits it under AMS's billing entity and NPIs.

No one builds a claim by hand, patient by patient, month by month. Over 24 months the program produces 55,185 claims and billable units in eClinicalWorks for AMS's billing team.

## 4.3 What AMS sees every month

| Report | What it shows | At month 12 in this forecast |
|---|---|---|
| **Operational outcomes for practice leadership** | Unique patients active; new enrollments; enrollments by program, office and physician; reading days per patient; escalations by route; discharges and graduations | **960 unique patients; 863 remote-monitoring and 323 principal care management enrollments** |
| **Clinical outcomes for the physicians** | Share of hypertensive patients at goal on home averages, by office and physician; heart-failure weight trends, diuretic changes and admissions; guideline-therapy steps completed; alerts by type, resolution and time to resolution | Built from the same chart data every month |
| **Claims batch for the billing team** | Claims created in eClinicalWorks for every patient whose codes were met that month | Reconciled in AMS's own work queue |

### 4.4 Build, cost and timing

The build runs alongside onboarding, so it does not hold up the first enrollments, and the eClinicalWorks version and modules AMS licenses are item five on the confirmation list. Patients who already use healow can keep using it, and nothing in the program depends on it.

## 5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so AMS never carries surveillance liability it did not agree to. Thresholds and routing are set with AMS's cardiologists, for each office, before the first patient enrolls.[14]

### 5.1 One shared escalation engine

| Branch | The rule | Why |
|---|---|---|
| **Critical value** | **Escalate to the practice, regardless of symptoms** | No practice preference can suppress it. A critical reading on its own goes to AMS, not to 911 |
| **Out of range, not critical** | Retake, then a structured symptom check | Most out-of-range readings resolve here, which keeps inboxes usable |
| **Trend** | **Three consecutive blood-pressure readings an hour or more apart; three heart-rate readings out of range within seven days; weight gain past the threshold AMS's cardiologists set for heart failure** | A confirmed trend escalates like a single threshold breach |
| **Patient unreachable** | Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend | Silence never downgrades a clinical finding |
| **Documentation** | **Six fields: vital · findings · method · contact · outcome · follow-up** | Any escalation can be reconstructed end to end |

### 5.2 The emergent pathway

#### Non-negotiable, and stated as such

**Triggers.** Chest pain · new shortness of breath · signs of stroke · fainting · worst-ever headache · sudden swelling, reported by the patient on a call.

**Action.** The care team calls 911 with the patient on the line, then notifies the AMS office. A critical reading alone, without those symptoms, goes to the office instead.

**If the patient refuses.** The office is called with the patient still on the line and directs care; if the office cannot be reached, CoachCare activates emergency services.

**The floor. CoachCare's emergent policy supersedes any practice escalation preference. This cannot be configured away.** AMS shapes routing for everything else.

### 5.3 Three-way routing, on business hours

| Route | What goes there | Who sees it |
|---|---|---|
| **Emergency** | Active emergent symptoms reported on a call | 911 with the patient on the line; the office notified |
| **Needs the practice** | A critical reading, or an out-of-range reading or trend confirmed after a retake | The clinician or nurse each office designates, in eClinicalWorks, with the readings and a recommended next step |

[14] CoachCare Care Management Programs standard operating procedures, March 2026: escalation logic, trend definitions, emergent protocol, care-management hours (Monday to Friday, 8:00 a.m. to 5:00 p.m. local patient time), post-discharge sequence and discharge governance.

| Route | What goes there | Who sees it |
|---|---|---|
| **Stable or resolved** | **Worked, retaken and resolved** | **Documented as an FYI in the chart, without paging anyone** |

The matrix is agreed for Welsh Road and North Wales separately. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, inside the hours the Welsh Road office keeps, so escalations land while AMS clinicians are working. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is AMS's own line, or 911.

