COACHCARE | SERVICE LINE STRATEGY

Okaloosa Heart & Vascular Center

Okaloosa Cardiology, P.A. · Crestview, Fort Walton Beach, Niceville and Destin, Florida — an independent, physician-owned cardiology group

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as the operating spine for heart failure population management, readiness for two mandatory CMS models, 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 Okaloosa Cardiology, P.A. It assembles the practice's public footprint, its CY2024 Medicare service record, its verified position relative to two mandatory CMS models, the county's cardiovascular outcome and utilization data, the 2026–2027 payment environment, and a modeled financial forecast into a single argument: this group already operates a remote-monitoring workflow at industrial scale, and the physiologic layer sitting directly beside it — the one CMS pays for separately, and the one that determines what happens between visits and after discharge — is currently neither staffed nor billed.

All facts are drawn from public sources current to August 2026 and cited in the References section. All financial projections are illustrative and modeled in the CoachCare Value Analysis (MAC locality auto-resolved for ZIP 32539 — Florida, locality 09102-99) — verify against practice data before budgeting.

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

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Executive Summary

Okaloosa Heart & Vascular Center is the trade name of **Okaloosa Cardiology, P.A.**, an independent, physician-owned Florida professional association headquartered at 129 East Redstone Avenue in Crestview, with additional offices in Fort Walton Beach, Niceville and Destin. CMS reassignment records current to July 1, 2026 show **19 providers billing under the group's own Medicare group-practice enrollment — 12 physicians and 7 nurse practitioners**.[1] The physician bench includes four electrophysiologists, three clinicians whose primary NPPES taxonomy is interventional cardiology, and five in general cardiovascular disease. The group holds its own organizational NPI and PECOS group enrollment; no provider in it reassigns benefits to a hospital system, and no management-services organization or private-equity sponsor appears in any public source. It is, in the most literal sense, still its own company.

Three facts define this report, and all three come from the group's own CY2024 Medicare claims record.

1. **The billable care-management layer is empty.** Every one of the 19 reassigned NPIs was queried individually against the full remote physiologic monitoring, remote therapeutic monitoring, chronic care management, principal care management and transitional care management code sets. **Zero services on every code, for every provider.**[2]
2. **The remote-monitoring layer, by contrast, is already running at industrial scale.** In the same year the group billed roughly **$366,000 of remote cardiac device monitoring** — approximately 999 beneficiaries on remote pacemaker interrogation (93294), 522 on remote defibrillator interrogation (93295), 1,285 on remote rhythm and loop-recorder monitoring (93298), and **558 on implantable hemodynamic monitors (93297)** — across seven physicians.[3] A practice doing that has device technicians, a triage inbox, an alert-review protocol and documented remote-monitoring habits. **It already runs the hardest part of a remote care program.**
3. **Two mandatory CMS models are already live around it.** Three of the group's clinicians are **named on the CMS preliminary CY2027 participant list for the Ambulatory Specialty Model**, Heart Failure cohort, under the organization's legal name. Separately, **both hospitals the group admits to are mandatory TEAM participants** — CCN 100223 and CCN 100054, CBSA 18880 — with a performance period running January 1, 2026 to December 31, 2030.[4] The practice itself holds no CCN and is not a TEAM participant; its hospital partners are.

[1] CMS Revalidation Clinic Group Practice Reassignment file (revalidation_clinic_group_practice_reassignment_pa_xref.csv), data vintage July 1, 2026, dataset modified July 14, 2026; exact match on the group legal business name, all rows carrying group PECOS associate ID 7315920899. NPPES taxonomy retrieved per NPI, August 3, 2026.

[2] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024 (released May 21, 2026). All 19 NPIs queried individually against 99453, 99454, 99457, 99458, 99091; 98975-98981; 99490, 99439, 99491, 99437, 99487, 99489; 99424-99427; G0511; 99495, 99496; and G0506. Zero services on every code, for every provider.

[3] Same file and vintage: CPT 93294, 93295, 93297, 93298 and 93268/93229, aggregated across the seven physicians with in-market CY2024 billing. Counts are beneficiary instances per code per provider and contain duplication across providers; they are not unique-patient counts.

[4] CMS Ambulatory Specialty Model Participants, file CY27_Prelim_ASMParticipants_Public.csv (CY2027 PRELIMINARY; dataset modified February 4, 2026; retrieved August 3, 2026) - three Heart Failure cohort NPIs under the organization legal name. No final CY2027 list existed in the CMS catalog as of the retrieval date. TEAM: CMS TEAM Participant List, hospital list as of April 15, 2026, CCN 100223 and CCN 100054, CBSA 18880, mandatory, performance period January 1, 2026 to December 31, 2030; CMS updates the list quarterly.

The central argument

1. Standalone value. TCM + RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based upside — modeled at **$4,685,339** of net reimbursement and **$1,986,060** net to the practice over 24 months, a **42.39% practice margin** (net to the practice ÷ net reimbursement). Illustrative, modeled — verify against practice data.

2. Connective tissue. One shared engine — enrollment, connected devices, 24/7 alerting and triage, nurse navigation, billing capture and analytics — simultaneously serves the CY2027 Ambulatory Specialty Model Heart Failure cohort, the hospitals' TEAM episode performance, procedural throughput in structural heart and electrophysiology, readmission and quality defense, and the standalone P&L. Build once, use everywhere.

The clinical case is unusual, and it needs stating precisely, because the obvious version of it is wrong. Okaloosa County sits in the **bottom decile of Florida counties on measured cardiovascular prevalence** — coronary heart disease 6.1% against a Florida county median of 8.6%, hypertension 32.7% against 39.2%, diabetes 10.8% against 14.3%. Yet the county runs *above* the state on cardiovascular mortality (heart disease **307.4 per 100,000 against 266.9 for Florida**), above state and national on 30-day acute readmissions (**19.54% against 18.89% for Florida and 18.07% nationally**), and above both on emergency-department use. Inpatient stays per 1,000 are *below* the Florida rate while readmissions are above it.[5] A population that looks healthier on paper, is admitted less often, and is nonetheless readmitted more often and dies of heart disease more often is not describing a disease-burden problem. **It is describing a detection, follow-up and transition problem** — which is precisely the gap that transitional care, remote physiologic monitoring and principal care management close. Do not read this as a claim about disease burden; the prevalence data will not support that, and a physician audience would know it immediately.

The market backdrop is favourable in a way that is easy to miss. Okaloosa County's Medicare Advantage penetration is **34.8% against 57.2% for Florida** and 51.2% nationally — the least MA-penetrated county in the Florida Panhandle by a wide margin, and a ~22-point gap to the state.[6] The mechanical explanation is the county's very large military-retiree population: TRICARE For Life functions as a wraparound secondary to Original Medicare and gives retirees little reason to trade fee-for-service freedom for a Medicare Advantage network. Because TCM, RPM and PCM are fee-for-service benefits, their economics work best exactly where the fee-for-service pool is deep — and here it is deep, and it is not eroding: Original Medicare enrollment in the county has been essentially flat since 2021 (31,085 to 30,421) while total Medicare enrollment grew 11% and Medicare Advantage absorbed nearly all of the growth. The direct answer to “won't Medicare Advantage eat this?” is that in this county it demonstrably has not.

The timing is specific. The CY2026 Physician Fee Schedule expanded remote monitoring in ways that suit a cardiology group that works inside hospitals: **99445** pays the monthly device-supply amount for 2–15 days of data where 16 or more were previously required, which makes short post-discharge and post-procedure windows billable for the first time, and **99470** pays for the first 10 minutes of monthly management time where the floor had been 20. TEAM began January 1, 2026. The Ambulatory Specialty Model begins January 1, 2027. A service line chartered in late 2026 is operating at census before the first ASM performance year opens.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **10,740-patient in-scope Medicare base across 19 billing providers** — *a discovery-stage estimate to validate against the practice's own chart counts* — with RPM and PCM only. It projects net reimbursement of **$1,152,701** in Year 1 and **$3,532,637** in Year 2 (**$4,685,339** over 24 months — RPM $3,475,286, PCM $1,210,053);

[5] CDC PLACES county estimates (resource swc5-untb, 2025 release, BRFSS survey year 2023) for prevalence; CDC heart disease and stroke mortality (resources mri7-5jtw and y5ii-knwc), 2022-2024 three-year average, age-adjusted, adults 35+; CMS Medicare Geographic Variation by County, CY2024 (updated May 15, 2026) for readmissions, emergency visits and inpatient stays per 1,000.

[6] CMS Medicare Advantage State/County Penetration file, July 2026, cross-validated against CMS Medicare Monthly Enrollment through April 2026 (dataset modified July 23, 2026), queried on county FIPS 12091.

$1,986,060 net to the practice after CoachCare fees; 380,017 physiologic readings; approximately **241 avoided hospitalizations**; and 39,820 care-team hours delivered, about **19.1 full-time equivalents** of clinical labour the practice does not have to hire. Month 1 is modeled at −$2,188 and every month from month 2 onward is net-positive. *All figures are illustrative, modeled — verify against practice data.*

2026–2027 Priority Recommendations

1. **Charter the Remote Care Service Line as a named program with its own P&L.** TCM at discharge, then RPM, then PCM, across heart failure, uncontrolled and resistant hypertension, post-ablation and post-device-implant windows, and post-structural-heart recovery. Name a physician lead and pair them with the practice's administrative lead on operations. Target the first billable enrollment within 90 days.
2. **Start with the heart failure cohort, because two clocks are running on it.** The 558 beneficiaries on implantable hemodynamic monitors in CY2024 are an already-identified, already-remotely-managed heart failure population, and heart failure is the cohort in which three of the group's clinicians appear on the CMS preliminary CY2027 Ambulatory Specialty Model participant list. Re-verify that list against the final CY2027 file when CMS publishes it (Section 5).
3. **Bill the transitional-care window the group already generates.** Roughly 2,194 initial-hospital-care beneficiaries in CY2024, and no transitional care management billed against any of them. TCM is deliberately excluded from every financial figure in this report so the forecast stays conservative — which makes it a separate, additive decision the practice can take on its own merits (Sections 2.1 and 6).
4. **Open the TEAM conversation with the hospitals rather than waiting to be asked.** Both admitting hospitals entered mandatory 30-day episode accountability on January 1, 2026, and so did every other hospital in CBSA 18880. The clinicians who determine what happens in those 30 days sit outside the entity carrying the risk. That is leverage, and it is perishable (Section 6).
5. **Confirm the EMR before scoping any integration.** The branded patient portal is consistent with a Veradigm ambulatory EHR but does not prove one, because that portal product is sold standalone and can sit on other vendors' systems. Section 8 is written conditionally for exactly this reason.
6. **Write the attribution policy before the first enrollment.** The practice owns transitional care at discharge and RPM plus PCM on the cardiac condition; the referring primary-care physician owns any longitudinal primary-care wrapper; one shared care plan, with explicit task ownership. This prevents duplicate-billing denials and referral friction, and it is also the substrate for the collaborative care arrangement the Ambulatory Specialty Model requires (Sections 2.1 and 5).

