BAKER-GILMOUR CARDIOVASCULAR INSTITUTE

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

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

Purpose of this report

This report maps Baker-Gilmour Cardiovascular Institute's position entering the 2026 Medicare payment environment and lays out a build plan for a managed Remote Care Service Line — a practice-owned program spanning transitional care management (TCM), remote physiologic monitoring (RPM), chronic care management (CCM), and principal care management (PCM), operated with CoachCare as the delivery partner.

The thesis: one service line generates recurring, margin-positive professional-fee revenue for the practice and, at the same time, becomes the connective tissue for the episode-cost accountability its two anchor hospitals assumed on January 1, 2026 under the CMS Transforming Episode Accountability Model (TEAM).

July 2026 · Prepared by CoachCare · Confidential — prepared for Baker-Gilmour Cardiovascular Institute

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Executive Summary

For more than 70 years, Baker-Gilmour Cardiovascular Institute has been an independent, physician-owned cardiology practice serving Northeast Florida. Founded in 1953 by Dr. Roy Baker — Florida's first pediatric heart physician — the practice today fields **three cardiologists spanning electrophysiology, interventional cardiology, and general/nuclear cardiology, supported by three advanced practice providers**, across two offices: one on University Boulevard in Jacksonville, directly across the street from HCA Florida Memorial Hospital, and one on the Flagler Hospital campus in St. Augustine. (Practice profile per bakerandgilmour.com and CMS registries, reviewed July 2026.)

The practice's history contains its 2026 strategy. In the 1960s and 1970s, Dr. Baker pioneered ambulance EKG telemetry adapted from NASA technology and developed early remote cardiac patient monitoring systems. **Remote cardiac care is literally in this practice's DNA.** Yet today the practice operates no remote physiologic monitoring program and no chronic or principal care management program. The modern successor to the founder's work — connected-device monitoring and between-visit care management, now reimbursed by Medicare under mature code families — is open whitespace at the very practice that helped invent the category.

The timing matters because the ground shifted on January 1, 2026. CMS's **Transforming Episode Accountability Model (TEAM)** — a mandatory, episode-based payment model covering five surgical episode categories including coronary artery bypass graft (CABG) — went live in 188 selected core-based statistical areas, including Jacksonville (CBSA 27260). **Both of the practice's anchor hospitals are mandatory TEAM participants: HCA Florida Memorial Hospital (CCN 100179) and Flagler Hospital (CCN 100090).** Those hospitals are now accountable for 30-day episode spending — and the post-discharge period where episodes are won or lost is precisely where an ambulatory cardiology practice with remote monitoring infrastructure operates. In parallel, the CY2026 Medicare Physician Fee Schedule expanded RPM billing with new short-window and shorter-increment codes (99445, 99470), making the first two weeks after discharge billable in ways they were not in 2025.

The central argument

A managed Remote Care Service Line — TCM at every discharge, RPM, CCM, and PCM — delivers value two ways at once:

1. Standalone value. Recurring, subscription-like professional-fee revenue at top-of-license staffing. Modeled against the practice's estimated Medicare panel at CY2026 Florida locality rates: approximately $1.86M in practice net reimbursement over 24 months and approximately $630K in practice profit at a 51.0% margin — margin-positive from month two, cumulative breakeven by month three.

2. Connective tissue. One shared engine — enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, medication-titration support, billing capture, analytics — that simultaneously powers the TEAM episodes the practice's two anchor hospitals now own, converts existing Holter/event/pacemaker/ICD/loop-recorder volume into an enrollment funnel, and builds the hypertension cohort that renal denervation whitespace requires. Build once, reuse everywhere.

The economics above are modeled in the accompanying CoachCare Value Analysis at CY2026 Medicare rates for the practice's Florida payment locality, against a **2,200-patient Medicare panel estimate (plausible range 1,800–2,900; derived from practice claims volume and sized to today's provider complement — to be validated against practice chart counts in discovery)**. Pricing is CoachCare list — the Jacksonville-locality rates support the full margin with no discount. All modeled figures are illustrative — verify against practice data.