## 5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence. After a hospital or observation stay it also meets the two-business-day contact that transitional care requires, and each readmission it prevents is one fewer at the hospital where the patient was treated.

| Touch | Window | What happens |
|---|---|---|
| **1 · Stabilize** | **Day 1–2** | What led to the stay; discharge medications reconciled against what is in the house; an AMS follow-up visit confirmed within 7 to 14 days |
| **2 · Detect** | **Day 5–8** | Adherence verified, weight and blood pressure trends re-checked, appointment and ordered labs confirmed |
| **3 · Secure** | **Day 12–14** | Medication and risk review, visit outcome, cardiac rehab referral confirmed where it applies, and a handoff into monthly monitoring |

For heart failure the cadence runs on daily weight and blood pressure from day two, with guideline-therapy steps scheduled while the patient is watched. After a heart attack or a stent it tracks blood pressure and heart rate while new medications settle; after an ablation or a cardioversion, rate and blood pressure.

## 5.5 Built for an older, phone-first panel

AMS's traditional-Medicare patients average 77 years old, and 27.0% of Montgomery County's residents 65 and older report a disability. The program is set up for them. Devices are cellular and arrive ready to use, with no home internet, smartphone or pairing. The welcome call, the monthly care-management call and every escalation call are made by phone, so no patient has to learn an app. Patients who already use healow can keep using it. The routine is set on the welcome call to fit the patient's day, and a missed run of readings prompts a call, not a portal message.

## 5.6 Continuity and discharge governance

1. **Unreachable patients escalate on a fixed clock.** Monitoring patients unreachable 45 days from enrollment, or 90 days without readings, go to the office as an FYI; in principal care management the first notice comes at six months without a live conversation.
2. **There is a hard backstop.** A recommended discharge goes to the office and is re-sent every 30 days; without an instruction, discharge from monitoring proceeds at 180 days, with the office notified.
3. **AMS always decides.** Discharge criteria, thresholds and routing belong to AMS's cardiologists, with the single exception of the emergent floor in Section 5.2.

# 6. Value Analysis: The 24-Month Forecast

## 6.1 The headline economics

The forecast covers remote monitoring and principal care management across a Medicare panel of 13,000, all 13,000 in scope, at the CY2026 Pennsylvania locality 01 amounts, with 27 referring clinicians and one CoachCare-funded on-site enrollment specialist at 80 enrollments a month. No transitional care or value-based payment is in these numbers.[15]

| Full service line | Year 1 | Year 2 | 24 months |
|---|---|---|---|
| **Unique patients, end of period** | 960 | 2,191 | 2,191 |
| **Contribution margin** | **$247,684** | **$1,055,324** | **$1,303,008** |

Enrollment builds through year one, so the program enters year two with 960 unique patients and ends it with 2,191. Year two returns **$1,055,324 of the $1,303,008 contribution margin**.

## 6.2 Two deployments, side by side

The full service line is the forecast of record. It adds principal care management for 742 patients at month 24, 222 of them patients the monitoring does not reach, and $360,283 more contribution margin over 24 months; avoided admissions are the same in both because they come from the monitoring.

| 24 months | Remote monitoring on its own | Full service line, RPM + PCM |
|---|---|---|
| **Contribution margin** | **$942,725** | **$1,303,008** |
| **Unique patients at month 24** | 1,969 | 2,191 |
| **Hospitalizations avoided** | About 148 | About 148 |

## 6.3 Where the patients come from

| Program | Active enrollments, month 12 | Active enrollments, month 24 | Ceiling |
|---|---|---|---|
| **Remote physiologic monitoring** | 863 | **1,969** | 2,438, not reached by M24 |
| **Principal care management** | 323 | **742** | 2,210, not reached by M24 |
| **Unique patients** | **960** | **2,191** | |

Remote monitoring is the larger program: 1,969 enrollments at month 24, still growing, and it produces the readings, alerts and avoided admissions. Principal care management reaches 742 enrollments, also still growing. The **2,710 active program enrollments at month 24 belong to 2,191 unique patients**, because most care-management patients are also monitored.