1. Footprint & Operating Model

1.1 The practice

The legal entity is **Okaloosa Cardiology, P.A.** — a Florida professional association whose corporate record indicates continuous activity since a 1991 filing, with Medicare group enrollment recorded in 2004 and the practice domain registered in March of that year. The trade name “Okaloosa Heart & Vascular Center” carries no separate legal registration, so contracting documents should name the P.A. The organizational NPI is 1144270240 and the PECOS group associate ID is 7315920899; the provider type on file is Part B supplier, clinic/group practice, State of Florida.[7]

Office	Address	Status in CMS data
Crestview (main)	129 E. Redstone Ave, Suite A, Crestview, FL 32539	Corroborated — multiple providers billed Medicare from this address in CY2024. RUCA 2, the least urban of the four sites
Fort Walton Beach	1032 Mar Walt Dr, Unit 110, Fort Walton Beach, FL 32547	Corroborated — adjacent to the HCA hospital campus at 1000 Mar Walt Dr
Niceville	552 Twin Cities Blvd, Suite A, Niceville, FL 32578	Corroborated in submarket; a different Niceville street address appears in the CY2024 billing file — relocation or second site, worth confirming
Destin	36468 Emerald Coast Pkwy, Suite 1101, Destin, FL 32541	Advertised but not visible as a Medicare-registered practice location in CY2024. A 2026 job posting describes a clinical assistant rotating between Niceville and Destin, which is consistent with a part-time satellite billing to another site's address

Roster, counted from CMS rather than from the website. The practice's own provider page lists five physicians and a widely used commercial firmographic file reports eleven. Both undercount. The authoritative count is the set of providers who reassign Medicare benefits to the group's PECOS group associate ID: **19 providers — 12 physicians and 7 nurse practitioners**, as of the July 1, 2026 file.[8] Stated as a caveat rather than glossed over: reassignment records capture reassignment relationships, so they can lag a departure and will miss a hire made after the snapshot. Treat 19 as the best available upper bound and confirm the live roster in discovery.

Sub-specialty mix, confirmed by procedure evidence rather than by claim. Interventional cardiology is confirmed by coronary stent (92928) and left-heart catheterisation with coronary angiography (93458) volume. **A genuine structural heart programme is confirmed by 84 percutaneous left atrial appendage occlusion procedures (33340) in CY2024 across three operators** — that is procedure data, not a marketing claim. **Four electrophysiologists** is the single most distinctive structural fact about this group; a four-EP bench in a market this size is disproportionate, and it is corroborated by atrial-fibrillation ablation (93656) and pacemaker implant (33208) billing. Non-invasive imaging is the second-largest line in the practice: complete transthoracic echocardiography with Doppler (93306) covered 8,006 beneficiaries and roughly $740,000 of allowed charges in CY2024, with substantial nuclear cardiology alongside it. Vascular work is present but modest relative to cardiac — carotid and venous duplex in the low hundreds of patients — so the “& Vascular” in the trade name is not matched by a large peripheral-vascular interventional book in the Medicare data.

[7] CMS Medicare Fee-For-Service Public Provider Enrollment extract, vintage July 1, 2026, and the NPPES NPI Registry (live API, retrieved August 3, 2026): organizational NPI, PECOS associate ID, Medicare enrollment identifier, provider type and registered address. The corporate filing date is snippet-derived from the Florida corporate register, which blocks automated retrieval - treat it as probable rather than confirmed.

[8] CMS Revalidation Clinic Group Practice Reassignment file, vintage July 1, 2026. Reassignment records capture reassignment relationships, so they can lag a departure and will miss a hire made after the snapshot date. Treat 19 as the best available upper bound and confirm the live roster in discovery.

1.2 The operating model: an office-based group that works inside hospitals

The place-of-service split across the seven physicians with in-market CY2024 billing is **80.4% office and 19.6% facility**, and the facility fifth is the part that matters strategically. **Every catheterisation, every coronary stent, every left atrial appendage occlusion, every device implant and every ablation was billed facility-side** — that is, performed inside a hospital rather than in a practice-owned laboratory. Combined with roughly 1,525 initial-hospital-care beneficiaries (99222) among those same physicians, the picture is unambiguous: this is an independent office-based group that admits, rounds and operates inside hospitals it does not own.[9] The practice's own website describes its ablations as being performed in "our electrophysiology lab at Fort Walton Beach Medical Center or North Okaloosa Medical Center" — its own phrasing for space inside two hospitals, owned by two different and competing systems.

Geography reinforces the point and adds an option the group may not be pricing. The Crestview headquarters at 129 East Redstone Avenue sits roughly one block from North Okaloosa Medical Center at 151 East Redstone Avenue — a Community Health Systems hospital. The Fort Walton Beach office at 1032 Mar Walt Drive sits on or adjacent to the HCA campus at 1000 Mar Walt Drive. Ascension operates a third hospital in the same core-based statistical area. **The group is therefore not captive to any one system**, and all of those hospitals entered the same mandatory episode model on the same day (Section 6).

The administrative layer is the constraint, and it is a familiar one. The practice's top published administrative contact is a practice manager, not a chief operating officer; a 2026 job-board sweep found one active clinical-assistant posting at roughly $19 an hour and one recently expired sonographer posting, and **no posting at all for a care coordinator, a chronic-care or remote-monitoring nurse, a cardiac device technician, or a practice administrator**.[10] That evidence is deliberately weak — most major job boards blocked automated access during research, so "no posting found" is a floor and not a ceiling. But taken with the rest of the picture it points to a lean back office with no dedicated care-management staffing. That is a staffing objection to anticipate rather than to argue with, and it is precisely the gap a full-service model fills (Section 9.2).

1.3 Design principles for the 2026 service line

Principle	What it means at this practice
Longitudinal by default	Every heart failure, uncontrolled-hypertension, post-ablation, post-implant and post-discharge patient leaves the encounter enrolled in monitoring or monthly management — not merely scheduled for a return visit a quarter later
Start at the discharge, not at the office visit	The group generates its own highest-value windows: roughly 2,194 initial-hospital-care beneficiaries a year, each opening a 30-day transitional window, and every ablation, implant and structural case opening a post-procedure window that 99445 now makes billable
One front door	A single enrollment, consent and device-logistics workflow; referral to the service line is one order inside the practice's existing chart, with enrollment status visible in real time (Section 8)
The partner carries the load	A lean administrative layer and no dedicated care-management staff means the practice supplies clinical direction and supervision while the partner supplies enrollment, devices, monitoring, documentation and claims
Separate the two remote programmes cleanly	Implanted-device interrogation and patient physiologic monitoring are different benefits over different data. Define the boundary, the data source and the documentation for each before launch, so neither service is at risk (Section 9.3)

[9] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026) for the place-of-service split, and the by Provider and Service file for initial-hospital-care beneficiary counts (99222, 99223) and for facility-side procedure billing.

[10] Job-board sweep, August 2026. Most major job boards and professional networks blocked automated access during research, so an absent posting is weak evidence rather than proof of absence. One active clinical-assistant posting and one recently expired sonographer posting were located; no care-coordinator, chronic-care nurse, device-technician or practice-administrator posting was found.

Principle	What it means at this practice
Four sites, two markets, one programme	Crestview is inland, younger and materially less affluent; Destin and Niceville are coastal and affluent. Enrollment scripting and device logistics should be designed for both ends of the county, not just for the headquarters
Single scorecard	Clinical, operational and financial KPIs for the service line reviewed monthly by the physician lead and the administrative lead, and mapped explicitly to the model measures the group will be scored on from 2027 (Sections 5 and 9.5)

None of these principles requires new technology, and none of them requires the practice to become something it is not. They require one decision — **who owns the layer of care between visits and after discharge** — and a second decision to charter that ownership as a service line with a budget and a scorecard rather than as an initiative. Section 2 prices it. Section 9 staffs it.

2. The Remote Care Service Line — The Operating Spine

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

2.1 What it is: the cardiology clinical & billing stack

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

Programme	Core codes	What it does	Where it lands at this practice
TCM — Transitional Care Management ***(identified, not modeled)***	99495 / 99496	The 30-day post-discharge transition: interactive contact within two business days, face-to-face visit within 14 or 7 days depending on complexity	Roughly 2,194 initial-hospital-care beneficiaries in CY2024, and no TCM billed against any of them. The single largest identified gap — and deliberately excluded from every financial figure in this report
RPM — Remote Physiologic Monitoring	99453; 99454 / 99445; 99457 / 99470; 99458	Cellular blood-pressure cuffs, weight scales and pulse oximeters; daily physiologic data; 24/7 review and alert triage; monthly clinical management time	The between-visit layer for heart failure (weight and blood pressure), for uncontrolled and resistant hypertension, and — via the new short-window code 99445 — for the 2–15 day post-discharge, post-ablation, post-implant and post-structural-heart windows
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Heart failure as the qualifying condition. In a cardiology panel the single dominant condition genuinely is the cardiac one — the clinical situation PCM was written for, and the monthly chassis under the CY2027 Heart Failure cohort designation

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

The one coordination rule

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

The practical rule here: the practice owns the transitional-care window at discharge and owns RPM plus PCM on the cardiac condition; the referring primary-care physician owns any longitudinal primary-care management wrapper; both work from **one shared care plan** with explicit task ownership. Write that policy before the first enrollment. It prevents duplicate-billing denials, it protects the referral relationship, and it is the same substrate the Ambulatory Specialty Model's collaborative care arrangement will require from 2027 (Section 5).

