

POLARIS HEART & VASCULAR CLINIC

Woodbridge, Virginia

Cardiovascular Service Line Performance & Optimization 2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as the operating spine

Purpose of this report

This report assesses how a managed Remote Care Service Line — built on the remote patient monitoring program Polaris Heart & Vascular already operates — can serve simultaneously as (1) a standalone, margin-positive recurring revenue line, (2) the episode-performance engine for the practice's two TEAM-mandatory hospital partners, (3) the total-cost-of-care lever inside its two-sided-risk ACO participation, and (4) the throughput multiplier for its new outpatient cardiovascular center. All financial figures are illustrative, modeled outputs of the accompanying CoachCare Value Analysis and should be verified against practice data.

Prepared by CoachCare · August 2026

Confidential — prepared for the leadership of Polaris Heart & Vascular Clinic

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Executive Summary

Polaris Heart & Vascular Clinic is the leading independent cardiology group in Prince William County, Virginia: three physicians and four nurse practitioners operating from Woodbridge, with an in-office nuclear stress lab, an active cardiac-device clinic, and — as of July 2025 — co-ownership of a \$7.1 million outpatient cardiovascular center operated as a joint venture with Sentara Health, offering same-day cardiac catheterization, PCI, and electrophysiology procedures. The practice's estimated Medicare panel is approximately 1,100 patients (credible range 800–1,500), and roughly 44–46% of the physicians' Medicare panels carry a heart failure diagnosis.

Three facts define the practice's 2026 position. **First, Polaris already runs remote patient monitoring** — approximately 110–122 patients and roughly \$85,600 in CY2024 allowed charges, billed under a single physician NPI. This is a real, functioning program, and it proves the clinical model works here. **Second, the payment environment around the practice changed on January 1, 2026.** Both hospitals where Polaris physicians hold their primary affiliations — Sentara Northern Virginia Medical Center (CCN 490113) and Virginia Hospital Center (CCN 490050) — are mandatory participants in CMS's Transforming Episode Accountability Model (TEAM) for 2026–2030, and Polaris Heart & Vascular PLLC itself entered the Medicare Shared Savings Program for PY2026 through Mary Washington Health Alliance LLC (ACO A5828) at BASIC Track Level E — two-sided risk, with the practice's fee-for-service panel prospectively assigned. **Third, the care-management layer that both models reward is not yet built:** the practice billed no CCM, PCM, or TCM at meaningful scale in CY2024, and second-increment RPM time capture (99458) ran at just 3.6% of first-increment volume.

The central argument

One service line is the connective tissue. The same enrollment, monitoring, and escalation engine powers the practice's fee-for-service P&L, its hospital partners' TEAM episodes, and its ACO's two-sided risk. Build once, reuse everywhere. Modeled over 24 months, the expanded program produces **\$833,925 in net reimbursement and \$356,769 in practice profit — a 42.8% margin on net reimbursement** (Year 1: 40.7%; Year 2: 44.1%) — while avoiding a modeled 33–66 hospitalizations worth roughly \$493,000–\$987,000 in total cost of care, depending on the admission baseline assumed. All figures are illustrative, modeled — verify against practice data.

The clinical wedge is the 30 days after discharge. Sentara Northern Virginia Medical Center's 30-day mortality is no different than the national rate across reported measures — the inpatient care is good — but all four of its reported excess readmission ratios exceed 1.0, with heart failure the worst at 1.0877 (measure period 07/2021–06/2024). Virginia Hospital Center's weak spot is CABG readmissions (ERR 1.1233) — precisely the episode TEAM now prices. The gap is not the hospitalization; it is the post-discharge window. That window is exactly what a TCM-at-discharge → short-window RPM (99445/99470) → longitudinal RPM/PCM pathway covers, and as of 2026 both TEAM and the ACO attach direct financial consequences to it.

The expansion model is deliberately conservative: it is ceiling-limited, not outreach-limited. Program ceilings of 236 RPM and 230 PCM enrollments (305 unique patients at steady state) derive from the estimated eligible population — not from enrollment capacity — and the model saturates them by months 5, 6, and 9 respectively. The binding constraint is the size of the eligible panel, which makes verifying the Medicare panel estimate the single most important discovery item. Month 1 is modeled

at -\$5,616 (one-time implementation and EMR integration setup); every month from month 2 forward is positive, reaching a steady state of approximately \$18,912 per month from month 14.

2026–2027 Priority Recommendations

1. **Scale the RPM program from ~110 patients toward its modeled ceiling of 236** — the heart-failure-diagnosed cohort on the practice's largest physician panel alone (~300+ patients) is nearly three times the current census — and fix 99458 second-increment capture (3.6% today) inside the same workflow.
2. **Stand up PCM as a new program** (no program at meaningful scale in CY2024) to create the longitudinal care-management layer the ACO's two-sided risk now rewards.
3. **Install TCM at every discharge** from Sentara Northern Virginia Medical Center and Virginia Hospital Center, chained into short-window RPM (99445/99470) — the operational response to both hospitals' readmission profiles and their TEAM episode accountability.
4. **Present the program to hospital and ACO partners as shared infrastructure** — episode-cost support for the two TEAM hospitals; total-cost-of-care contribution for Mary Washington Health Alliance.
5. **Use remote monitoring to protect same-day discharge at the new outpatient center** — post-procedure short-window RPM supports the center's same-day cath/PCI/EP model and differentiates the practice's procedural offer.
6. **Verify the two open model inputs on the first discovery call:** the true Medicare panel size (the model's binding constraint) and the practice's EHR vendor (integration path and setup assumption).

1. Footprint & Operating Model

1.1 The Practice

Polaris Heart & Vascular Clinic (Polaris Heart & Vascular PLLC) is a single-specialty cardiovascular group headquartered at 2022 Opitz Blvd, Woodbridge, Virginia — Prince William County, inside CBSA 47900 (Washington–Arlington–Alexandria, DC-VA-MD-WV). The billing roster comprises three physicians (two interventional cardiologists and one cardiovascular disease specialist) and four nurse practitioners — seven referring clinicians in the expansion model. The physician bench roughly tripled between CY2024 and mid-2025 through recruitment, and the practice maintained an active cardiology NP posting as of August 2026 — a group in growth mode.