## 6.4 The ramp, month by month

Contribution margin runs −$5,567 in month 1 while the program ramps, on 23 enrollments. It is positive from month 2, with $2,378 on 55 enrollments, and cumulative contribution margin is above zero by the end of month 3. New patients join faster each month as referrals build, reaching about 149 a month by month 12, so the monthly contribution margin climbs every month: neither program reaches its ceiling, and both keep adding patients through month 24, when it is $115,560 a month. At month 12 the program

[15] CoachCare Value Analysis for AMS Cardiology, 2026, the source of all Section 6 figures; sensitivity runs change one input at a time on the same workbook.

holds 1,187 active program enrollments across 960 unique patients, and cumulative contribution margin passes $35,825 at month 6, $247,684 at month 12 and $1,303,008 at month 24.

| Month | Active enrollments | Monthly contribution margin | Cumulative contribution margin |
|---|---|---|---|
| **M1** | 23 | **−$5,567** | −$5,567 |
| **M2** | 55 | $2,378 | −$3,190 |
| **M3** | 106 | $4,628 | $1,439 |
| **M6** | 357 | $15,516 | $35,825 |
| **M12** | 1,187 | $51,060 | $247,684 |
| **M18** | 2,018 | $86,248 | $680,327 |
| **M22** | 2,494 | $106,378 | $1,076,410 |
| **M24** | 2,710 | **$115,560** | **$1,303,008** |

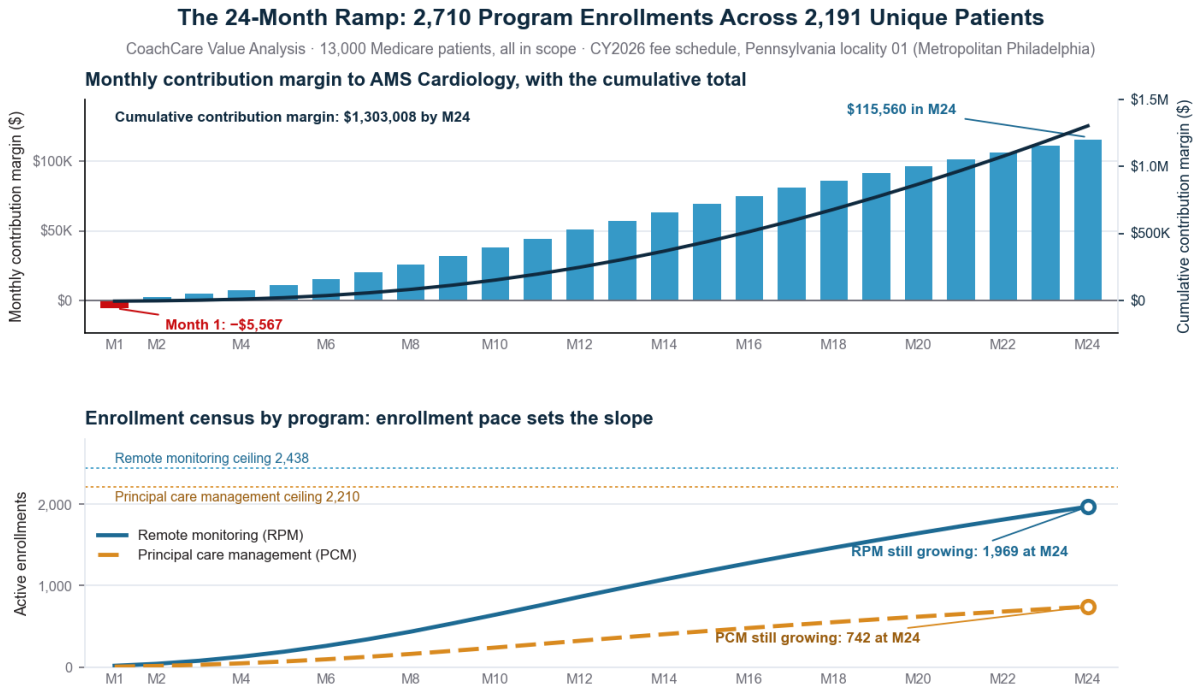



*Figure 1. Monthly contribution margin, with cumulative contribution margin, and the enrollment census by program: both programs are still growing at month 24, below their eligible ceilings. CoachCare Value Analysis, full service line.*