2026–2027 Priority Recommendations

1. **Charter the Remote Care Service Line.** Stand up RPM + CCM + PCM, with TCM at every discharge, as a named practice program under CoachCare's full-service model — CoachCare supplies and funds the on-site enrollment specialist, connected devices, 24/7 monitoring, and billing-capture infrastructure.
2. **Seed enrollment from the device clinic.** Holter, event-monitor, implantable loop recorder, and pacemaker/ICD follow-up volume is a ready-made, clinically pre-qualified RPM enrollment funnel already flowing through the practice.
3. **Take a TEAM episode pathway to Memorial and Flagler.** Offer both hospitals' episode teams a defined post-discharge cardiology pathway: interactive contact within two business days, a TCM visit inside the code window, and a first-14-day RPM monitoring window — the operational answer to the 30-day episode accountability both hospitals carry as of January 1, 2026.
4. **Reclaim the heritage narrative.** Position the program publicly as the modern successor of Dr. Baker's remote cardiac monitoring legacy — a differentiated story no competing program in the market can tell.
5. **Build the hypertension cohort now.** A BP-monitored RPM cohort is both a standalone revenue engine and the patient-selection and evidence substrate for renal denervation whitespace under CMS NCD 20.40 (coverage with evidence development, effective October 28, 2025).
6. **Validate in discovery.** Confirm the Medicare panel estimate against practice chart counts, and confirm the exact Veradigm product and integration scope in contracting.

1. Footprint & Operating Model

1.1 The practice at a glance

Attribute	Detail
Founded	1953, by Dr. Roy Baker — Florida's first pediatric heart physician; 70+ years serving Jacksonville and St. Augustine
Ownership	Independent, physician-owned cardiology practice (no health-system or private-equity ownership identified)
Providers	3 cardiologists (electrophysiology; interventional; general/nuclear) + 3 advanced practice providers
Locations	Jacksonville (3550 University Blvd S — directly across the street from HCA Florida Memorial Hospital) and St. Augustine (300 Health Park Blvd — on the Flagler Hospital campus)
In-house diagnostics	Holter (24-hr) and event monitors (2 weeks–1 month), nuclear cardiology / cardiac PET
Procedural footprint	EP: pacemaker insertion, ICD placement, implantable loop recorders, biventricular pacing, catheter ablation. Interventional: coronary and peripheral vascular intervention
Patient portal / EMR	FollowMyHealth portal (bakerandgilmour.followmyhealth.com); Veradigm EMR confirmed — exact product/version to be confirmed in contracting
Medicare panel	Estimated 2,200 patients (range 1,800–2,900) — estimate from claims-volume method; validate in discovery

Profile per bakerandgilmour.com, NPPES, and CMS Doctors & Clinicians registry data, reviewed July 27, 2026.

1.2 The physicians

Physician	Focus	Why it matters for this strategy
Trevor Greene, MD, FACC, FACP	Cardiac electrophysiology — pacing, catheter ablation, device implantation	Director of the Electrophysiology Laboratory at HCA Florida Memorial Hospital — a mandatory TEAM participant. EP leadership at an anchor hospital makes the practice a natural post-discharge episode partner, and EP device volume is a built-in RPM/device-clinic funnel.
Edward Pereira, MD	Interventional cardiology — coronary and peripheral vascular intervention, preventive cardiology	Interventional capability anchors the post-procedure monitoring pathway and the hypertension/renal-denervation whitespace discussed in Section 6.
Bashar Saikaly, MD, FACC	General and nuclear cardiology; St. Augustine site	Anchors the Flagler Hospital campus presence and the longitudinal chronic-disease panel that CCM/PCM serve.

Physician	Focus	Why it matters for this strategy
Katie DeGoursey, PA-C; Frances Tanner, APRN; Madelyn Pellicer, APRN	Advanced practice providers	Top-of-license capacity: reviews remote-monitoring data, runs protocolized titration, delivers TCM visits without consuming physician slots.

1.3 The heritage asset

Most practices adopting remote monitoring must convince patients and referrers that it is real medicine. Baker-Gilmour has the opposite starting position: its founder helped create the field. Dr. Baker's work in the 1960s and 1970s — ambulance EKG telemetry adapted from NASA technology, and early remote cardiac patient monitoring systems — is documented practice history. A Remote Care Service Line is not a bolt-on for this organization; it is the return of a founding capability, at modern scale, with modern reimbursement behind it — a story that differentiates the program to referrers, hospital episode teams, and patients deciding whether to enroll.