And a boundary specific to this practice: implanted-device interrogation (93294–93298) and patient physiologic monitoring (99453 onward) are different benefits over different data — the device's own telemetry versus patient-generated physiologic readings from a separate connected device. The rule to design around is that the same data stream is not billed twice. *Confirm the specific pairings with the payer and with billing counsel before launch.*

2.2 Standalone value: a margin-positive service line

Before any value-based upside, the service line stands on four layers of value:

1. **Direct professional-fee revenue.** Recurring monthly billing on a population the practice already manages clinically, delivered at top-of-license staffing under general-supervision rules. Modeled at $4,685,339 of net reimbursement over 24 months, $1,986,060 of it net to the practice.
2. **Avoided cost and readmission exposure.** Modeled at approximately 241 avoided hospitalizations over 24 months — on the order of $3.6 million at an illustrative $15,000 per admission. In a market where every hospital now carries 30-day episode accountability, and where the county's readmission rate runs above both the state and the national figure, that value is visible to the group's referral partners as well as to the group.
3. **Procedural throughput.** A monitored discharge pathway is what converts a structural heart or ablation case from a bed-day into a same-or-next-day discharge. Freed bed-days are the constraint on procedural volume in a market with one cardiac-surgery-capable hospital (Section 7).
4. **Strategic position and model readiness.** The practice keeps its own TIN, its own data and its own patient relationships while adding an infrastructure layer it would otherwise have to build, buy, or depend on a hospital partner to supply. Under a preliminary CY2027 Heart Failure designation and inside a hospital market fully inside TEAM, that infrastructure is also the group's negotiating position.

The CY2026 billing stack

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

Rates are illustrative

The figures above are illustrative national non-facility magnitudes for CY2026. Actual payment is locality-adjusted and set by the Medicare Administrative Contractor for Florida (Jurisdiction N). The financial model in this report uses MAC-locality rates auto-resolved for ZIP 32539 in the CoachCare Value Analysis — Florida, locality 09102-99. Verify against the current CY2026 Physician Fee Schedule and the applicable Florida locality files before budgeting, and note that CMS rulemaking for CY2027 is in progress: remote-monitoring code values are subject to change inside the 24-month window modeled here.

One local factor cuts in the practice's favour at the point of enrollment. The county's Medicare population carries an unusually high Part A + B take-up and a large TRICARE For Life retiree base, for whom Medicare cost-sharing is generally wrapped by a secondary payer. That materially reduces the patient-collection friction on the 20% coinsurance that remote monitoring and care management would otherwise generate — historically the most common patient-side objection to launching these programmes.

Modeled economics

The companion Value Analysis prices an RPM + PCM programme on the practice's Medicare base. The modeled population is an estimated **10,740-patient in-scope Medicare base across 19 billing providers**, all of it in scope in Year 1. *This is a discovery-stage estimate and should be validated against the practice's own chart counts before budgeting.* For reference, CMS publishes 7,552 beneficiaries on the established moderate-complexity office visit (99214) alone across the ten physicians with CY2024 billing, and the sum of per-provider beneficiary counts is 22,838 — a figure that contains substantial duplication, because a patient seen by two physicians is counted twice. A unique-patient denominator cannot be derived from the public file and has to come from the practice's own record.

Enrollment builds bottom-up from **19 referring providers at eight referrals per provider per month with 80% patient acceptance**, supported by **one on-site enrollment specialist** at approximately 80 enrollments per month — **staffed at CoachCare's expense: embedded value, never deducted from the practice's margin**. Programme eligibility is modeled at 75% of the in-scope population for RPM (8,055 patients) and 85% for PCM (9,129), with acceptance of 35% and 30% respectively. Revenue is reported as **net** reimbursement — gross allowed amounts less an 18% realization discount for payer mix and collection, as configured in the model.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$1,152,701	$3,532,637	**$4,685,339**
CoachCare fees (incl. setup & integration)	—	—	$2,699,278
Net to the practice	**$482,128**	**$1,503,932**	**$1,986,060**
Practice margin	**41.83%**	—	**42.39%**
Net reimbursement by programme	RPM $859,892 · PCM $292,810	RPM $2,615,394 · PCM $917,243	RPM $3,475,286 · PCM $1,210,053
Claims / billed units	—	—	88,611
Physiologic readings collected	—	—	380,017
Hospitalizations avoided (modeled)	—	—	~241 (≈$3.6M at an illustrative $15,000 each)
Care-team hours delivered	—	—	39,820 (≈19.1 FTE)
Active programme enrollments at month 24	—	—	3,901 (RPM 2,819 · PCM 1,081)
Unique patients (de-duplicated)	1,649 at month 12	3,144 at month 24	—

CoachCare Value Analysis, MAC locality FL 09102-99 (ZIP 32539), RPM and PCM only. Chronic care management is carried at zero eligibility. Transitional care management is excluded entirely. Illustrative, modeled — verify against practice data.

The margin, and how it is defined

24-month practice margin: 42.39% — net to the practice ÷ net reimbursement. Year 1 is **41.83%**, on $4,685,339 of net reimbursement and $1,986,060 net to the practice over the full 24 months.

Month 1 is modeled at **−$2,188** because one-time implementation lands there, and **every month from month 2 onward is net-positive**. By month 24 the programme is modeled at $364,389 of monthly net reimbursement and $155,303 of monthly net to the practice. The more useful way to describe the timing is this: no practice capital is at risk while the census builds, because CoachCare funds the enrollment engine, the devices and the monitoring staff.

The two arms behave differently, and it matters for planning. **RPM is ceiling-pinned**: it reaches its modeled ceiling of 2,819 enrolled patients at month 23 and holds there, so Year 2 RPM growth is a function of how quickly the census fills rather than of how large the eligible pool is. **PCM is not** — it stands at 1,081 patients at month 24 against a modeled ceiling of 2,739, still climbing, limited by enrollment pace rather than by eligibility. **Year 2 is therefore a growth year rather than a steady state, and the census at month 24 is not the programme's terminal size**. Raising referral throughput or adding a second enrollment pathway moves the PCM arm materially; it does very little for RPM once the ceiling is reached.

Recurring-revenue mechanics

Each month's enrolled census re-bills, so revenue is a function of census and capture rate rather than of visit volume. Year 2 net reimbursement ($3,532,637) is 3.1× Year 1 ($1,152,701) on the same referral engine, purely from census accumulation. Unit economics are modeled at approximately $96.02 of net reimbursement per RPM patient-month and $90.54 per PCM patient-month.

The two value streams compound rather than compete. The professional fee is the practice's revenue and depends on no reconciliation, no shared-savings determination and no hospital agreement — while the same monitored census is what moves the readmission, cost and quality results that the Ambulatory Specialty Model will score from 2027 and that the hospitals' TEAM episodes are reconciled on from 2026. *All figures are illustrative, modeled — verify against practice data.*

2.3 Connective tissue: one infrastructure, every lever

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

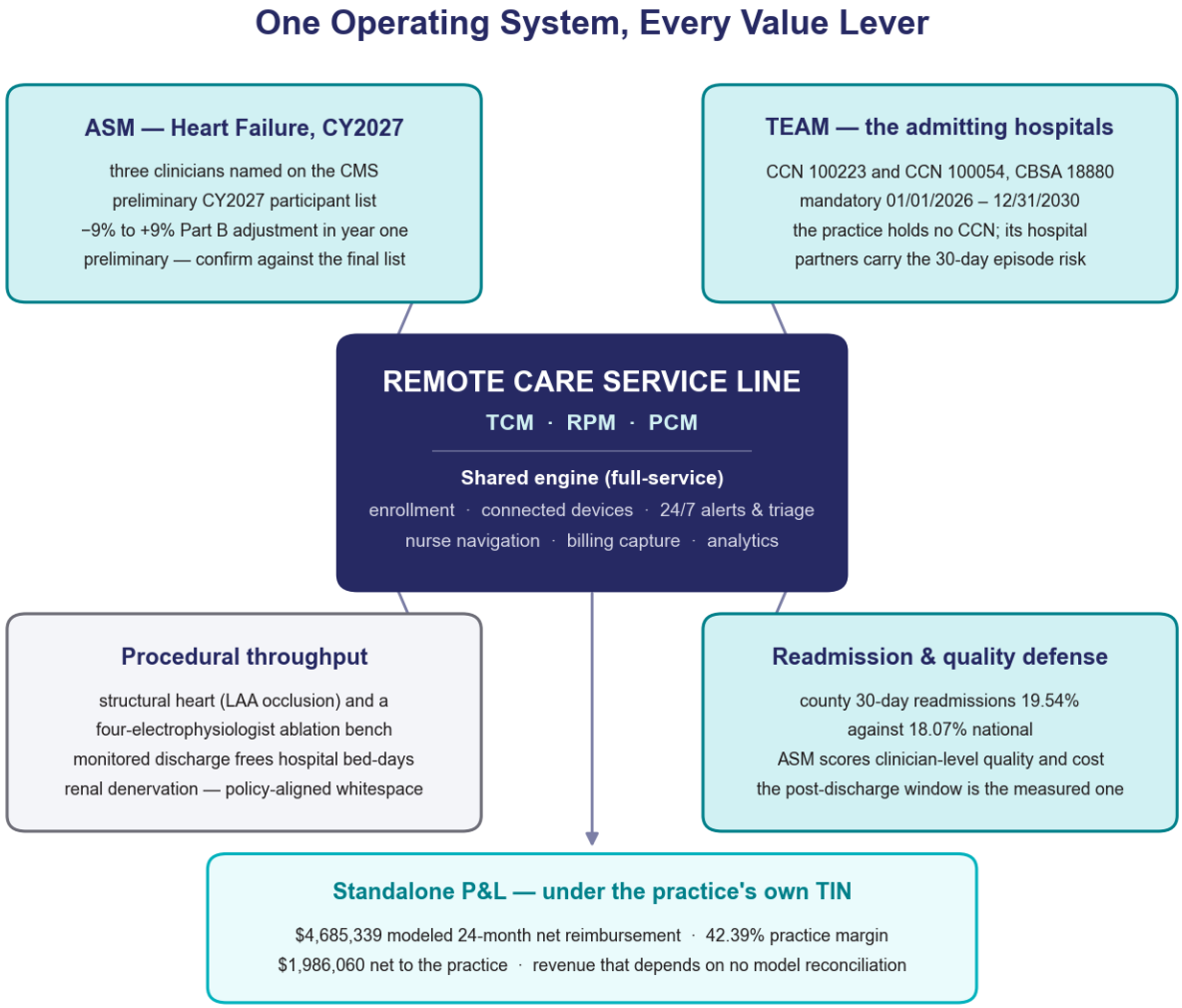

Figure 1. The Remote Care Service Line as connective tissue: one operating system powering the CY2027 Ambulatory Specialty Model Heart Failure cohort (preliminary participant list), the admitting hospitals' TEAM episode performance, procedural throughput in structural heart and electrophysiology, readmission and quality defense, and the standalone P&L.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
ASM — Heart Failure cohort, CY2027	Three of the group's clinicians are named on the CMS preliminary CY2027 participant list; a −9% to +9% Part B adjustment applies in the first payment year; clinician-level quality and cost, plus group-level care improvement	A monitored heart failure census produces the between-visit intervention that moves cost and utilization, and produces the documentation the quality measures are scored from. The shared care plan is also the substrate for the required collaborative care arrangement with primary care
TEAM — the admitting hospitals	CCN 100223 and CCN 100054 are mandatory participants from January 1, 2026; the practice holds no CCN and is not itself a participant	TCM at discharge plus short-window RPM via 99445 covers exactly the 30 days the hospital is accountable for. The group is the instrument by which its partners defend episode performance — and that is a negotiating position, not just a clinical one
Procedural throughput	84 left atrial appendage occlusions and a four-electrophysiologist ablation bench in CY2024, all performed inside hospitals the group does not own	A monitored discharge pathway converts a post-procedure bed-day into a same-or-next-day discharge. Freed bed-days are capacity, and capacity is procedural volume