## 6.5 Enrollment capacity sets the pace

| Program | Eligible share of the 13,000 in scope | Acceptance | Ceiling | Reached |
|---|---|---|---|---|
| **Remote physiologic monitoring** | 75%, 9,750 patients | 25% | **2,438** | **Not by M24 (1,969 enrolled)** |
| **Principal care management** | 85%, 11,050 patients | 20% | **2,210** | **Not by M24 (742 enrolled)** |

### Say the constraint out loud

At a Medicare panel of about 13,000, enrollment capacity sets the pace, not panel size. One on-site specialist, 27 referring clinicians and telephonic outreach take remote monitoring to 1,969 of its 2,438 ceiling and principal care management to 742 of its 2,210 by month 24. A second on-site enrollment specialist cannot raise the ceilings, but reaches them sooner: remote monitoring fills in month 22, and 24-month contribution margin rises from $1,303,008 to $1,831,286 (+$528,278, +41%). A third specialist reaches $2,094,960. The forecast holds new enrollment to what one care team can onboard well: no more than 1,500 new patients a year. With no on-site specialist the forecast falls to $746,748.

**The second specialist is a recommendation to scope.** The forecast of record keeps one. The Medicare chart count is still confirmation item one, because it sets both ceilings.

Panel size moves this forecast far less than enrollment capacity does. Across 11,000 to 13,800 patients, the panel sizes AMS's claims support, 24-month contribution margin moves by $21,586; a second specialist adds $528,278 at the same 13,000. Referring clinicians are the other pace lever: the 19 cardiologists alone return $1,108,452, 24 clinicians $1,230,050 and 30 clinicians $1,375,967. Each run changes one input, and principal care management reaches its ceiling in none.[16]

| Scenario | 24-month contribution margin | Unique patients at M24 | RPM ceiling reached |
|---|---|---|---|
| **Base: panel 13,000, all in scope, 27 clinicians, one enrollment specialist** | **$1,303,008** | **2,191** | **Not by M24** |
| **No on-site enrollment specialist** | $746,748 | 1,300 | Not by M24 |
| **A second on-site enrollment specialist** | **$1,831,286** | **2,776** | **M22** |
| **A third on-site enrollment specialist, held to 1,500 new patients in year one** | $2,094,960 | 2,880 | M18 |
| **Panel 11,000, all in scope** | $1,287,590 | 2,168 | Not by M24 |
| **Panel 13,800, all in scope** | $1,309,176 | 2,200 | Not by M24 |
| **Panel 13,000 with 60% in scope (7,800)** | $1,194,304 | 1,681 | M19 |
| **The 19 cardiologists referring alone** | $1,108,452 | 1,850 | Not by M24 |
| **24 referring clinicians** | $1,230,050 | 2,063 | Not by M24 |
| **30 referring clinicians** | $1,375,967 | 2,319 | Not by M24 |

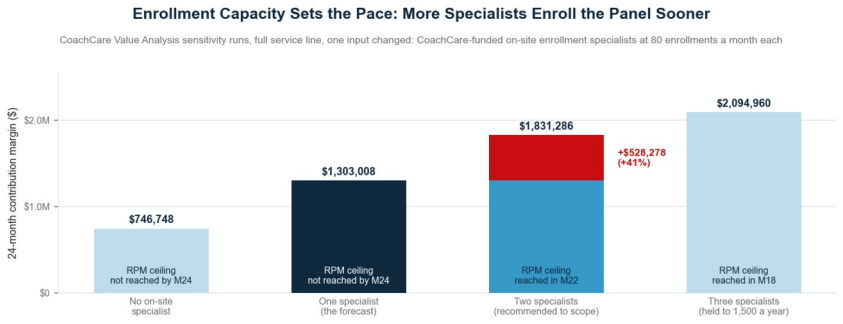



*Figure 2. 24-month contribution margin with zero to three CoachCare-funded on-site enrollment specialists, the month remote monitoring reaches its ceiling in each run, and the second specialist's addition in red. CoachCare Value Analysis sensitivity runs.*