1.4 Hospital relationships

The practice's physical geography is its partnership map. The Jacksonville office faces **HCA Florida Memorial Hospital (CCN 100179)** across University Boulevard, where Dr. Greene directs the EP laboratory. The St. Augustine office sits on the **Flagler Hospital (CCN 100090)** campus. Both hospitals became mandatory participants in CMS's TEAM episode model on January 1, 2026 (Section 3). No other hospital relationship is treated as an anchor in this report.

1.5 What the practice does not have today

As of a July 2026 review of the practice's public materials: no remote physiologic monitoring program, no chronic care management or principal care management program, and no published telehealth offering. Ambulatory rhythm monitoring (Holter, event) exists as a diagnostic workflow — episodic, in-office-managed — but not as a longitudinal monitored-care program. The status of remote follow-up for the implanted-device population is not publicly documented and should be confirmed in discovery. This is the whitespace the service line fills.

1.6 Design principles for the service line

Principle	What it means in practice
Longitudinal by default	Every cardiac patient leaves with a monitoring plan — diagnostics feed enrollment.
One front door	One enrollment funnel across office visits, device clinic, and discharges — one consent, one care plan.
Hub-and-spoke	Jacksonville is the hub; St. Augustine runs the same protocols and scorecard.
Single scorecard	Clinical, operational, financial, and partnership KPIs in one monthly view (Section 4).
Digital-as-care	Remote readings are clinical touches — the founder's model at modern scale.

2. The Remote Care Service Line — The Spine

2.1 What It Is: The Specialty Billing Stack

The service line is a coordinated stack of four Medicare-reimbursed care-management programs, run on one shared engine. For a cardiology practice, the stack is specialty-arm only — each program is billed by the practice for its own patients.

Program	What it is	Who qualifies	Cadence & core codes
TCM — Transitional Care Management	Structured 30-day transition after any inpatient/observation discharge: interactive contact within 2 business days, medication reconciliation, face-to-face visit	Every discharged patient	One claim per discharge — 99495 (moderate; visit ≤14 days) / 99496 (high; visit ≤7 days)
RPM — Remote Physiologic Monitoring	Connected devices (BP cuff, weight scale, pulse oximeter) transmitting daily readings into 24/7 monitored workflows	HF, hypertension, arrhythmia, post-procedure patients	Monthly — 99453 setup; 99454 supply/transmission (16+ days); new 99445 (2–15 days, CY2026); 99457/99458 management time; new 99470 (first 10 min, CY2026)
CCM — Chronic Care Management	Between-visit care coordination for multi-morbid patients: care plan, med management, 20+ min/month clinical staff time	2+ chronic conditions expected to last 12+ months (common in a cardiology panel: HF + CKD, AFib + HTN + diabetes)	Monthly — 99490; 99439 each additional 20 min
PCM — Principal Care Management	Disease-focused management of one high-risk condition (e.g., heart failure) driving the care plan	Single high-risk condition expected to last 3+ months	Monthly — 99426; 99427 each additional 30 min (clinical staff)

The coordination rule (set it at enrollment, audit it monthly)

CCM and PCM are mutually exclusive for the same patient in the same month — each patient is assigned one longitudinal pathway at enrollment: **PCM** where a single dominant condition (typically heart failure) drives care; **CCM** where two or more chronic conditions are co-managed. **RPM stacks with either** (discrete time and documentation), and **TCM** precedes both at each discharge. One care plan lives in the Veradigm record; the billing engine enforces the exclusivity rules so clean claims are automatic, not manual.

2.2 Standalone Value: The 24-Month Forecast

Four value layers, in order of immediacy:

1. **Direct professional-fee revenue** — recurring monthly claims across RPM, CCM, and PCM, plus per-discharge TCM. This is the layer modeled in detail below.
2. **Avoided cost and readmission exposure** — monitored patients decompensate visibly; interventions happen before the ED. The model projects ~48 avoided hospitalizations over 24 months (~$721K at $15,000 per admission) — value that accrues to payers, hospital partners under episode accountability, and the practice's referral reputation.
3. **Throughput and device-clinic capacity** — remote pathways decongest clinic slots: monitored stability replaces low-acuity in-person checks, freeing capacity for new patients and procedures (Section 6).
4. **Strategic positioning** — the infrastructure that makes the practice indispensable to two TEAM-participant hospitals (Sections 3 and 5), and the evidence engine for hypertension/renal-denervation whitespace (Section 6).