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Readmission and quality defense	County 30-day readmissions run 19.54% against 18.07% nationally, with emergency use and cardiac mortality also above benchmark despite below-benchmark prevalence	Daily physiologic signal with 24/7 triage turns deterioration into a same-week outpatient intervention instead of an emergency-department visit. This is the measure the group will be scored on from 2027 and the one its hospitals are reconciled on now
Transitional care *(identified, not modeled)*	Roughly 2,194 initial-hospital-care beneficiaries in CY2024, no TCM billed	The same enrollment and monitoring engine covers the 30-day window; short-window RPM is billable today via 99445, and TCM remains a separate decision the practice can take on its own merits
Standalone P&L	CY2026 code expansion (99445, 99470); revenue durability regardless of how any model performance year reconciles	$4,685,339 of modeled 24-month net reimbursement at a 42.39% practice margin — billed under the practice's own TIN and dependent on no reconciliation

Read that table one way and it is six separate problems, each with its own project plan, its own budget line and its own reason to be deferred. Read it the other way and it is **one asset, built once and paid for once, that answers all six**. The practice already owns the hardest input to that asset — a working remote-monitoring habit operating at scale, with staff who already triage alerts for a living. What it does not yet own is the physiologic data layer, the enrollment engine and the billing capture that turn a habit into a service line.

3. 2026–2027 Policy & Payment Environment

Two mandatory CMS models now bear on this practice — one directly, one through its hospital partners. Neither is optional, and neither is far away.

3.1 ASM: a CY2027 Heart Failure designation, on a preliminary list

The **Ambulatory Specialty Model** begins **January 1, 2027** and runs through PY2031. It covers two conditions — low back pain and **heart failure**, with cardiology accountable for heart failure. It is a clinician-level model: participants are scored on quality and cost measures with a group-level care-improvement and interoperability component, and performance drives a Part B payment adjustment of **−9% to +9% in the first payment year**. It also requires an electronic **collaborative care arrangement with primary care**. Most importantly for planning: ASM is **mandatory for attributed clinicians** — there is no opting in and no opting out.

What the verification actually says — and what it does not

Verified. Three of the group's clinicians appear in the CMS Ambulatory Specialty Model participants file, **Heart Failure cohort**, under the organization legal name, with the CY2027 participant flag and the CY2027 small-practice flag both set to Yes. All three matched on both an organization-name query and an exact NPI query against the 19-provider roster; no other NPI in the roster appears anywhere in the file.[11]

The caveat, stated plainly. The file is the **CY2027 preliminary participant list** (dataset modified February 4, 2026, retrieved August 3, 2026). **No final CY2027 list existed in the CMS catalog as of that date.** The phrasing this report holds to throughout — and the phrasing to hold to in any external material — is that these clinicians are **named on the CMS preliminary participant list**. *Preliminary lists can be revised. Re-verify against the final CY2027 file when CMS publishes it, before acting on anything in Section 5.*

A finding worth knowing: the practice was findable in this file *only* under its legal name. Searching CMS files for the trade name returns nothing at all — which is why an account like this can look unaffiliated on a first pass.

Scale, for context. Of the 2,610 Heart Failure cohort NPIs nationally, the per-organization distribution is heavily long-tailed: 536 organizations have a single attributed clinician, 138 have two, and 78 have three. **At three, this group sits in the upper half of Heart Failure participants by size** — a real cohort participant rather than a marginal one. The group also carries the small-practice flag, which triggers distinct reporting-burden and scoring accommodations; *confirm the current-year specifics of that flag before relying on it*.

3.2 TEAM: every hospital in this market carries 30-day episode risk

The **Transforming Episode Accountability Model** is mandatory and episode-based, running **January 1, 2026 through December 31, 2030** across selected core-based statistical areas. It covers five surgical episode categories including **coronary artery bypass graft**, and reconciles a hospital's episode spending against a CMS target price with a quality adjustment. **Participation attaches to a hospital CCN.**

Hospital	CCN	Owner	TEAM status	Performance period
HCA Florida Fort Walton-Destin	**100223**	HCA	**Mandatory**	01/01/2026 – 12/31/2030
HCA Florida Twin Cities (Niceville)	**100054**	HCA	**Mandatory**	01/01/2026 – 12/31/2030

[11] CMS Ambulatory Specialty Model Participants, CY27_Prelim_ASMParticipants_Public.csv (CY2027 preliminary; dataset modified February 4, 2026; retrieved August 3, 2026). The file carries 6,637 rows across two cohorts - Heart Failure 2,610 and Low Back Pain 4,027. Matching used the organization legal name and an exact NPI match against the 19-provider roster; the file's state column was not used as a filter because it is known to be miscoded for some participants.

Hospital	CCN	Owner	TEAM status	Performance period
North Okaloosa Medical Center (Crestview)	100122	Community Health Systems	Mandatory	01/01/2026 – 12/31/2030
Sacred Heart Hospital on the Emerald Coast	100292	Ascension	Mandatory	01/01/2026 – 12/31/2030
North Walton Doctors Hospital	100365	—	Mandatory	01/01/2026 – 12/31/2030

CMS TEAM Participant List, as of April 15, 2026 (CMS updates the list quarterly). All five hospitals in CBSA 18880 — Crestview–Fort Walton Beach–Destin, FL — are mandatory participants. Re-check at the next quarterly update.

Stated plainly, so it is not overstated

The practice holds no CCN. It is not a TEAM participant and cannot be one — TEAM participation attaches to a hospital CCN, and this is an office-based physician group. Its exposure to the model is entirely indirect.

What is direct is the leverage. The two hospitals the group admits to carry 30-day post-discharge episode accountability, including readmissions, from January 1, 2026 — and so does every other hospital in the core-based statistical area, including the Community Health Systems hospital one block from the practice's Crestview office and the Ascension hospital in the same market. **There is no hospital in this practice's service area that is not carrying mandatory episode risk**, and the group is the shared cardiology bench across several of them.

3.3 Why the two models are one transformation program

It is tempting to treat these as two separate compliance problems with two separate project plans. They are not. **Both are reconciled on what happens to a cardiac patient in the weeks after they leave a building.** TEAM measures it at the hospital, over a 30-day episode, from 2026. The Ambulatory Specialty Model measures it at the clinician, over a heart failure year, from 2027. The operational answer is identical in both cases: know which patients were discharged, reach them within days rather than weeks, watch weight and blood pressure between visits, escalate deterioration to an outpatient intervention instead of an emergency department, and document all of it in a form that survives audit. **One service line answers both. That is the whole argument of this report** — build once, reuse everywhere.

3.4 The CY2026 fee schedule: remote care gets more billable

The CY2026 Physician Fee Schedule expanded the remote-monitoring toolkit in ways that suit a cardiology group whose highest-value windows are short. **99445** pays the monthly device-supply amount for 2–15 days of data, where 16 or more days were previously required — which had made short post-discharge and post-procedure windows effectively unbillable. **99470** pays for the first 10 minutes of monthly management time, where the floor had been 20. Together they convert the two windows this practice generates most of — the 30 days after a cardiac discharge, and the days after an ablation, device implant or structural procedure — from unfunded care into billable events. PCM (99424–99427) remains the monthly chassis for single-condition specialty management, and RPM and PCM stack in the same month with discrete documentation.

3.5 The market: the least MA-penetrated county in the Panhandle

County	Medicare eligibles	MA enrolled	MA penetration
Okaloosa — the practice's county	47,127	16,408	**34.82%**

County	Medicare eligibles	MA enrolled	MA penetration
Walton	20,726	8,802	42.47%
Bay	44,559	19,253	43.21%
Santa Rosa	44,914	20,810	46.33%
Escambia	77,743	38,788	49.89%
Florida	5,315,144	3,040,341	**57.2%**
National	70,330,194	36,015,422	51.2%

CMS Medicare Advantage State/County Penetration, July 2026 file. Okaloosa is the least MA-penetrated county in the Florida Panhandle by a wide margin.

For a Florida coastal county with a large retiree population this is a striking anomaly, and it has a mechanical explanation: **the military-retiree population**. Eglin Air Force Base and Hurlburt Field make Okaloosa one of the densest military-retiree counties in the country, and TRICARE For Life — the Medicare-wraparound benefit for military retirees at 65 — requires both Part A and Part B and pays second to Medicare. A retiree who moves to Medicare Advantage does not lose the benefit but largely neutralises its value, because the plan becomes primary. The rational choice is to stay in Original Medicare, and the county's enrollment data carries that signature, including an unusually low and falling dual-eligible share.[12] *Label this honestly: the penetration figures are hard CMS data; the TRICARE attribution is a well-supported hypothesis rather than a measured finding.*

Three consequences follow for a remote care service line. First, **TCM, RPM and PCM are fee-for-service benefits**, so their economics work best where the fee-for-service pool is deep — and here it is roughly 22 points deeper than the Florida average. Second, **the pool is not eroding**: Original Medicare enrollment in the county has been essentially flat since 2021 (31,085 to 30,421) while total Medicare enrollment grew 11% and Medicare Advantage absorbed nearly all the growth, so the billable denominator is stable rather than shrinking. Third, the county holds roughly **30,400 Original Medicare beneficiaries** before counting Walton, Santa Rosa and the southern-Alabama catchment the practice's own marketing footprint now reaches. *Caveat: these are county figures, and the practice draws from a wider catchment that was not separately queried.*

[12] CMS Medicare Monthly Enrollment through April 2026 (dataset modified July 23, 2026), queried on county FIPS 12091, and the CMS Medicare Advantage State/County Penetration file, July 2026. The TRICARE For Life explanation for the low penetration is a well-supported hypothesis; no study quantifying that link specifically for this county was located.

4. Performance Snapshot: The Starting Position

4.1 The panel: old, high-risk, and unusually fee-for-service

A national-average Medicare beneficiary carries an HCC risk score of 1.00. Across the physicians in this group with CY2024 Medicare billing, average panel risk runs **1.63 to 2.42**, at an average beneficiary age of **75 to 78**.[13] That is a sick, old, chronic-heavy panel — the ideal denominator for remote monitoring and care management, and the population in which avoided admissions are both most achievable and most valuable.