[16] Established-visit pairs for the 25 clinicians billing from AMS's address (11,747), de-duplicated at 70% and grossed up for the county's Medicare Advantage share: 12,994.

## 6.6 What the program produces clinically and operationally

| Output over 24 months | Volume | What it represents |
|---|---|---|
| **Physiologic readings received** | **233,447** | Blood pressure, heart rate and weight values arriving between visits |
| **Claims and billable units** | **55,185** | Created in eClinicalWorks for AMS's billing team |
| **Care-team hours** | **24,604** | **About 11.8 full-time-equivalent years of work AMS does not employ**: 110,371 care-management tasks and 16,556 patient conversations over 920 hours of call time |

*24-month totals, full service line. The program also avoids about 148 hospitalizations at the workbook's 20% annual admission rate; at a 40% annual admission baseline, realistic for a heart-failure-heavy panel with an average risk score of 1.79, it is about 296.*

## 6.7 Published results from CoachCare cardiology programs

- **Blood pressure, in West Phoenix.** Cardiac Solutions, a physician-owned cardiology practice with three West Phoenix offices, put 2,738 patients on CoachCare remote monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.[17]
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.[18]
- **Heart failure, at Iowa Heart.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.[19]

# 7. Quality: The MIPS Measures This Program Works On

AMS's clinicians are MIPS-eligible as a group for the 2026 performance year, so every Medicare Part B payment they receive two years later moves with the quality score. Five cardiology quality measures depend on work this program does every month.[20]

| Measure | What it counts | What the program does each month |
|---|---|---|
| **Q236 Controlling high blood pressure** | Hypertensive patients whose latest blood pressure is under 140/90 | Home averages give an accurate reading of control and a monthly chance to act on it; the documented status reflects home data, not one rushed office reading |
| **Q005 Heart failure: ACE inhibitor, ARB or ARNI for reduced ejection fraction** | Patients with reduced ejection fraction prescribed one of these agents | Principal care management tracks where each patient sits on guideline therapy, and home blood pressure and weight show when the next dose step is safe |
| **Q008 Heart failure: beta-blocker for reduced ejection fraction** | Patients with reduced ejection fraction prescribed a beta-blocker | Heart rate and blood pressure from the cuff show whether the dose can go up; the care manager catches the patient who stopped it because of fatigue |
| **Q326 Atrial fibrillation and flutter: chronic anticoagulation** | Patients at high stroke risk prescribed an anticoagulant | The monthly call confirms the anticoagulant is taken and refilled, flags bleeding or a missed lab, and routes a patient who stopped to the cardiologist |

[17] Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.
[18] Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.
[19] Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.
[20] CMS Quality Payment Program participation status, 2026 performance year, queried by NPI for AMS's clinicians: MIPS-eligible at the group level.

| Measure | What it counts | What the program does each month |
|---|---|---|
| **Q243 Cardiac rehabilitation referral from an outpatient setting** | Eligible patients after a heart attack, a stent, bypass or valve surgery referred to cardiac rehab | The post-discharge calls confirm the referral was made and the patient has started, and document it in the chart |

With hypertension in nearly every AMS Medicare chart, Q236 covers most of the panel. With heart failure in one patient of three, the two heart-failure measures move with each titration step, and AMS's own cardiac rehab program makes Q243 a referral the practice can complete inside its own walls.