The practice's CY2024 Medicare billing spine shows a full-service ambulatory cardiology operation: high-volume office E/M, in-office ECG and nuclear stress testing, hospital-based E/M and diagnostic catheterization, in-office loop-recorder implantation, and — notably — an established remote-monitoring footprint spanning both RPM (99453/99454/99457/99458) and remote cardiac-device monitoring (93298 implantable-loop-recorder checks, mobile cardiac telemetry). Section 3 details this incumbency; it is the foundation the expansion builds on, not a gap.

1.2 Operating Context: Hospitals, ACO, and the New Outpatient Center

Relationship	Detail	2026 significance
Sentara Northern Virginia Medical Center (CCN 490113), Woodbridge	Primary hospital affiliation for the majority of the practice's physicians and NPs; the only acute-care hospital in the immediate service area (CMS overall rating 3)	Mandatory TEAM participant, 01/01/2026–12/31/2030; all four reported excess readmission ratios above 1.0
Virginia Hospital Center (CCN 490050), Arlington	Secondary hospital affiliation (CMS overall rating 4)	Mandatory TEAM participant, same period; CABG ERR 1.1233 — TEAM's CABG episode
Mary Washington Health Alliance LLC (ACO A5828)	Polaris Heart & Vascular PLLC is a PY2026 MSSP participant — BASIC Track Level E (two-sided risk), agreement period 3, start 01/01/2026, low-revenue, prospective assignment, SNF 3-day waiver	The practice's fee-for-service Medicare panel is prospectively assigned into downside risk as of January 2026
Northern Virginia outpatient cardiovascular center (Groupe Drive, Woodbridge)	\$7.1M ambulatory center opened July 2025 as a joint venture with Sentara Health; same-day outpatient catheterization, PCI, EP device procedures, peripheral vascular	Procedural growth engine; same-day discharge model that post-procedure remote monitoring directly supports

Market context: Prince William County has 65,722 Medicare eligibles with Medicare Advantage penetration of 37.23% (July 2026), leaving a fee-for-service share of roughly 63%. The practice draws from Prince William, eastern Fairfax, and Stafford counties; a blended service-area MA share of ~35% is used in the panel model (Section 9).

1.3 Service Line Design Principles

Principle	What it means for Polaris
Longitudinal by default	Every eligible patient leaves an encounter enrolled in a monitoring or care-management pathway — not just post-event referrals
One front door	A single enrollment workflow (on-site enrollment specialist + referral + telephonic) feeds RPM and PCM according to eligibility, not program silos
Single scorecard	One dashboard covers census, capture rate, revenue per patient per month, readmissions among enrolled discharges, and escalations
Build once, reuse everywhere	The same enrollment/device/monitoring/billing engine serves the fee-for-service P&L, TEAM episodes, and ACO total-cost performance
Digital as care, not add-on	Remote readings, alert escalation, and titration support are part of the clinical model — the billing follows the care

2. The Remote Care Service Line — The Spine

2.1 What It Is: The Three-Program Stack

The Remote Care Service Line is one clinical operation billed through four coordinated Medicare programs. For a cardiology group, the stack runs from the discharge event to longitudinal management:

Program	Codes	Clinical role	Cadence
TCM — Transitional Care Management	99495 / 99496	Contact within 2 business days of discharge; face-to-face within 14 / 7 days; medication reconciliation	Per discharge
RPM — Remote Physiologic Monitoring	99453, 99454, 99457, 99458 + new 2026 codes 99445 (2–15-day device supply) and 99470 (first 10 min management)	Connected BP cuffs, scales, pulse oximetry; daily readings; alert-and-escalation; GDMT titration support	Monthly, recurring
PCM — Principal Care Management	99426 / 99427	Single high-risk condition management (heart failure) — the specialist-owned care plan	Monthly, recurring

Coordination rules (the fine print that makes the stack work)

RPM stacks with PCM for the same patient in the same month (discrete time and documentation). CCM and PCM do not stack with each other, and this model runs PCM — the usual fit where one cardiac condition dominates. TCM is billed at the discharge event and hands off to the longitudinal programs. The model applies a 70% dual-enrollment assumption — at steady state, approximately 466 program enrollments (Enrolled Services) across 305 unique patients (Enrolled Patients, deduplicated). Enrollment policy: PCM as the longitudinal wrapper, RPM layered on the monitored cohort — one care plan per patient, one program owner per month.

2.2 Standalone Value: Five Value Layers and the CY2026 Billing Stack

The service line justifies itself on the first layer alone; the other four are leverage on the same infrastructure:

1. **Standalone recurring P&L (the lead layer).** Subscription-like monthly professional-fee revenue: modeled \$833,925 net reimbursement and \$356,769 practice profit over 24 months — a 42.8% margin on net reimbursement — at top-of-license staffing, with CoachCare carrying enrollment, monitoring, and documentation labor.
2. **TEAM episode-cost performance.** Post-discharge monitoring compresses readmissions and post-acute utilization inside the 30-day episode windows now priced at Sentara Northern Virginia Medical Center and Virginia Hospital Center (Section 6).

3. **Two-sided-risk total-cost-of-care contribution.** The practice's prospectively assigned panel now sits in a downside-risk ACO with zero care-management infrastructure billed in CY2024 — avoided admissions flow directly against the ACO benchmark (Section 7).
4. **Procedural throughput.** Post-procedure remote monitoring protects the same-day discharge model at the new outpatient center and supports structural-heart and renal-denervation whitespace (Section 8).
5. **Quality-rating halo defense.** Readmission performance among the practice's discharges defends referral relationships, publicly reported quality measures, and the hospital partners' ratings.