CY2026 billing stack — practice-locality rates

Code	Service	~CY2026 rate	Basis
99495 / 99496	TCM, moderate / high complexity	~$200 / ~$280	National non-facility magnitude (TCM revenue not included in the modeled totals below — upside)
99453	RPM device setup & patient education (one-time)	~$20	National non-facility magnitude
99454	RPM device supply & transmission, 16–30 days	$50.00	CY2026 PFS, FL locality (carrier 09102, locality 99)
99445 (new 2026)	RPM device supply, 2–15 days — short post-discharge/post-procedure windows	~$50 (parallels 99454)	National magnitude; verify locality
99457	RPM management, first 20 min/month	$51.12	CY2026 PFS, FL locality
99458	RPM management, each additional 20 min	$41.22	CY2026 PFS, FL locality
99470 (new 2026)	RPM management, first 10 min/month	~$26	National magnitude; verify locality
99490 / 99439	CCM, first 20 min / each additional 20 min (clinical staff)	$65.97 / $50.16	CY2026 PFS, FL locality
99426 / 99427	PCM, first 30 min / each additional 30 min (clinical staff)	$67.57 / $53.69	CY2026 PFS, FL locality

Illustrative rates — actual payment is set by the Medicare Administrative Contractor for the practice's locality; verify against the current CY2026 PFS before financial planning.

Panel basis

How the 2,200-patient Medicare panel estimate was built

Practice Medicare allowed charges of approximately $3.82M (Definitive Healthcare claims data) divided by a typical cardiology allowed-amount of ~$1,300 per beneficiary-year yields an upper bound of roughly 2,900 Medicare patients. That figure was adjusted conservatively to reflect the practice's current provider complement of three cardiologists and three advanced practice providers, giving a **working estimate of 2,200 (plausible range 1,800–2,900)**. This is an estimate for planning, not a census — the first discovery task is validating it against practice chart counts.

Headline economics (modeled, CoachCare Value Analysis)

	Year 1	Year 2	24-Month Total
Practice net reimbursement	$591,162	$1,273,400	$1,864,561
CoachCare fees (all-in)	$398,900	$835,715	$1,234,614
Practice profit	$192,262	$437,685	$629,947
Practice margin	48.2%	52.4%	51.0%

Program (24-month)	Net reimbursement	Practice profit
RPM	$689,163	$214,185
CCM	$760,580	$302,789
PCM	$414,818	$151,602

Pricing is **CoachCare list — no discount**: Jacksonville's Florida-locality rates are strong enough to deliver the full 51.0% 24-month margin at list pricing. TCM claims are additive upside not included in these totals. CoachCare's on-site enrollment specialist, 24/7 monitoring staff, and device logistics are funded inside CoachCare's fees — embedded value, never a deduction from the practice's margin.