# 8. Policy Watch: The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at Pennsylvania locality 01 on AMS's own billing mix, with enrollment held constant.[21]

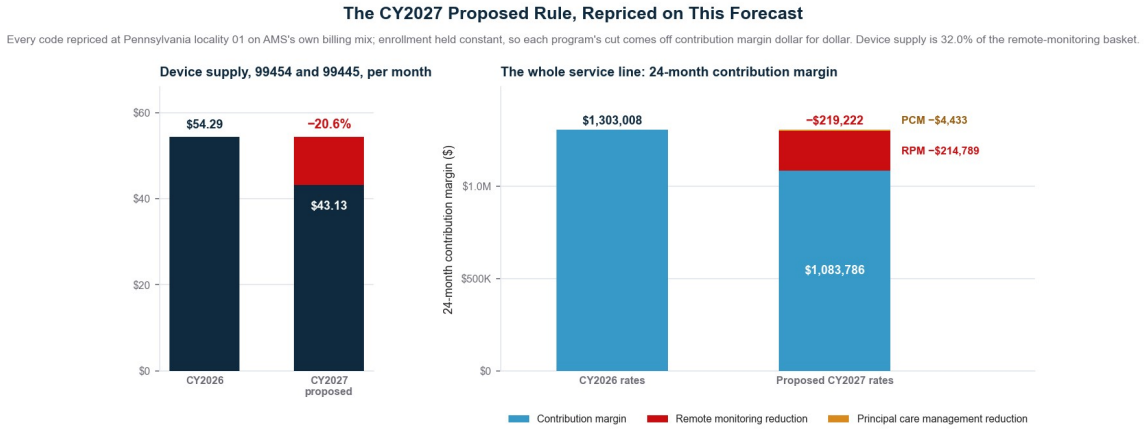



*Figure 3. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the 24-month contribution margin of the whole service line at CY2026 and proposed CY2027 rates, with the reduction from each program shown. Enrollment held constant.*

| Level | CY2026 rates | Proposed CY2027 rates | What changes |
|---|---|---|---|
| **Device supply, 99454 and 99445** | $54.29 a month | **$43.13 a month, −20.6%** | The code CMS proposes to cut |
| **Remote monitoring arm, change in contribution margin** | | **−$214,789** | Device supply is 32.0% of the remote monitoring basket |
| **Principal care management, change in contribution margin** | | −$4,433 | Routine rate changes only (−0.6%); not targeted |
| **Whole service line, 24-month contribution margin** | **$1,303,008** | **$1,083,786 (−$219,223)** | Enrollment held constant, so the repricing passes through dollar for dollar |

[21] CMS-1848-P, published July 2026. CoachCare repricing at Pennsylvania locality 01, conversion factor $32.8409 against $33.4009: device supply 32.0% of the remote monitoring basket; remote monitoring 74.3% of the line.

With enrollment held constant, every dollar of repricing comes off contribution margin: $214,789 from remote monitoring and $4,433 from principal care management, which barely moves, leaving $1,083,786 over 24 months. Section 1848(c)(7) of the Act limits how far a code's relative value can fall in one year. CoachCare will rerun the forecast at the final rates before AMS commits to anything.

# 9. Implementation Roadmap

## 9.1 Who runs what

| Function | CoachCare | AMS Cardiology |
|---|---|---|
| **Identification and enrollment** | Registry query in eClinicalWorks starting with heart failure and uncontrolled hypertension; an on-site enrollment specialist at 80 enrollments a month; telephonic outreach; devices shipped, cellular-connected and replaced | Approves the flag criteria and target list; clinicians order at the follow-up visit, after an echo or after a procedure |
| **Transitional care** | Two-business-day contact and medication reconciliation after each cardiac discharge AMS learns of; visit booked inside the 7- or 14-day window | Furnishes the visit and bills 99495 or 99496 |
| **Monitoring and escalation** | Reading review, monthly outreach, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager | **Sets thresholds and routing for each office; receives escalations** |
| **Device clinic and Coumadin clinic** | Adds a cuff and a scale for device and anticoagulation patients who qualify; never reads device transmissions | Keeps reading devices and managing INR as today |
| **Documentation, billing, reporting** | Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports | **Reconciles and files under its own NPIs; keeps the revenue; names a program lead** |