CY2026 Billing Stack — MAC locality rates (Woodbridge, VA 22191)

Code	Service	CY2026 locality rate	Cadence
99453	RPM setup & patient education	\$21.16	One-time
99454	RPM device supply, 16–30 days of readings	\$51.13	Monthly
99445	RPM device supply, 2–15 days (new for 2026)	\$51.13	Monthly (short window)
99457	RPM treatment management, first 20 min	\$50.87	Monthly
99470	RPM treatment management, first 10 min (new for 2026)	\$25.60	Monthly (short window)
99458	RPM treatment management, each add'l 20 min	\$40.69	Monthly
99426	PCM, first 30 min clinical staff time	\$66.57	Monthly
99427	PCM, each add'l 30 min	\$53.13	Monthly
99495 / 99496	TCM, moderate / high complexity (illustrative national magnitude — additive; not included in the modeled totals)	~\$200 / ~\$280	Per discharge

Rates are CY2026 Physician Fee Schedule amounts for the practice's MAC locality (zip 22191), per the CoachCare Value Analysis workbook; TCM shown at illustrative national magnitude. Illustrative — verify against current CMS fee schedules and payer mix. Modeled net reimbursement applies a 15% collections haircut to allowed amounts.

Recurring-revenue mechanics

Unlike encounter-driven revenue, every enrolled month bills. A patient enrolled in RPM + PCM generates predictable monthly professional fees (device supply + management time + care-management time) for as long as clinically enrolled — the model assumes 1.5% monthly attrition. The new 2026 short-window codes (99445/99470) extend the same economics to 2–15-day post-discharge and post-procedure windows that were previously unbillable — the exact windows TEAM prices.

2.3 Connective Tissue: One Engine, Every Value Lever

One Engine, Every Value Lever — Build Once, Reuse Everywhere

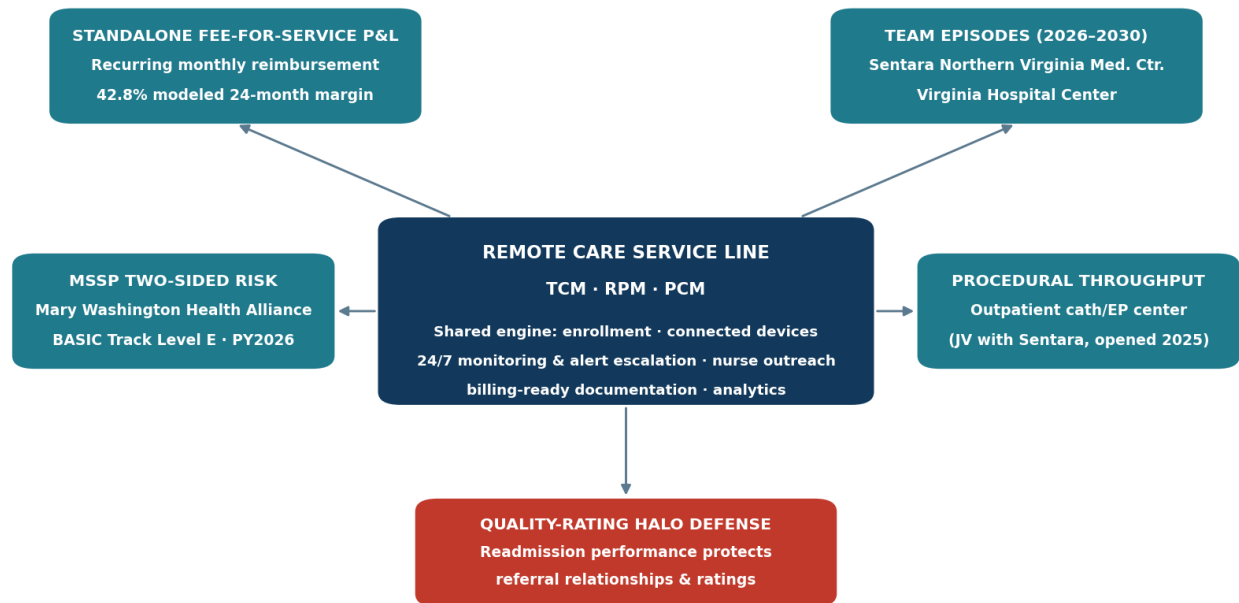


Figure 1. One shared engine — enrollment, connected devices, 24/7 monitoring and alert escalation, nurse outreach, billing-ready documentation, analytics — powers all five value levers simultaneously.

Value lever	What it needs	What the shared engine supplies
Standalone fee-for-service P&L	Enrollment at scale; documented monthly time; clean claims	On-site enrollment specialist; monitoring minutes captured and documented; billing-ready output per code
TEAM episodes (both partner hospitals)	Lower 30-day readmissions and post-acute spend inside priced episodes	TCM contact within 2 business days; short-window RPM from day 1 post-discharge; escalation before the ED visit
MSSP two-sided risk (ACO A5828)	Fewer admissions/ED visits against the ACO benchmark on the assigned panel	Longitudinal RPM/PCM on the highest-risk cohort; early decompensation detection; documented care coordination
Procedural throughput (outpatient center)	Confidence in same-day discharge; post-procedure surveillance	Post-procedure short-window monitoring (99445/99470); alert coverage without added practice staffing
Quality-rating halo	Publicly reported measures and referral-partner confidence	Measurably lower readmissions among enrolled discharges; auditable care documentation

3. Building on the Program Polaris Already Runs

Polaris is not a remote-care greenfield — and that is the strongest argument for expansion. In CY2024 the practice billed a real RPM program under a single physician NPI: approximately 110–122 patients, ~\$85,600 in allowed charges, roughly 14% of that physician's total allowed billing. Alongside it runs an active cardiac-device clinic — implantable-loop-recorder remote checks (398 services across 53 beneficiaries), mobile cardiac telemetry, and in-office loop-recorder implantation. The clinical case for remote monitoring is already proven inside this practice, by this practice.