The dual-eligible share is the counter-intuitive part. The largest panel in the group carries roughly 6.8% dual-eligible beneficiaries, and the county-level fee-for-service dual share is 7.62% against 10.06% for Florida and 14.57% nationally. **A low-dual, high-risk panel is unusual**, and it is consistent with an affluent military-retiree population rather than a Medicaid-heavy one. Commercially it is favourable: high acuity drives clinical need, while strong secondary coverage reduces the patient-collection friction on coinsurance at enrollment.

One caution on panel size. Six of the group's highest-volume physicians were still billing Medicare from out-of-market addresses in CY2024 — Ohio, Illinois, Mississippi, Tallahassee, Titusville and Pensacola — and have since reassigned into this group. The practice's *current-state* Medicare book is therefore materially larger than any CY2024 practice-level roll-up implies, and a forward-looking model should not anchor on a backward-looking practice total. That recruitment wave is itself the most encouraging structural signal in the file: a group that has roughly doubled its physician bench in about 18 months, importing three electrophysiologists from out of market, is buying infrastructure, carries unabsorbed capacity, and has partners actively making investment decisions.

4.2 The service record: remote monitoring at scale, care management at zero

Every HCPCS line billed by all 19 reassigned providers in CY2024 was screened against the full remote-monitoring and care-management code set — remote physiologic monitoring, remote therapeutic monitoring, chronic care management, principal care management, and transitional care management. **Not one code from that set appears, for any provider.**[14] In the same file, the group's remote *device* monitoring is one of its larger lines:

CPT	What it is	Beneficiaries	Services	Allowed
93294	Remote pacemaker interrogation, up to 90 days	999	1,282	$36,734
93295	Remote defibrillator interrogation, up to 90 days	522	1,065	~$37,800
93297	**Remote implantable hemodynamic monitor**	**558**	**792**	**$37,410**
93298	Remote cardiac rhythm monitor / loop recorder, 30 days	1,285	2,510	$227,633
93268 / 93229	External event and mobile cardiac telemetry	~373	~375	~$228,000
Total, device remote monitoring (93294–93298)	—	—	—	**~$366,000**

[13] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026): average HCC risk score, mean beneficiary age and dual-eligible counts per rendering NPI; and CMS Medicare Geographic Variation by County, CY2024, for the county-level fee-for-service dual share.

[14] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024 (released May 21, 2026), screened against the full remote physiologic monitoring, remote therapeutic monitoring, chronic care management, principal care management and transitional care management code sets for all 19 reassigned NPIs.

CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024 (released May 21, 2026), across the seven physicians with in-market CY2024 billing. Counts are beneficiary instances per code per provider and contain duplication across providers.

Two things follow, and they matter more than anything else in this report. First, **this practice already runs a remote-monitoring nurse workflow**. A group interrogating roughly a thousand pacemakers, five hundred defibrillators and thirteen hundred loop recorders remotely has device technicians, a triage inbox, an alert-review protocol and documented remote-monitoring habits. The usual first objection to a remote care programme — that the nurses could not run one — is pre-answered by the group's own claims data. Second, **558 beneficiaries on implantable hemodynamic monitors is a heart failure population**. Implantable pulmonary-artery pressure sensors are placed in advanced heart failure patients. That is a large, identified, high-acuity heart failure cohort that is already being remotely managed — and it sits directly on top of the Heart Failure cohort designation in Section 3.1.

The concept needs no selling here — it needs rebuilding on a billable footing

Archived captures of the practice's own website show a named **Coumadin Clinic** and a **Pacemaker Clinic** running as distinct, separately described services from at least 2007 through 2019.[15] Neither appears on the current site, which was rebuilt around 2025 — and the CY2024 device billing above shows the pacemaker function still operating at scale, so the right reading is marketing simplification rather than programme discontinuation.

This matters because a Coumadin clinic *is* a care-management programme: scheduled non-visit touches, protocol-driven titration, nurse documentation, recurring billing. This group does not need persuading that nurse-run, protocol-driven, between-visit chronic care works. It built two such clinics itself and ran them for over a decade. The conversation is not whether to do this — it is that CMS now pays substantially more for the physiologic version of it, and that two mandatory models have put a clock on it.

Whether the anticoagulation clinic is still running is an open question and a good first discovery item.

What the CY2024 data proves, stated precisely

CMS suppresses any provider / HCPCS / place-of-service line with fewer than 11 beneficiaries, so a pilot-scale programme would not appear in this file. What the record therefore establishes is that **no remote physiologic monitoring or care-management programme at meaningful scale existed in CY2024**. It does not establish that literally zero patients were ever monitored, and it cannot speak to a programme launched in 2025 or 2026 — the next CMS release covering data year 2025 is not expected until roughly mid-2027. It also covers Medicare fee-for-service only; commercial or Medicare Advantage remote monitoring would not appear. *Confirm current-state programmes directly in discovery.*

[15] Internet Archive captures of the practice's own website: a services page from 2007 naming a Coumadin Clinic and a Pacemaker Clinic as distinct services, and an available-tests page from 2019 still listing them. Neither appears on the current site, which was rebuilt around 2025.

4.3 The county paradox: low prevalence, high mortality, high readmissions

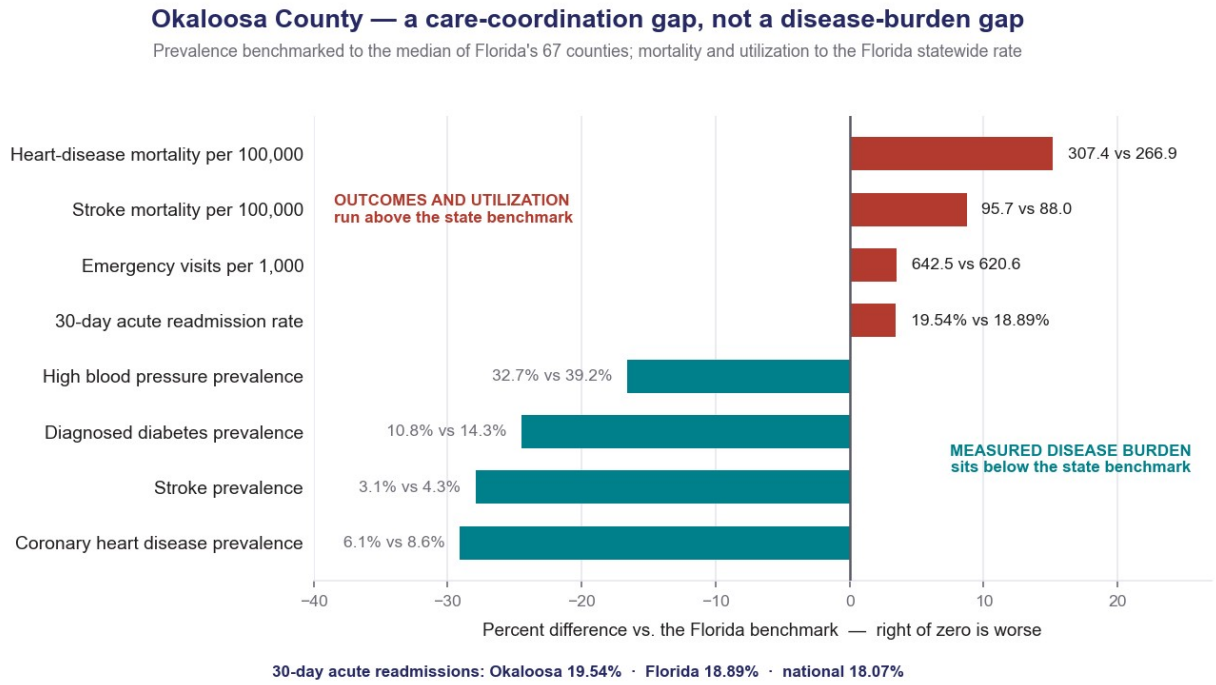

Figure 2. Okaloosa County against the Florida benchmark. Prevalence is benchmarked to the median of Florida's 67 counties (CDC PLACES, 2023 model year); mortality is age-adjusted for adults 35+, 2022–2024 three-year average; utilization is CMS Medicare Geographic Variation by County, CY2024. Directional snapshot — refresh against current data before use in any external material.

Okaloosa sits in the **bottom decile of Florida counties on measured cardiovascular prevalence** — coronary heart disease ranks 61st of 67, high blood pressure 63rd, stroke 63rd, diabetes 64th, where first is the highest burden. Age-adjusted figures tell the same story. **A physician audience will know this, so the report says it first: this is not a high-disease-burden market, and pitching it as one would not survive a single question**.

And yet the outcome and utilization data inverts. Heart-disease mortality runs **307.4 per 100,000 against 266.9 for Florida**; stroke mortality 95.7 against 88.0; the 30-day acute readmission rate **19.54% against 18.89% for Florida and 18.07% nationally**; emergency visits 642.5 per 1,000 against 620.6 for Florida and 590.5 nationally.[16] Inpatient stays per 1,000 are *below* the Florida rate at 233.2 against 261.7. A county this affluent, this well-insured and this low-prevalence should sit comfortably below the state mortality rate. It does not.

The reconciliation is the argument. Patients here are not being over-admitted — they are being poorly transitioned. Two mechanical explanations reinforce it, and both are specific to this geography. The county is roughly 53 miles north to south with a large federal reservation occupying the middle, leaving a single primary north–south corridor that state transportation authorities rated as failing its intended level of service in 2025 and that floods at one river crossing; relief funding is in a draft work programme for FY2028. From the practice's Crestview headquarters, Pensacola is about the same drive time as Destin — roughly an hour either way.[17] Routine follow-up is genuinely hard for north-county patients, and referral leakage westward is a live risk. **Remote care is a retention instrument here, not only a revenue line.**

[16] CDC heart disease and stroke mortality (resources mri7-5jtw and y5ii-knwc), 2022-2024 three-year average, age-adjusted, adults 35+; CMS Medicare Geographic Variation by County, CY2024 (updated May 15, 2026) for the 30-day acute readmission rate, emergency visits and inpatient stays per 1,000; CDC PLACES (swc5-untb, BRFSS survey year 2023) for prevalence and county ranking.

[17] Drive times computed via OSRM on OpenStreetMap and cross-checked against a commercial distance service, August 2026; Florida Department of Transportation 2024 average annual daily traffic counts and a February 2026 regional transportation position paper for the corridor level-of-service rating and the FY2028 draft work-programme funding.