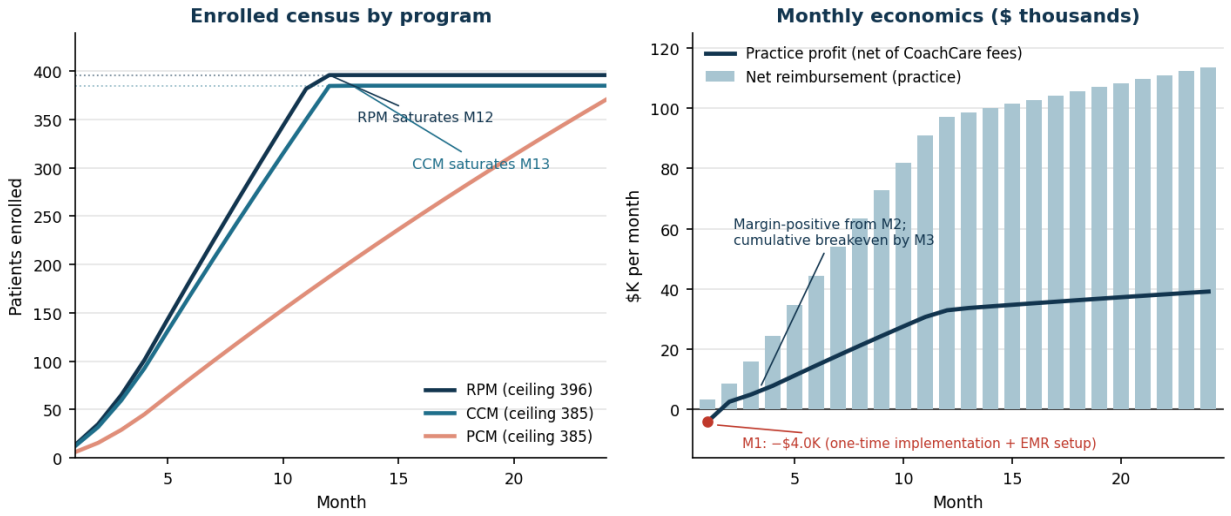

Figure 1. Modeled 24-month ramp: enrolled census by program (left) and monthly economics (right). RPM enrollment saturates at its 396-patient ceiling in month 12 and CCM at 385 in month 13; PCM (ceiling 385) is still growing at month 24 (~371 enrolled) — remaining headroom in the window. Illustrative, modeled — verify against practice data.

Month-one honesty

Month 1 is modeled at **−$4,031**: one-time implementation ($2,500) and Veradigm EMR integration setup ($2,400) land before census builds. The program is **margin-positive from month two** (+$2,596) and reaches **cumulative breakeven by month three**. By month 12 the run-rate is ~$97K/month in net reimbursement; at month 24 it is ~$113K/month with ~$39K/month in practice profit.

Clinical and operational value (24-month, modeled)

Measure	24-month modeled value
Claims generated & captured	34,819
Physiologic readings monitored	75,708
Hospitalizations avoided	48 (~$721K at $15,000/admission)
Care-team hours delivered by CoachCare	17,101 (≈8.2 FTE-years the practice does not hire)
Care-management tasks completed	69,637
Chart updates / patient conversations	17,409 / 10,446

All figures illustrative, modeled at CY2026 CMS PFS rates for Florida carrier 09102, locality 99 — verify against practice data.

2.3 Connective Tissue: One Engine, Every Lever

The same enrollment funnel, device fleet, monitoring team, and billing engine that produce the standalone P&L above also power every strategic lever the practice holds. That is the architecture argument: build the engine once, then route each population through it.