3.1 CY2024 RPM Billing Detail

Code	Services	Beneficiaries	Allowed
99453 (setup)	31	31	\$595
99454 (device supply)	838	110	\$38,230
99457 (management, first 20 min)	959	122	\$45,406
99458 (each add'l 20 min)	35	21	\$1,333
Total	1,863	~110–122 patients	~\$85,563

Source: CY2024 Medicare Physician & Other Practitioners PUF (by provider and service). Data vintage: services through 2024.

3.2 Three Expansion Gaps Inside the Same Workflow

1. **Second-increment time capture is 3.6%.** The program billed 959 units of 99457 but only 35 units of 99458. A well-run heart-failure-weighted program stacks substantially more second-increment time — at the locality rate of \$40.69 per unit, this is a same-workflow revenue lift: the monitoring minutes are likely already being spent, not captured.
2. **The census plateaued near 110 patients.** Only 31 setup codes (99453) were billed against 110 device-supply patients — most enrollees predate 2024, and enrollment stalled. Meanwhile the heart-failure-diagnosed cohort on the practice's largest physician panel alone is roughly 300+ patients (44% of 694 Medicare FFS beneficiaries), before counting the second interventionalist's panel (46% HF) or growth since. The modeled RPM ceiling of 162 is conservative against that cohort.
3. **CCM, PCM, and TCM: no program at meaningful scale in CY2024.** No codes from any of these families appear in the practice's CY2024 service-level file (CMS suppresses lines under 11 beneficiaries). For a group that entered two-sided ACO risk in January 2026, the longitudinal care-management layer — the layer the ACO benchmark rewards — is the whitespace.

3.3 Build vs. Partner

The practice has already made the hard decision — remote care is part of its clinical model. The open question is operational: scaling from ~110 patients to 305 unique enrolled patients across two programs (plus TCM at every discharge) requires enrollment labor, 24/7 monitoring coverage, documented time capture across four code families, and billing operations that the current plateau and 3.6% second-increment capture suggest are the binding constraints. The CY2024 pattern

(billing under one physician's NPI, stalled census, minimal 99458) is consistent with a program constrained by internal bandwidth — whether operated in-house or through a limited vendor (the current operating arrangement is a discovery item).

Dimension	Scaling in-house	CoachCare full-service model
Enrollment	Practice staff time; the historical plateau is the evidence base	CoachCare-funded on-site enrollment specialist (CoachCare's expense) + referral and telephonic pathways
Monitoring & escalation	Requires dedicated staffing to cover daily readings and alerts	24/7 monitoring with escalation per practice-approved protocols; ~4.4 FTE-equivalent care hours delivered over 24 months in the model
Time capture & billing	3.6% second-increment capture is the current state	Documented minutes per code family; billing-ready documentation for every claim
Devices & logistics	Procurement, provisioning, replacement on practice staff	Cellular-connected devices supplied, provisioned, and managed
Cost structure	Fixed staffing costs regardless of census	Fees scale with enrolled census; modeled all-in 24-month margin of 42.8% net of all CoachCare fees

4. 2026 Policy & Payment Environment: TEAM and Two-Sided ACO Risk

4.1 TEAM: Mandatory Episode Accountability at Both Partner Hospitals

The Transforming Episode Accountability Model (TEAM) is CMS's mandatory episode-based payment model running January 1, 2026 through December 31, 2030. Participant hospitals are accountable for 30-day episode spending — including readmissions and post-acute utilization — against CMS target prices for five surgical episode families, including CABG, lower-extremity joint replacement, surgical hip/femur fracture treatment, spinal fusion, and major bowel procedures.

Hospital	CCN	TEAM status	CBSA	Performance period
Sentara Northern Virginia Medical Center (Woodbridge)	490113	Mandatory participant	47900	01/01/2026 – 12/31/2030
Virginia Hospital Center (Arlington)	490050	Mandatory participant	47900	01/01/2026 – 12/31/2030

Source: CMS TEAM participant list as of April 15, 2026 (updated quarterly) — re-verify against the current quarterly CMS list before external use. Essentially the entire Northern Virginia acute-care market participates via CBSA 47900.

Polaris physicians round, consult, and perform diagnostic catheterization at these hospitals; the practice's discharged patients are the hospitals' episode patients. A cardiology group that can demonstrably compress 30-day readmissions is no longer just a referral source to a TEAM hospital — it is an episode-performance partner, with the leverage that implies in call coverage, co-management, and service-line planning conversations.

4.2 MSSP: Two-Sided Risk on the Practice's Own Panel

Verified for PY2026: Polaris Heart & Vascular PLLC is a participant in ACO A5828, Mary Washington Health Alliance LLC — BASIC Track Level E, the track's highest level, carrying two-sided (upside and downside) risk. The agreement period began January 1, 2026; the ACO is low-revenue with prospective assignment and the SNF 3-day-rule waiver. The practical meaning: the practice's fee-for-service Medicare panel was prospectively assigned into a downside-risk total-cost-of-care contract as of January 2026, and every avoidable admission, readmission, and ED visit on that panel now has direct financial consequence to the ACO — and through it, the practice.

The gap between the risk and the infrastructure

The practice entered two-sided risk with zero care-management infrastructure billed in CY2024 — no CCM, no PCM, no TCM at meaningful scale. The programs that manage total cost of care on an assigned panel are precisely the programs the Remote Care Service Line stands up. Section 7 quantifies the avoided-admission economics.

4.3 One Transformation, One Service Line

TEAM prices the 30 days after a surgical discharge. The ACO prices the total annual cost of the assigned panel. Both reward exactly one operational capability: continuous post-discharge and longitudinal monitoring with early escalation. The practice does not need a TEAM program and an ACO program — it needs one Remote Care Service Line whose enrollments serve both, which is why the standalone P&L (Section 9) should be read as the funded vehicle for the practice's entire value-based position.