One further caution on prevalence, because it explains rather than excuses the numbers. The county's adult denominator includes a very large young, screened, physically-qualified active-duty military population, which dilutes crude prevalence without saying anything about the 65-and-over panel a cardiology practice actually serves. **Frame this account on its Medicare sub-population, not on its adult population**: roughly 47,100 Medicare beneficiaries in the county, about 30,400 of them in Original Medicare, and a practice panel carrying HCC risk of 1.63 to 2.42 at an average age of 75 to 78. A practice can sit in a statistically healthy county and hold a very high-acuity panel. That is exactly what the claims data shows.

4.4 Position in the market

Cardiology supply here is thin, and this group holds most of it. Counting individually-billing cardiology, interventional and electrophysiology clinicians in the CY2024 Medicare file, Okaloosa County has **seven, serving 13,341 Medicare beneficiaries**. Pensacola, an hour west, has 41. Crestview alone carries 9,215 of the county's cardiology Medicare panel and roughly $4.12 million in allowed charges — the largest cardiology book in the county, concentrated in very few hands, and four of Crestview's five cardiology clinicians bill from the practice's own street. *This undercounts hospital-employed capacity*, because system-employed cardiologists often bill under a group NPI or a different address; read it as a measure of independent-practice density rather than a census.

Hospital	Florida AHCA cardiac licence	What it means
HCA Florida Fort Walton-Destin	**Level II Adult Cardiovascular Services**	Percutaneous coronary intervention with onsite cardiac surgery — the only Level II licence in Okaloosa County, and the county's only open-heart programme
North Okaloosa Medical Center (Crestview)	Level I Adult Cardiovascular Services	PCI without onsite surgery: catheterisation lab, coronary and peripheral intervention, device implant, nuclear cardiology, echo, cardiac rehabilitation
HCA Florida Twin Cities (Niceville)	None	Absent from all three AHCA cardiac lists — no cardiac programme
Sacred Heart Hospital on the Emerald Coast	Level I Adult Cardiovascular Services	Miramar Beach, Walton County — same CBSA

Florida Agency for Health Care Administration licensed Adult Cardiovascular Services lists, generated July 1, 2026. Florida has no STEMI receiving-centre designation; the Level I / Level II licence is the functional equivalent.

Two competitive facts complete the picture. **A new hospital-branded cardiology practice opened in Fort Walton Beach in November 2025**, affiliated with the same system that operates the county's only cardiac-surgery programme — the classic squeeze on an independent specialty group. And the nearest directly comparable competitor in the Ambulatory Specialty Model Heart Failure cohort is a hospital-affiliated cardiology network in Pensacola with two clinicians on the same preliminary list. **An independent group with a built, billable, hospital-facing post-discharge capability is materially harder to displace than one without**, and that is as much of the argument for building it as the revenue is.

5. Powering ASM: The Heart Failure Cohort

Reminder of the constraint on everything in this section. Three of the group's clinicians are **named on the CMS preliminary CY2027 participant list for the Ambulatory Specialty Model**, Heart Failure cohort. That is a preliminary list; no final CY2027 list had been published as of August 3, 2026. **Re-verify against the final file before acting on this section.** Everything below is written as readiness planning, not as a compliance instruction.

If the designation holds, the model is a good fit for what this practice already has and a poor fit for how it is currently staffed. ASM scores clinician-level quality and cost on a heart failure population across a performance year and converts that into a Part B payment adjustment of −9% to +9% in the first payment year. **A heart failure population is not managed in the exam room** — it is managed in the weeks between visits, on weight trend, blood pressure, symptom change and medication tolerance, and that is exactly the layer the group does not currently staff or bill.

The cohort is already identified

Most cardiology groups entering a heart failure model have to build the denominator first. This one largely has it. **558 beneficiaries carried implantable hemodynamic monitors in CY2024** — pulmonary-artery pressure sensors placed in advanced heart failure patients, already under remote surveillance, already attached to a nurse workflow. Add the heart failure patients within the roughly 2,194 initial-hospital-care beneficiaries a year, and the practice can populate a cohort from its own records in weeks rather than quarters.

The service line is the ASM operating model

What ASM scores	What the service line supplies
Cost of care across the heart failure year	A monitored census with 24/7 alert triage converts deterioration into a same-week outpatient intervention rather than an admission. Modeled at ~241 avoided hospitalizations over 24 months — illustrative, modeled, verify against practice data
Clinician-level quality measures	Monthly structured contact generates the documented blood-pressure readings, weight trends, symptom assessments and medication-tolerance notes the measures are scored from — as a by-product of care rather than as a separate abstraction project
Guideline-directed medical therapy titration	Titration is a production process, not an event. Home blood pressure and weight between visits give the clinical team the data to move doses on a schedule instead of waiting for the next quarterly visit — and PCM (99424–99427) is the monthly billing chassis for exactly that work
Group-level care improvement and interoperability	One enrollment workflow, one shared care plan and one analytics view across four offices is the group-level artifact this component asks for
The electronic collaborative care arrangement with primary care	This group has no primary-care panel of its own, so the arrangement is a collaboration with **external referring primary-care physicians**: a shared care plan, structured monthly reporting back to the referring physician, and explicit task ownership. The attribution policy in Section 2.1 is the substrate — write it once and it serves both purposes

Design decisions to take before PY2027, not during it

Attribution. Which heart failure patients are the practice's to manage, and which belong to a referring physician's longitudinal wrapper. Settle it in writing.

Targeting. Start with the identified hemodynamic-monitor cohort and the post-discharge heart failure population — highest acuity, highest avoidable-utilization yield, and both already visible in the practice's own data.

One shared care plan. The collaborative care arrangement is an electronic artifact, not a handshake. Build it as the same care plan the service line already maintains.

Small-practice status. The group carries the CY2027 small-practice flag, which triggers distinct reporting and scoring accommodations. *Confirm the current-year specifics before designing reporting around it.*

Re-verification. Diarise a check against the final CY2027 participant list the week CMS publishes it. Preliminary lists get revised.

The honest summary of this section is that the practice is **closer to readiness than most cardiology groups its size** — it has the cohort already identified, the remote-monitoring habit already running, the referral relationships already in place, and a documented history of operating exactly this kind of nurse-led, protocol-driven clinic. It is further away on precisely one dimension: **nobody currently owns the month between visits**. That is a staffing and workflow gap rather than a clinical one, and Section 9 is how it closes. Every commitment described above remains conditional on the final CY2027 participant list.

6. Powering TEAM: The 30-Day Post-Discharge Episode

The correct statement first. This practice holds no CCN. **It is not a TEAM participant and cannot become one** — participation attaches to a hospital CCN. Both hospitals the group admits to are mandatory participants (CCN 100223 and CCN 100054, CBSA 18880, January 1, 2026 through December 31, 2030), as are the other three hospitals in the same core-based statistical area. The group's exposure is indirect. Its *leverage* is not.

TEAM holds the hospital financially accountable for a 30-day post-discharge episode, readmissions included, reconciled against a CMS target price with a quality adjustment. The cardiac episode in the model is coronary artery bypass graft. **This group does not perform cardiac surgery** — the only Okaloosa County hospital licensed for it is HCA Florida Fort Walton-Destin — but it is the diagnostic and referral bench that feeds those cases, it rounds on those patients, and it owns the ambulatory cardiology relationship after discharge. **The clinicians who determine what happens in the 30 days after discharge therefore sit outside the entity that carries the risk.** That is the misalignment TEAM was designed to force a resolution to, and it is the opening for this conversation.

The episode bundle, in billing terms

Window	What the service line does	Billing
Day 0 — discharge	Discharge captured; patient enrolled before they leave, or within 48 hours; device shipped or handed over; interactive contact inside two business days	TCM 99495 / 99496 (identified, not modeled)
Days 1–14	Daily weight, blood pressure and symptom data with 24/7 triage — the window in which a readmission is still preventable	**Short-window RPM: 99445 + 99470** — newly billable in CY2026 for 2–15 days of data and the first 10 minutes of management time
Days 15–30	Face-to-face visit inside the TCM window; continued monitoring; medication titration against measured response	RPM 99454 / 99457 / 99458 once the data threshold is met
Month 2 onward	The patient transitions from an episode to a managed census — heart failure, hypertension, post-procedure recovery	Longitudinal RPM + PCM (99424–99427)

Why this is the same build as Section 5. Nothing in the table above is a TEAM-specific asset. It is the same enrollment engine, the same devices, the same triage protocol, the same documentation and the same billing capture that the heart failure cohort needs from 2027 and that the standalone P&L runs on from month one. **Build once, reuse everywhere** is not a slogan here; it is the reason a 12-physician group can credibly answer two mandatory models at once.

The hospital conversation — and one condition on it

Every hospital in this market entered episode accountability on the same day, and this group is the shared cardiology bench across more than one of them. A post-discharge capability that measurably reduces 30-day readmissions is worth something specific to a hospital that is now reconciled on exactly that — and the group's headquarters sits one block from a competing system's hospital, so this is a conversation it can credibly take to more than one buyer.

The condition. Any arrangement in which a hospital supports, subsidises or co-invests in physician-practice services must be structured to comply with the physician self-referral and anti-kickback rules. *Take that structure to healthcare counsel before it is proposed, not after.*

TEAM-readiness checklist

- A daily feed or process that tells the practice which of its patients were discharged yesterday, from which hospital — the single most common point of failure in a TCM programme.

- A standing two-business-day interactive contact protocol with named ownership and an escalation path, documented to survive audit.
- Device logistics that work at discharge rather than at the next office visit — the first 14 days are the window that matters, and 99445 now pays for them.
- A shared readmission dashboard with the admitting hospitals, so the group's contribution is measured rather than asserted.
- An agreed definition of the cardiac episode population with each hospital, and clarity on which post-discharge activity is the practice's and which is the hospital's.

One last point on sequencing, because it determines who has to say yes. None of this requires a hospital's agreement to begin. The transitional-care and short-window remote-monitoring revenue is the practice's own, billed under its own TIN, whether or not any hospital ever co-invests a dollar. **The hospital conversation is what the capability makes possible — not what it depends on**, and that is the right order to build in. A group that arrives with a working post-discharge programme and measured readmission data is negotiating from a different position than one arriving with a proposal.

7. Powering Procedural Growth: Structural Heart, EP and Hypertension

Remote care is usually sold as a chronic-disease programme. In a group with this procedural profile it is also a throughput multiplier, and the mechanism is specific: **a monitored discharge pathway is what lets a post-procedure patient go home on the same or next day instead of occupying a bed overnight**. In a county with one cardiac-surgery-capable hospital and a 65-bed hospital with no cardiac programme at all, bed-days are the binding constraint on procedural volume — and the hospitals now have an episode-cost reason to care about them too.