## 9.2 The model inputs

| Input | Value in this forecast |
|---|---|
| **Medicare panel** | **13,000 patients, all 13,000 in scope; all payers** |
| **Referring clinicians** | 27: 19 cardiologists and eight nurse practitioners and physician assistants |
| **Programs** | Remote monitoring and principal care management; transitional care named at zero dollars |
| **Eligibility and acceptance** | Remote monitoring 75% eligible, 25% accept; principal care management 85%, 20%; 5 referrals per clinician a month at 70% acceptance; 70% of care-management patients also monitored; 3% monthly attrition; referrals and on-site enrollment build to full pace over the first 12 months |
| **Enrollment staffing** | One CoachCare-funded on-site enrollment specialist at 80 a month, plus telephonic outreach |
| **EMR** | eClinicalWorks, integrated as described in Section 4 |
| **Rates** | CY2026 fee schedule, non-facility, Pennsylvania locality 01, ZIP 19044; every patient priced at the Medicare amount |

## 9.3 Enrollment staffing for Welsh Road and North Wales

The forecast carries one CoachCare-funded enrollment specialist across AMS's offices, alongside telephonic outreach and the clinicians' own orders at the visit. At that pace neither program reaches its ceiling in 24 months. The option worth scoping is a second specialist, one stationed at Welsh Road and one covering North Wales and the Prudential Road schedules, so every follow-up visit, echo and post-stent check has someone in the building to enroll the patient that day. It costs AMS nothing in staff, fills remote monitoring in month 22, and adds $528,278 of contribution margin over 24 months. The care-management staffing at 165 patients each grows with it.

### 9.4 The first 90 days, and after

| Window | What happens | Result |
|---|---|---|
| **Weeks 0–6 Integrate and charter** | eClinicalWorks workshop with the practice and billing leads; chart counts and payer mix; today's discharge workflow and the device clinic mapped; thresholds, routing and the enrollment staffing plan agreed | Integration live, protocol signed, staffing decided |
| **Weeks 6–12 Launch at Welsh Road and North Wales** | Enrollment at both offices from the first week; remote monitoring and principal care management for heart failure and uncontrolled hypertension; the post-discharge cadence live | 23, 33 and 52 new enrollments in months 1 to 3 |
| **Months 3–12 Build the census** | Same protocols; atrial fibrillation, post-stent and device patients with heart failure added; care managers added as the census grows | 1,187 enrollments, 960 unique patients at month 12 |
| **Months 13–24 Grow toward the ceilings** | Remote monitoring grows to 1,969 of its 2,438 ceiling and principal care management to 742 of 2,210; transitional care volume reviewed with AMS | Year 2: $1,055,324 of contribution margin |

Remote monitoring and principal care management carry Part B coinsurance, so the consent conversation explains the monthly cost plainly before the device ships.

### 9.5 What we would confirm together

1. **The Medicare chart count, by payer and office.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry heart failure, hypertension or atrial fibrillation. It sets both ceilings in Section 6.
2. **The heart-failure and hypertension flag criteria.** Ejection fraction, diuretic use, recent admissions and office readings: the rules that put a patient on the worklist.
3. **The device clinic.** Who reads device transmissions today, and how device patients with heart failure are co-managed with a cuff and a scale.
4. **Transitional care today.** Who runs the discharge workflow, where discharge notifications come from, and how many cardiac discharges a year reach the practice in time for the two-business-day contact.
5. **The eClinicalWorks version and modules.** The version, the healow and care-management modules licensed, and any device connection already in place.
6. **The billing practitioner.** Who bills remote monitoring and principal care management for patients the nurse practitioners and physician assistants manage, and the supervision workflow that goes with it.
7. **Coinsurance at consent.** How the monthly Part B coinsurance is explained at enrollment, and who answers billing questions afterwards.