5. Performance Snapshot: The 30-Day Post-Discharge Gap

The Care Compare data on the practice's two primary hospital partners tells one consistent story: inpatient care quality is not the problem — the 30 days after discharge are. At Sentara Northern Virginia Medical Center, 30-day mortality is no different than the national rate across reported measures (heart failure mortality 10.6%). The hospital keeps patients alive. But all four of its reported excess readmission ratios exceed 1.0 — heart failure worst at 1.0877 (predicted 21.7% vs. expected 19.9%), with pneumonia 1.0594, COPD 1.0426, and AMI 1.0330. Patients leave the hospital in good condition and come back too often.

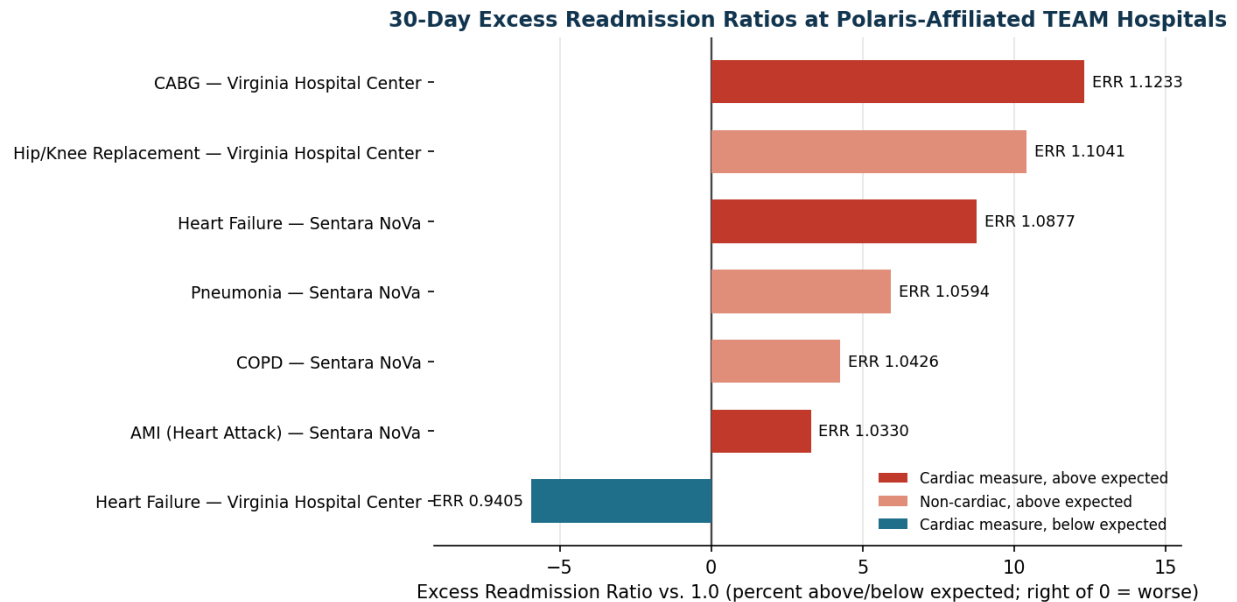


Figure 2. Excess Readmission Ratios (ERR) vs. 1.0 at the practice's two TEAM-mandatory partner hospitals; bars right of zero indicate readmissions above the expected rate (lower is better). Source: CMS Care Compare / Hospital Readmissions Reduction Program, measure period 07/2021–06/2024 — directional snapshot; refresh against current HRRP data.

Virginia Hospital Center shows the mirror image at the surgical end: strong heart failure performance (ERR 0.9405) but elevated CABG readmissions (ERR 1.1233) and hip/knee (1.1041) — and CABG is a TEAM-priced episode as of January 2026. Neither hospital's gap is a care-quality indictment; both are the signature of a missing post-discharge monitoring layer. That is the layer this service line supplies, and the practice — as the cardiology group inside both readmission funnels — is positioned to supply it.

Why this is Polaris's opportunity rather than the hospitals' problem

Roughly 44–46% of the practice's physician panels carry a heart failure diagnosis — the practice's own patients populate the heart failure readmission measure at its primary hospital. A TCM contact within 2 business days of discharge, a connected scale and BP cuff on day 1, and escalation at the first weight or symptom signal is the highest-leverage intervention available for this measure — and every element of it is billable under the 2026 stack, including the previously unbillable 2–15-day window (99445/99470).

6. Powering TEAM: Episode Accountability at Two Partner Hospitals

TEAM makes Sentara Northern Virginia Medical Center and Virginia Hospital Center financially accountable for 30-day episode spending on priced surgical episodes — including the readmissions their current profiles show. For the CABG episode specifically, Virginia Hospital Center's ERR of 1.1233 sits directly on the episode TEAM prices. The hospitals own the accountability; the practice owns the patients and the post-discharge relationship. That asymmetry is the partnership opportunity.

6.1 The Episode Bundle, Operationally

Episode window	Service	What happens
Day 0 (discharge)	TCM initiation (99495/99496)	Interactive contact within 2 business days; medication reconciliation; face-to-face within 7–14 days
Days 1–15	Short-window RPM (99445 + 99470)	Connected devices deployed at or before discharge; daily weight/BP/SpO ₂ ; alert thresholds tuned to the episode (volume status post-CABG, access site, arrhythmia)
Days 16–30	RPM (99454 + 99457/99458)	Continued monitoring through the episode window; escalation to the practice before an ED visit becomes a readmission
Day 31+	Longitudinal RPM + PCM	The episode patient converts to a longitudinal enrollment — the fee-for-service and ACO layers take over

The 2026 code changes make this bundle billable end-to-end for the first time: 99445 and 99470 pay for the 2–15-day monitoring windows that previous rules left uncompensated. The episode workflow is therefore not a cost center the practice absorbs to help its hospital partners — every step generates professional-fee revenue while compressing the episode spend the hospitals answer for.