Procedural line	What the CY2024 data shows	What the service line adds
Structural heart — left atrial appendage occlusion	84 procedures (CPT 33340) across three operators, all billed facility-side. A genuine programme, evidenced by procedure data rather than by marketing	Post-procedure rhythm and blood-pressure monitoring in the 2–15 day window, now billable via 99445; earlier discharge; structured anticoagulation follow-up in a practice that ran a named anticoagulation clinic for over a decade
Electrophysiology — ablation and device implant	Four electrophysiologists; atrial-fibrillation ablation (93656) and pacemaker implant (33208) volume; a published procedure range including leadless pacing, defibrillators, loop recorders and a hybrid atrial-fibrillation approach	Post-ablation and post-implant physiologic monitoring sits alongside — not inside — device interrogation. Blood pressure, weight and symptom data are patient-generated and distinct from the device's own telemetry (see the boundary rule in Section 2.1)
Transcatheter valve therapy	**Not performed by this group**. The county's only cardiac-surgery-capable hospital delivers it; the group's role is diagnostic, referral and post-discharge	Pre-procedure optimisation and post-discharge monitoring on referred patients — which keeps the patient attached to this practice rather than transferring the relationship with the referral
Hypertension and renal denervation	**No evidence of renal denervation** in the group's CY2024 Medicare billing or on its published procedure list. County hypertension prevalence is 32.7% with 75.7% of those diagnosed on antihypertensive medication — a large treated-hypertension base	**Policy-aligned whitespace, not a current capability.** CMS national coverage determination 20.40 covers renal denervation for uncontrolled hypertension effective October 28, 2025 under Coverage with Evidence Development. Blood-pressure RPM is intrinsic to that pathway — for candidate identification, for titration, and for the evidence the coverage condition requires

Read the renal-denervation row as an option, not a plan. Nothing in the public record indicates this group performs the procedure today, and this report does not assume it will. The point is narrower and more useful: a practice that already runs blood-pressure monitoring at scale, in a county with a large treated-hypertension population and above-benchmark cardiac mortality, is in the natural position to build a resistant-hypertension pathway — and that pathway is the prerequisite for the procedure whenever the group chooses to look at it.

8. EMR Integration & Technology Architecture

8.1 What is known about the platform — and what is not

This section is written conditionally, on purpose

What is verified: the practice operates a branded patient portal on the FollowMyHealth platform at an organisation-specific subdomain, with a custom theme, logo and stylesheet — a real provisioned deployment rather than a generic link. Archived pages show the practice equating that portal with its electronic medical record since at least 2018.[18]

What is not verified: that the underlying ambulatory EHR is Veradigm. **FollowMyHealth is sold as a standalone patient-engagement platform and can be deployed on top of another vendor's EHR**, so the branded portal is *consistent with* a Veradigm ambulatory EHR but does not prove one. No job posting, vendor case study or page source names an EHR product; the one live clinical job posting asks for generic "EMR systems" experience with no vendor named. Equally, no evidence of a switch to any other platform was found.

The practical consequence: treat Veradigm as **probable but unconfirmed**. *Confirm the actual EHR and its integration surface in discovery before any integration scoping, timeline or contractual commitment.*

8.2 What the integration does, once the platform is confirmed

The integration pattern is the same whichever platform is confirmed; only the connector and the timeline change. What it delivers:

- **Enrollment inside the chart.** Referral to the service line is one order in the existing record, not a separate system, a separate login or a paper form.
- **Enrollment status visible in real time.** Whether a patient is enrolled, which programmes they are on, and which device they hold — visible to the clinician at the point of the next decision rather than in a monthly report.
- **Structured clinical exchange.** Health history out; vitals, evidence of care and care plans back into the chart on a monthly cadence, so the record the practice is audited on is the record it already keeps.
- **Automated claim generation.** The monthly per-patient claim is generated by the billing engine rather than assembled by hand.

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

8.3 Why automated claim generation matters here specifically

This is not a general benefit; it is the specific difference between a programme that runs at this practice and one that does not. At a modeled census of **3,901 active programme enrollments at month 24**, across four offices and 19 billing providers, the monthly billing task is thousands of per-patient, per-code, time-documented claims — each one dependent on evidence that the monitoring days and the management minutes were actually met. **The model projects 88,611 billed units over 24 months.** A lean administrative layer cannot assemble that by hand, and the failure mode is not a rejected claim; it is a programme that quietly stops billing what it delivers. Automated generation from the monitoring record is what makes the capture rate in Section 9.5 a real operating metric rather than an aspiration.

[18] The practice's patient portal resolves to an organisation-specific FollowMyHealth subdomain with a custom theme, logo and stylesheet (verified live, August 2026); an archived resources page from 2018 describes that portal as the patient's electronic medical record. FollowMyHealth is marketed by Veradigm as a standalone patient-engagement platform that can be deployed over another vendor's EHR, so this evidence is consistent with - but does not prove - a Veradigm ambulatory EHR.

9. Implementation Playbook: Building the Remote Care Service Line

9.1 Goals, scope, and the modeled funnel

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

Model input	Value	Note
In-scope Medicare base	10,740	Discovery-stage estimate — validate against chart counts
Referring providers	19	The full reassigned roster as of July 1, 2026
Referrals per provider per month	8	With 80% patient acceptance
On-site enrollment specialist	1 (≈80 enrollments / month)	**CoachCare's expense — embedded value, never deducted from practice margin**
RPM eligibility / acceptance	75% (8,055) / 35%	Modeled ceiling 2,819 patients; reached at month 23
PCM eligibility / acceptance	85% (9,129) / 30%	Modeled ceiling 2,739; at 1,081 at month 24 and still climbing
Monthly attrition	1.5%	Discharge from programme
Revenue basis	Net of an 18% realization discount	Payer mix and collection, as configured in the model

Target populations and clinical pathways

Population	Why it is first	Pathway
Heart failure — the identified cohort	558 beneficiaries already on implantable hemodynamic monitors in CY2024, and the cohort named in the CY2027 preliminary participant list	Weight + blood-pressure RPM with 24/7 triage; PCM as the monthly chassis; titration against measured response
Post-discharge cardiac	Roughly 2,194 initial-hospital-care beneficiaries a year, no TCM billed, and the exact 30 days the admitting hospitals are now accountable for	TCM 99495 / 99496 (not modeled) + short-window RPM via 99445 / 99470
Uncontrolled and resistant hypertension	County hypertension prevalence 32.7% with 75.7% of those diagnosed on medication; above-benchmark cardiac mortality	Blood-pressure RPM; protocolised titration; the candidate pool for any future resistant-hypertension pathway (Section 7)
Post-ablation and post-device-implant	Four electrophysiologists and a large implant and ablation book — every case opens a short window that is now billable	Short-window RPM (99445), kept explicitly distinct from device interrogation
Post-structural-heart	84 left atrial appendage occlusions in CY2024, all facility-side	Short-window RPM plus structured anticoagulation follow-up

9.2 Staffing: nobody has to be hired

The model delivers **39,820 care-team hours over 24 months — approximately 19.1 full-time equivalents** — supplied by the partner under the practice's protocols and clinical supervision, alongside 177,222 care-management tasks, 44,305 chart updates, 26,583 patient conversations and 1,477 hours of call time. For a group whose published administrative layer is lean and whose job-board footprint shows

no care-coordinator or chronic-care nurse role, this is the layer that makes the programme possible at all rather than a nice-to-have. **The on-site enrollment specialist is funded by CoachCare: embedded value, never deducted from the practice's margin, and never a practice cost line.**

What the practice supplies is clinical direction, general supervision, and the physician lead who owns the programme's escalation protocol. What it does not supply is headcount.

9.3 "We already do remote monitoring" — the answer

This objection is going to come up in the first meeting, and it should — the practice does already do remote monitoring, at a scale most cardiology groups never reach. The answer is not to argue with it. It is to be precise about what is and is not already covered.

	Remote cardiac device monitoring (93294–93298)	Remote physiologic monitoring (99453 onward)
What is measured	The implanted device's own telemetry — lead integrity, arrhythmia episodes, device diagnostics	Patient-generated physiologic data from a separate connected device — blood pressure, weight, pulse oximetry
Who it covers	Patients with an implanted pacemaker, defibrillator, loop recorder or hemodynamic sensor	Any patient with a qualifying condition — the great majority of the practice's heart failure and hypertension panel has no implanted device at all
What clinical question it answers	Is the device working, and has an arrhythmia occurred	Is this patient decompensating, is the blood pressure controlled, is the titration working
Status at this practice	Running at scale — roughly $366,000 in CY2024	**Zero in CY2024**

The two are different benefits over different data, and they answer different questions. The design rule is that the same data stream is not billed twice: a distinct device generating distinct physiologic data supports a distinct service, and the documentation has to make that distinction obvious on its face. *Confirm the specific code pairings with the payer and with billing counsel before launch.* The larger point is the encouraging one: the group has already proved it will operate a remote-data workflow at industrial scale. It simply has not monetised the physiologic side of it.

9.4 Clinical workflow

1. **Identify.** Heart failure, uncontrolled hypertension, post-discharge, post-procedure. Built from the practice's own record, seeded by the identified hemodynamic-monitor cohort and the daily discharge list.
2. **Enroll.** One order in the chart. Consent, device selection and logistics handled by the partner; the on-site enrollment specialist covers the offices in rotation, with a telephonic pathway behind it for patients who cannot come in.
3. **Monitor.** Daily physiologic data with 24/7 review and alert triage against thresholds the physician lead sets — not vendor defaults.
4. **Escalate.** A defined path from alert to nurse contact to same-week outpatient intervention, with the emergency department as the exception rather than the default. This is where the 241 modeled avoided admissions actually come from.
5. **Titrate.** Guideline-directed therapy adjusted against measured response on a schedule, with PCM as the monthly billing chassis for the work.
6. **Document and bill.** Time, readings and interventions captured as a by-product of care; claims generated automatically from the monitoring record (Section 8.3).

7. **Report back.** Structured monthly reporting to the referring primary-care physician — which is both good practice, a referral-retention mechanism, and the substrate for the collaborative care arrangement the Ambulatory Specialty Model requires.