## 10. Recommendations

1. **Launch the full service line at Welsh Road and North Wales together.** $1,303,008 of contribution margin over 24 months, positive from month 2, with nobody hired.
2. **Scope a second on-site enrollment specialist.** Enrollment capacity sets the pace at this panel size: a second specialist fills remote monitoring in month 22, which one specialist does not do in 24 months, and adds $528,278 of contribution margin.
3. **Pull the Medicare chart count by payer in week one.** It sets both ceilings.
4. **Start with heart failure and uncontrolled hypertension.** A cellular scale and cuff for the readings, principal care management for the care plan, and the follow-up visit or the echo as the enrollment conversation.

5. **Put the 30 days after discharge on the care team.** CoachCare makes the two-business-day call after every cardiac discharge AMS learns of; AMS bills 99495 or 99496.
6. **Pair physiologic data with the device clinic.** Device patients with heart failure add a cuff and a scale, in the same chart.
7. **Aim the monthly work at the five MIPS measures, and report it outward.** About 148 admissions avoided over 24 months, and a monthly summary to every referring primary-care physician.
8. **Keep clinical governance where it is.** AMS's cardiologists decide; CoachCare does the work and documents it.

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The Medicare panel AMS already manages supports a service line that returns $1,303,008 of contribution margin over 24 months, on staff AMS does not hire and devices it does not buy, before any value-based dollar. How fast it gets there depends on enrollment capacity, which is CoachCare's to supply.

# About CoachCare

> **The experience to get it right**
>
> CoachCare manages more than 500,000 patients across over 400 conditions, with more than 10,000 clinicians running remote care programs on its platform day to day. Its teams have stood up more than 1,000 programs, built the care-plan coding and billing behind more than 5 million claims, and recorded over 100 million vitals.

- **It builds on what AMS already does.** AMS reads implanted-device transmissions for about 1,700 patients, runs a nurse-led Coumadin clinic with home INR testing, and brings patients back through its own cardiac rehab program. Remote monitoring and principal care management apply the same between-visit discipline to blood pressure, weight and the heart-failure care plan.
- **It runs inside the chart AMS already uses.** Readings, documentation and claims live in eClinicalWorks, and enrollment status is visible at every office.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll, with no capital outlay.
- **Cardiologists stay in charge.** AMS's physicians and advanced practice clinicians set the protocols, sign the care plans and make every clinical decision. Claims go out under AMS's own billing entity and NPIs.
- **Designed for an older panel.** Cellular devices with nothing to pair, and outreach by phone, so no patient has to learn an app.
- **Published cardiology results.** A 29.1 mmHg drop in Stage 2 hypertension across 2,738 patients at Cardiac Solutions, half the 30-day readmission rate across 26,689 patients at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session to confirm AMS's Medicare chart count by payer, agree on the heart-failure and hypertension flag criteria, scope the eClinicalWorks integration, and set enrollment staffing for the Welsh Road and North Wales offices before the first patient enrolls.

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**Prepared by CoachCare for discussion with AMS Cardiology. © 2026 CoachCare.**

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- **Market:** CMS Medicare Advantage State/County Penetration, October 2026; CMS Medicare Monthly Enrollment, July 2026; American Community Survey 2020–2024; CDC PLACES, 2024 release.
- **CoachCare:** eClinicalWorks integration overview, 2026; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for AMS Cardiology, 2026, the source of every financial, enrollment, clinical-output and operational figure in Sections 6 to 10.


**Unique patients and program enrollments are different numbers.** At month 24 the program holds 2,710 active program enrollments belonging to 2,191 unique patients, because a patient may hold both a care-management and a monitoring enrollment. The 13,000-patient panel covers every AMS office and all payers; the CY2024 claims profile is traditional Medicare only.