6.2 What to Bring to the Hospital Conversation

- A standing offer: every Polaris-attributed discharge from either hospital leaves with TCM scheduled and a monitoring kit — measured by enrollment rate at discharge and 30-day readmission rate among enrolled patients.
- Episode-aligned reporting: monthly readmission and escalation summaries for the hospitals' TEAM populations touched by the practice.
- A shared-accountability frame: the hospitals face TEAM reconciliation; the practice brings the infrastructure neither hospital has to build — and the same engine already serves the practice's own ACO position.

7. Powering the ACO: Two-Sided Risk Contribution

Lead with the admissions, not the fees. The Value Analysis is a fee-for-service model, and its P&L stands on its own (Section 9). But for the practice's ACO position, the more consequential number is utilization: the modeled program avoids **23.4 hospitalizations over 24 months** at the model's deliberately generic 20% annual admission baseline — approximately **\$350,869 in avoided admission cost at \$15,000 per admission**. For a heart-failure-weighted cohort like this one, published admission rates run materially higher; at a 40% baseline — the realistic anchor for this panel — the same program avoids roughly 46.8 admissions, approximately \$702,000.

Annual admission baseline	Hospitalizations avoided (24 mo)	Avoided cost @ \$15,000/admission
20% (model default, generic)	23.4	≈ \$350,869
30%	≈ 35.1	≈ \$526,000
40% (realistic for an HF-weighted cohort)	≈ 46.8	≈ \$702,000
50%	≈ 58.5	≈ \$877,000

Sensitivity scales linearly with the admission baseline. Illustrative, modeled — verify against practice data and ACO benchmark reports. Avoided-cost figures are a separate value layer and are NOT added to the fee-for-service P&L in Section 9.

These avoided admissions land on a panel that is prospectively assigned to Mary Washington Health Alliance under two-sided risk: reductions in total cost of care accrue against the ACO benchmark, participate in shared savings, and defend against shared losses. The practice is a low-revenue participant in a BASIC Track Level E ACO — the configuration where a specialty group's utilization performance is most visible and most valuable. The service line also produces the documented care-coordination artifacts (care plans, medication reconciliation, escalation logs) that ACO quality reporting rewards.

The fee-for-service margin is the second story here, not the first: the same enrollments that generate the 42.8% modeled margin are the instrument that moves the ACO's cost curve. One program, two balance sheets.

8. Powering Procedural Growth: The Outpatient Center and Whitespace

8.1 The New Outpatient Cardiovascular Center

In July 2025 the practice opened a \$7.1 million outpatient ambulatory cardiovascular center on Groupe Drive in Woodbridge as a joint venture with Sentara Health — same-day outpatient cardiac catheterization, PCI, EP device procedures (pacemakers, ICDs, loop recorders), and peripheral vascular work, described publicly as the first of its kind in Northern Virginia. The center's economics depend on the same-day model: cases that discharge safely the same day keep the schedule dense and the cost per case low.

Post-procedure remote monitoring is the natural risk-management layer for that model. A patient leaving after PCI or a device implant with a connected BP cuff, pulse oximeter, and symptom check-ins — with 24/7 alert coverage and escalation to the practice — extends clinical surveillance beyond the recovery bay without adding practice staffing. Under the 2026 codes, that 2–15-day window is billable (99445/99470). The result: same-day discharge confidence for clinicians and referring physicians, a differentiated patient experience, and a revenue-positive safety net.

8.2 Whitespace: Structural Heart and Renal Denervation

- **Structural heart.** The practice's interventional depth and its hospital relationships position it to participate in structural-heart growth (TAVR/TEER-adjacent workup, WATCHMAN referral pathways) where volumes justify — and every structural pathway depends on optimized, monitored patients pre- and post-procedure. The monitoring layer is the on-ramp.
- **Renal denervation.** CMS finalized national coverage for renal denervation for uncontrolled hypertension in October 2025 under Coverage with Evidence Development. RDN is remote-care-dependent by design: patient selection requires documented BP control failure across medication titration, and CED evidence expectations reward continuous BP data. A practice already running BP monitoring at scale holds the qualifying funnel. This is clean whitespace for an interventional group with an outpatient procedural facility.

Both plays reuse the same engine — no additional infrastructure beyond the service line this report already models.

9. The Value Analysis: Modeled 24-Month Economics

Figures in this section are outputs of the CoachCare Value Analysis workbook for Polaris Heart & Vascular (CY2026 Physician Fee Schedule rates, MAC locality for zip 22191, built August 2026). All figures are **illustrative, modeled — verify against practice data**. Net reimbursement applies a 15% collections haircut to allowed amounts; practice profit is net of all CoachCare fees.

9.1 Model Inputs

Input	Value	Basis / vintage
Total Medicare panel (estimate)	1,100 (credible range 800–1,500)	CY2024 CMS claims roll-up grossed up by 37.23% Prince William MA penetration (July 2026); the #1 discovery item
Year-1 in-scope population	900	Condition-eligible estimate, ~82% of panel
Referring clinicians	7 (3 physicians + 4 NPs)	Current registry roster, August 2026
Program eligibility (RPM / PCM)	60% / 70% / 70% of in-scope	Cardiology eligibility profile
Enrollment acceptance (RPM / PCM)	30% / 25% / 25%	CoachCare implementation experience
Program ceilings (RPM / PCM)	236 / 230 enrollments	In-scope × eligibility × conversion
Unique patients at steady state	305 (dual-enrollment deduplicated)	70% dual-enrollment assumption
Enrollment staffing	One CoachCare-funded on-site enrollment specialist	CoachCare's expense — embedded value, not netted from practice margin
Monthly attrition	1.5%	Model assumption
EMR integration	\$4,000 one-time setup (catalog range \$0–\$4,000; conservative end)	EHR vendor unverified — confirm in contracting (Section 10)

The constraint is the panel, not the outreach

This model is ceiling-limited: RPM saturates its 236-enrollment ceiling in month 7 and PCM its 230-enrollment ceiling in month 13, and every month thereafter runs at the ceilings. The binding constraint is the size of the eligible population — not enrollment capacity, marketing, or outreach. If the true panel is at the upper end of the 800–1,500 range (the practice added a physician and two NPs after the CY2024 data vintage), the ceilings — and every revenue figure below — scale up with it. Verifying the panel estimate is the single most important discovery item in this report.