9.5 KPI dashboard and expected impact

Domain	Metric	Why it is on the dashboard
Clinical	Blood-pressure control rate; weight-alert response time; heart failure admissions and 30-day readmissions among the enrolled census	These are the measures ASM will score from 2027 and the ones the hospitals' TEAM episodes are reconciled on now
Operational	Enrolled census by programme; enrollment conversion rate; device compliance (days with data); alert-to-contact time	Census is revenue. Days-with-data is what makes 99454 and 99445 billable in the first place
Financial	Time to first billable enrollment; capture rate (billed ÷ eligible); net reimbursement per patient per month; net to practice	Modeled at ~$96.02 per RPM patient-month and ~$90.54 per PCM patient-month. Capture rate is the metric that quietly decides whether the modeled P&L is realised
Strategic	Post-discharge reach rate within two business days; readmission delta versus the unenrolled panel; referral retention	The numbers to take into a hospital conversation, and the ones that make the group's contribution measurable rather than asserted

Expected impact over 24 months, as modeled: $4,685,339 of net reimbursement and $1,986,060 net to the practice at a 42.39% margin; 3,144 unique patients and 3,901 active programme enrollments at month 24; 380,017 physiologic readings; 88,611 billed units; approximately 241 avoided hospitalizations; and 39,820 care-team hours delivered. *All figures are illustrative, modeled — verify against practice data.*

9.6 Twelve-month roadmap

Phase	Months	What happens
Charter	0–1	Physician lead named; service line chartered with its own P&L; target populations agreed; EHR confirmed (Section 8.1); attribution and coordination policy written before the first enrollment
Stand up	1–3	Integration built against the confirmed EHR; alert thresholds and escalation protocol set by the physician lead; on-site enrollment specialist placed; discharge-notification process agreed with the admitting hospitals
First census	2–6	Heart failure and post-discharge cohorts enrolled first; first billable enrollment inside 90 days; month 2 is the first net-positive month in the model
Extend	6–9	Hypertension, post-ablation, post-implant and post-structural-heart pathways added; second enrollment pathway opened to move the PCM arm, which is enrollment-limited rather than eligibility-limited
Institutionalise	9–12	Monthly scorecard running; capture rate and readmission delta reported; TCM decision taken on its own merits; the final CY2027 Ambulatory Specialty Model participant list re-verified and the readiness plan in Section 5 confirmed against it

References & Data Sources

- **CMS Revalidation Clinic Group Practice Reassignment** (`revalidation_clinic_group_practice_reassignment_pa_xref.csv`, data vintage July 1, 2026; dataset modified July 14, 2026): the 19-provider reassigned roster, group PECOS associate ID 7315920899, and every secondary group affiliation held by those providers.
- **CMS Medicare Fee-For-Service Public Provider Enrollment** (`PPEF_Enrollment_Extract_2026.07.17.csv`, vintage July 1, 2026) and the NPPES NPI Registry (live API, retrieved August 3, 2026): organizational NPI 1144270240, PECOS enrollment record, provider type, taxonomy codes and registered address.
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024** (released May 21, 2026): beneficiary counts, service counts, allowed amounts, average HCC risk scores, mean beneficiary age, dual-eligible counts, place-of-service split and rurality coding, per rendering NPI.
- **CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024** (released May 21, 2026): the published HCPCS mix, the remote cardiac device monitoring lines (93294, 93295, 93297, 93298, 93268/93229), and the negative screen across the full remote physiologic monitoring, remote therapeutic monitoring, chronic care management, principal care management and transitional care management code sets for all 19 NPIs. CMS suppresses lines with fewer than 11 beneficiaries.
- **CMS Ambulatory Specialty Model Participants** (`CY27_Prelim_ASMParticipants_Public.csv` — **CY2027 preliminary**; dataset modified February 4, 2026; retrieved August 3, 2026): three Heart Failure cohort NPIs under the organization legal name, CY2027 participant and small-practice flags both Yes; national cohort size 2,610 and the per-organization size distribution. **No final CY2027 list existed in the CMS catalog as of the retrieval date.**
- **CMS TEAM Participant List** (published at cms.gov/team-model-participant-list; hospital list as of April 15, 2026, updated quarterly; retrieved August 3, 2026): CCN 100223, 100054, 100122, 100292 and 100365, all mandatory, CBSA 18880, performance period January 1, 2026 to December 31, 2030.
- **CMS Medicare Shared Savings Program participants, PY2026** (dataset modified February 4, 2026) and the ACO REACH PY2024 Provider Public Use File (modified July 20, 2026): both searched in full; the practice does not appear in either. Its only identified CMS model relationship is the preliminary Ambulatory Specialty Model listing.
- **CMS Hospital Enrollments** (`Hospital_Enrollments_2026.07.17.csv`, vintage July 1, 2026): CCN-to-entity resolution, ownership and addresses for the five hospitals in CBSA 18880.
- **CMS Medicare Monthly Enrollment** (through April 2026; dataset modified July 23, 2026, queried on county FIPS 12091) and the **CMS Medicare Advantage State/County Penetration file, July 2026**: county Medicare, Original Medicare and Medicare Advantage enrollment by year, and the Panhandle penetration comparison.
- **CMS Medicare Geographic Variation by County, CY2024** (updated May 15, 2026): 30-day acute readmission rate, emergency visits and inpatient stays per 1,000, standardized payment per capita, and dual share, for Okaloosa County against Florida and national.
- **CDC PLACES county estimates** (resource `swc5-untb`, 2025 release, BRFSS survey year 2023) and **CDC heart disease and stroke mortality** (resources `mri7-5jtw` and `y5ii-knwc`, 2022–2024 three-year average, age-adjusted, adults 35+): county prevalence, county mortality, and the Florida and county-median benchmarks used in Figure 2.
- **Florida Agency for Health Care Administration** — licensed Adult Cardiovascular Services Level I and Level II lists, generated July 1, 2026: hospital cardiac capability across the market.

- **The practice's own website and its archived captures** (okaloosaheart.com — home, about, contact, procedures, available tests, atrial-fibrillation pages, retrieved August 3, 2026; Internet Archive captures from 2007, 2018 and 2019): locations, the published procedure range, the branded patient-portal deployment, and the named Coumadin and Pacemaker clinics running 2007–2019.
- **CMS — CY2026 Medicare Physician Fee Schedule:** TCM 99495 and 99496; RPM 99453, 99454, 99445, 99457, 99470 and 99458; PCM 99424–99427; and the concurrency rules under which RPM and PCM stack. Locality-adjusted payment for this practice is set by the Florida Medicare Administrative Contractor, Jurisdiction N.
- **CMS policy references:** the Transforming Episode Accountability Model (mandatory, January 1, 2026 – December 31, 2030; five episode categories including coronary artery bypass graft; participation by hospital CCN); the Ambulatory Specialty Model (January 1, 2027 start; low back pain and heart failure; PY2027–2031; −9% to +9% Part B adjustment in the first payment year; electronic collaborative care arrangement with primary care); and national coverage determination 20.40, renal denervation for uncontrolled hypertension, effective October 28, 2025 under Coverage with Evidence Development.
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 5, 6 and 9, including the 10,740-patient in-scope base, 75% / 85% RPM / PCM eligibility, 35% / 30% acceptance, the 19-provider referral engine at eight referrals per provider per month with 80% acceptance, one on-site enrollment specialist at CoachCare's expense, and MAC-locality rates auto-resolved for ZIP 32539 (Florida, locality 09102-99).

Items not independently verified

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

- **Whether any remote monitoring, chronic care or principal care management programme exists today.** CY2024 Medicare shows zero across all 19 providers, but a programme launched in 2025 or 2026 would be invisible in current data, and Medicare Advantage or commercial activity would not appear at all. *This is the single most important thing to ask directly.*
- **The final CY2027 Ambulatory Specialty Model participant list.** The verification in this report rests on the **preliminary** CY2027 file. Re-verify when CMS publishes the final list, and confirm the current-year specifics of the small-practice flag.
- **The electronic health record.** Veradigm is probable but unconfirmed; the branded FollowMyHealth portal is suggestive but that product is sold standalone and can sit on other vendors' systems. Confirm the platform and its integration surface before any scoping commitment.
- **Who owns the device-monitoring workflow, on which platform, and with what capacity.** The practice remotely monitors roughly a thousand pacemakers, five hundred defibrillators, thirteen hundred loop recorders and 558 implantable hemodynamic monitors. No named vendor appears anywhere on the practice's site. Identify the staff, the platform, and whether that team has capacity to absorb a physiologic programme.
- **Whether a named heart failure clinic or disease-management pathway exists.** The implantable hemodynamic monitor volume implies one, but no named clinic appears in any public source.
- **Whether the anticoagulation clinic is still running.** It was named on the practice's own site from 2007 to 2019 and is absent from the current site. If it still exists it is the closest existing analogue to a care-management programme; if it was discontinued, understanding why is equally valuable.

- **The terms of the hospital relationships.** Whether any professional services agreement, co-management arrangement, medical directorship, call-coverage contract or clinically integrated network membership exists is not disclosed in any public CMS file. This determines whether a hospital-supported post-discharge programme is contractually and legally feasible (Section 6).
- **True unique-patient panel size and payer mix.** A unique-patient denominator cannot be derived from the public CMS files, which report beneficiary instances per code per provider and contain duplication. The modeled 10,740 is a discovery-stage estimate. Commercial and Medicare Advantage volume is additive to every figure in this report.
- **The live roster.** Nineteen providers as of July 1, 2026, but reassignment records lag departures and miss recent hires, and at least one provider on the file has a competing local practice affiliation reported in local press. Confirm the current roster before any outreach that depends on it.
- **The Destin office's operating model.** Advertised on the practice website but not visible as a Medicare-registered billing location in CY2024; a 2026 job posting implies a rotating part-time staffing pattern. Confirm how it is staffed and how it bills.
- **Medicare Advantage risk contracts.** Not publicly discoverable. Relevant here because the county's low Medicare Advantage penetration is a genuine commercial asset and worth understanding contract by contract.
- **County-level heart failure prevalence.** CDC PLACES does not model heart failure and the county chronic-conditions file was not reachable during research. This is the one disease-burden figure that would most directly support the heart failure story, and it is missing rather than negative.
- **Corporate filing details.** The Florida corporate register blocks automated retrieval and every third-party mirror is likewise gated, so the entity's filing date, document number and officer set are snippet-derived rather than page-verified. A manual lookup is needed before any contractual use.

Global verification caveat

Facts in this report reflect public sources current to August 2026 and are cited above. Items flagged “CoachCare-provided,” “stated assumption,” “estimate,” “probable” or “confirm” were not independently verifiable from public sources. Reimbursement figures are illustrative national or modeled locality magnitudes — verify against the current CY2026 Physician Fee Schedule and the applicable Florida locality files, and note that CY2027 rulemaking is in progress. The Ambulatory Specialty Model verification rests on the **preliminary** CY2027 participant list and must be re-checked against the final file; the TEAM hospital list is current as of April 15, 2026 and CMS updates it quarterly; the practice itself holds no CCN and is not a TEAM participant. The electronic health record is probable but unconfirmed. All Value Analysis outputs are illustrative, modeled — verify against practice data.

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