9.2 Headline Results

24-month modeled results

Net reimbursement \$833,925 · CoachCare fees \$477,155 · Practice profit \$356,769

24-month margin on net reimbursement: 42.8% (Year 1: 40.7% · Year 2: 44.1%)

Illustrative, modeled — verify against practice data.

Period	Net reimbursement	CoachCare fees	Practice profit	Margin
Year 1	\$319,425	\$189,505	\$129,920	40.7%
Year 2	\$514,500	\$287,650	\$226,849	44.1%
24 months	\$833,925	\$477,155	\$356,769	42.8%

By program (24 months)

Program	Net reimbursement	CoachCare fees	Practice profit
RPM (ceiling 236)	\$471,704	\$263,214	\$208,489
PCM (ceiling 230)	\$362,221	\$188,681	\$173,540

9.3 The Monthly Ramp

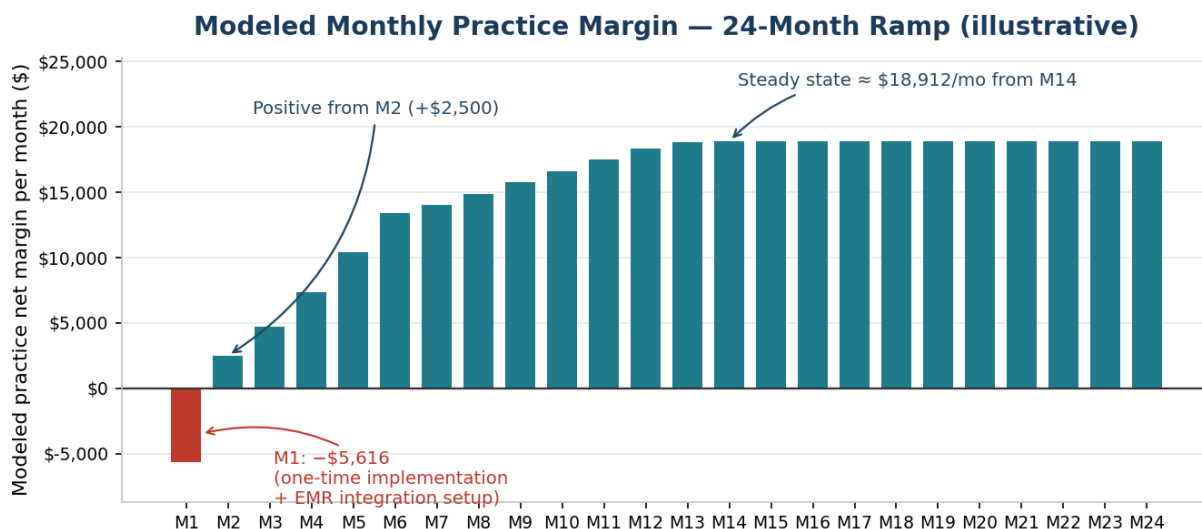


Figure 3. Modeled monthly practice margin. Month 1 is -\$5,616 — the one-time implementation and EMR integration setup post in month 1. Every month from month 2 forward is positive (M2: +\$2,500), reaching steady state of ≈ \$18,912/month from month 14. Illustrative, modeled — verify against practice data.

The program is not margin-positive in month 1 — the one-time implementation and integration costs land there — but it is margin-positive from month 2 onward and recovers the month-1 investment in month 2–3. Enrollment saturates quickly precisely because the model is ceiling-limited: the on-site enrollment specialist and referral pathways fill the eligible population within three quarters.

9.4 Clinical Impact Layer

Over 24 months at the ceilings, the model projects approximately 36,800 patient readings and 18,300 billed claims, with roughly 9,200 care-team hours (≈ 4.4 FTE-equivalents) delivered by CoachCare — monitoring labor the practice does not hire. The clinical output: 23.4 hospitalizations avoided at the generic 20% admission baseline ($\approx \$350,869$ at $\$15,000/\text{admission}$), scaling to ≈ 46.8 avoided ($\approx \$702,000$) at the 40% baseline realistic for a heart-failure-weighted cohort — see the sensitivity table in Section 7. These avoided-cost figures are a separate value layer for the ACO and TEAM conversations; they are not added to the fee-for-service P&L above.

10. Technology & EMR Integration

What is verified: the practice runs an Updox forms and patient-communication layer — new-patient registration routes through Updox secure e-forms. Updox is an interoperability and portal layer used across many ambulatory EHRs; it does not by itself establish which EHR the practice runs. **The practice's EHR vendor is unverified**, and confirming it is an explicit first-call discovery item.

CoachCare maintains catalog integrations across the major ambulatory EHR platforms — Athenahealth, eClinicalWorks, Epic, Greenway, NextGen, Veradigm, Oracle Cerner, and others — covering demographic sync, encounter/document push of monitoring summaries and care plans, and billing-ready charge output. Whichever platform the practice runs, the integration workstream follows the same shape: confirm the vendor, map the interface (native API, HL7, or document-based), and stand up charge capture for the four code families.

Modeling assumption — confirm in contracting

The Value Analysis assumes a \$4,000 one-time catalog integration setup — the conservative (high) end of the \$0–\$4,000 catalog range. If the practice's EHR carries a no-cost catalog integration, month-1 economics improve accordingly. EHR vendor confirmation is flagged as a first-call discovery item and a contracting checkpoint.

Beyond the EHR: CoachCare supplies cellular-connected devices (no patient Wi-Fi dependency), the patient app and reading pipeline, the monitoring and escalation platform, and the documentation layer that produces auditable time logs per claim. The practice's existing Updox workflows are unaffected; the service line adds a monitoring stack alongside them.

11. Implementation Playbook

11.1 Goals and Scope

- Scale RPM from ~110 patients to the 236-enrollment ceiling; recover 99458 second-increment capture inside the same workflow.
- Launch PCM to its 230-enrollment ceiling; reach 305 unique enrolled patients ($\approx$ 466 program enrollments) by month 13–14.
- Install TCM at every discharge from both partner hospitals, chained into short-window RPM (99445/99470).
- Operate one scorecard serving the practice P&L, the TEAM hospital conversations, and the ACO reporting cadence.

11.2 Target Populations

Cohort	Primary program	Entry point
Heart-failure-diagnosed panel (~300+ on the largest physician panel alone)	RPM + PCM	Office visit enrollment (on-site specialist); device-clinic crossover
Multi-chronic panel (HTN ~75%, diabetes ~47%, CKD ~35% of the largest panel)	RPM + PCM	Office visit enrollment; annual wellness touchpoints
Hospital discharges (both TEAM hospitals)	TCM → short-window RPM → longitudinal conversion	Discharge workflow; rounding clinicians
Post-procedure patients (outpatient center)	Short-window RPM (99445/99470)	Procedure-day kit deployment

11.3 Staffing and the Operating Split

CoachCare operates the full-service model: enrollment (including the CoachCare-funded on-site enrollment specialist — CoachCare's expense, embedded value to the practice), device logistics, 24/7 monitoring, alert escalation per practice-approved protocols, and billing-ready documentation. The practice retains what only it can do: clinical judgment on escalations, medication titration decisions, TCM face-to-face visits, and the billing itself under practice NPIs. Modeled CoachCare-delivered care labor over 24 months: $\approx$ 9,200 hours ($\approx$ 4.4 FTE-equivalents) the practice does not hire, recruit, or manage.

11.4 KPI Dashboard

Domain	KPIs
Enrollment	Census vs. ceiling by program (236/230); unique enrolled patients (target 305); time-to-first-billable-enrollment; enrollment rate at discharge
Clinical	30-day readmission rate among enrolled discharges; alert response time; escalations

Domain	KPIs
	resolved without ED; GDMT titration events supported
Financial	Revenue per patient per month; 99458 second-increment capture rate (baseline 3.6% — target $\geq 40\%$); claim acceptance rate; margin vs. 42.8% model
Partner-facing	TEAM-episode enrollment coverage at both hospitals; monthly utilization summary for the ACO; avoided-admission estimate vs. baseline

11.5 12-Month Roadmap

1. **Month 0–1:** Contracting; EHR confirmation and integration setup; protocol sign-off; on-site enrollment specialist placed. Month 1 carries the one-time setup cost (modeled $-\$5,616$).
2. **Month 1–2:** RPM launch — migrate the existing ~110-patient census onto the managed platform; begin new enrollment from the HF cohort; 99458 capture live from the first migrated patient. Margin-positive from month 2 ($+\$2,500$).
3. **Month 2–3:** TCM discharge workflow live at Sentara Northern Virginia Medical Center, then Virginia Hospital Center.
4. **Month 3–5:** PCM launch; post-procedure short-window RPM live at the outpatient center; RPM reaches ceiling (month 7).
5. **Month 6–9:** PCM ceiling (month 13); first quarterly report to hospital partners and the ACO.
6. **Month 10–12:** Steady state ($\approx \$18,912/\text{month}$ modeled margin); re-verify panel estimate against actuals and re-size ceilings; annual review against the 42.8% margin model and the avoided-admission sensitivity.

References & Data Sources

- CMS TEAM Model participant list, as of April 15, 2026 (updated quarterly) — cms.gov/team-model-participant-list. Re-verify against the current quarterly list.
- CMS Medicare Shared Savings Program PY2026 Participants dataset, data.cms.gov (queried August 2026) — Polaris Heart & Vascular PLLC under ACO A5828, Mary Washington Health Alliance LLC.
- CY2024 Medicare Physician & Other Practitioners PUF (by provider; by provider and service), data.cms.gov — practice billing detail; data through 2024.
- CMS Care Compare: Hospital Readmissions Reduction Program and Complications & Deaths datasets (provider-data.cms.gov), measure period 07/2021–06/2024; Hospital General Information (overall star ratings). Confirm current values on Care Compare.
- NPPES NPI Registry and CMS Doctors & Clinicians national file (snapshots August 2026) — roster and affiliation verification.
- CMS Medicare Advantage State/County Penetration file, July 2026 — Prince William County MA penetration 37.23%.
- Sentara Health news release, July 29, 2025, and regional press coverage (August 2025) — Northern Virginia outpatient cardiovascular center opening.
- Polaris Heart & Vascular Clinic website (accessed August 2026) — services, locations, patient-forms (Updox) workflow.
- CY2026 Medicare Physician Fee Schedule, MAC locality rates for zip 22191, via the CoachCare Value Analysis workbook ([Polaris_Heart_CoachCare_Value_Analysis_2026.xlsx](#), built August 2026).
- CMS National Coverage Determination: Renal Denervation for Uncontrolled Hypertension (October 2025, Coverage with Evidence Development).
- About CoachCare: 400+ managed conditions for 500,000+ patients; 10,000+ providers; 1,000+ implementations; 5 million+ claims generated; 100 million+ vitals recorded; 4 million+ care actions enabled.

Global caveat

All financial figures in this report are illustrative, modeled outputs of the CoachCare Value Analysis (CY2026 PFS rates, MAC locality for zip 22191) and must be verified against practice data, current CMS fee schedules, and payer mix before any operational or contractual decision. Readmission and quality data carry the vintages noted; confirm current values on CMS Care Compare. TEAM participation should be re-verified against the current quarterly CMS participant list. Panel-size and eligibility inputs are estimates pending discovery. This report contains no individual patient information and names no individual clinicians.