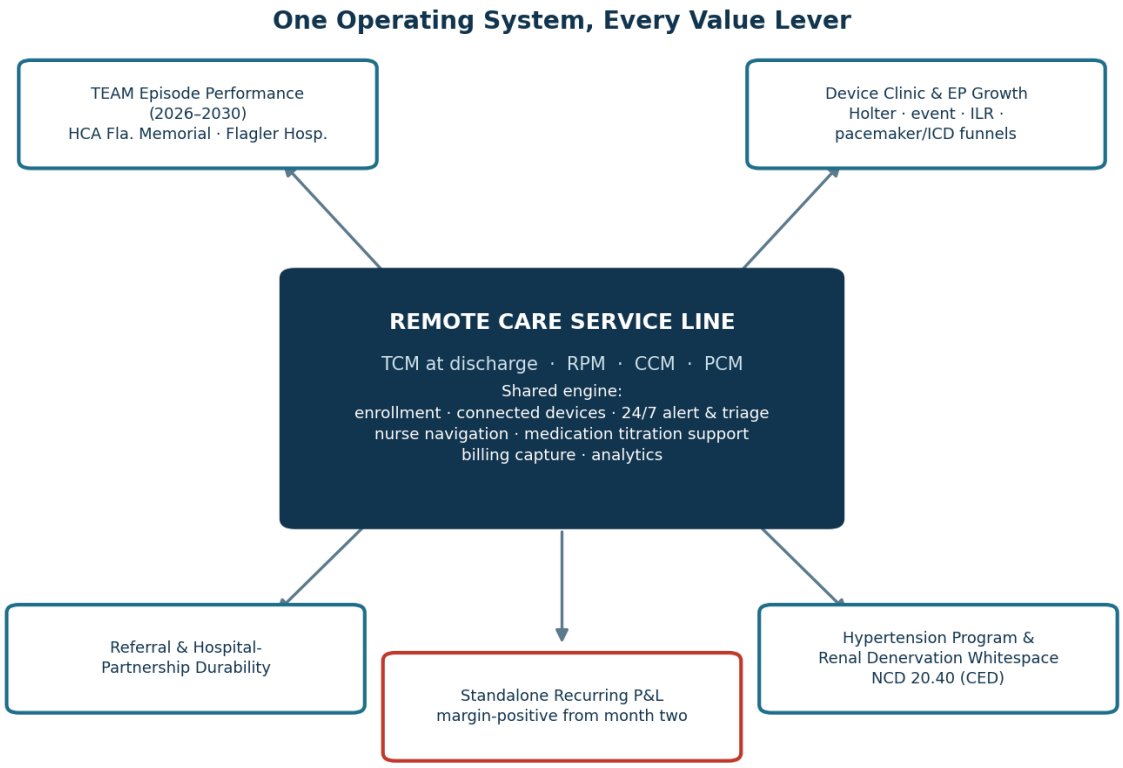

Figure 2. The Remote Care Service Line as connective tissue: one shared engine powering five value levers.

Value lever	What the shared engine contributes	What it earns
TEAM episode performance (2026–2030) — HCA Florida Memorial & Flagler Hospital	TCM contact within 2 business days of discharge; first-14-day RPM window (99445); GDMT titration and escalation before the ED	Episode-cost partnership with the two hospitals that now own 30-day spending (Sections 3, 5); billable TCM + RPM on every routed patient
Device clinic & EP growth	Converts Holter/event/ILR/pacemaker/ICD follow-up volume into enrolled, monitored patients	RPM revenue from an already-qualified funnel; decongested clinic slots; EP referral confidence (Section 6)
Hypertension program & renal denervation whitespace	BP-cohort RPM: patient selection, titration documentation, and the evidence trail NCD 20.40 (CED) requires	Standalone RPM revenue now; procedural whitespace optionality (Section 6)
Referral & hospital-partnership durability	Visible post-discharge outcomes, shared reporting, 24/7 coverage referrers can rely on	Defends and grows the independent practice's referral base
Standalone recurring P&L	The engine itself	$630K modeled 24-month practice profit at 51.0% margin — margin-positive from month two

3. 2026 Policy & Payment Environment: The TEAM Model

The Transforming Episode Accountability Model (TEAM) is CMS's mandatory episode-based payment model, running **January 1, 2026 through December 31, 2030**. Hospitals in 188 selected core-based statistical areas are accountable for total Medicare spending across a 30-day post-discharge episode for five surgical categories: **coronary artery bypass graft (CABG)**, lower-extremity joint replacement, surgical hip/femur fracture treatment, spinal fusion, and major bowel procedure. Episode spending is reconciled against a CMS target price with a quality adjustment, per hospital CCN. Jacksonville (CBSA 27260) is one of the 188 selected CBSAs.

3.1 Which hospitals — specifically

Hospital	CCN	TEAM status	Baker-Gilmour connection
HCA Florida Memorial Hospital (Jacksonville)	100179	Mandatory participant, effective Jan 1, 2026 (CBSA 27260)	Office directly across the street; Dr. Greene directs the EP laboratory; Drs. Greene and Pereira on the medical staff
Flagler Hospital (St. Augustine)	100090	Mandatory participant, effective Jan 1, 2026 (CBSA 27260)	Office on the hospital campus; all three cardiologists hold affiliations

Verification basis and caveat

CBSA 27260 verified on the FY2025 IPPS Final Rule 188-CBSA list; CCNs 100179 and 100090 verified on published renditions of the CMS participant hospital list, anchored to CMS Care Compare identities (July 27, 2026). Re-confirm both CCNs against the current CMS participant file in discovery; only these two hospitals are treated as TEAM anchors.

3.2 Why episode accountability runs through cardiology

CABG episodes are cardiac by definition — the 30-day window after bypass surgery is a cardiology co-management problem: volume status, rhythm, blood pressure, titration. And the dependency extends across all five episode categories: heart failure decompensation, arrhythmia, and uncontrolled hypertension are leading drivers of unplanned readmissions in orthopedic, spine, and bowel-surgery populations. Every dollar of that spending now lands inside a budget the two hospitals own.

The hospitals hold the risk; the practice holds the levers. A hospital cannot run daily-touch post-discharge cardiac management from inside its walls — it needs an ambulatory partner with monitoring infrastructure, near-campus presence, and top-of-license staffing. Baker-Gilmour has the geography and the relationships; this service line adds the infrastructure. TEAM also contemplates formal arrangements with collaborating providers as the model matures; the immediate play is operational indispensability — and the practice carries **no downside exposure of its own under TEAM**: episode performance for the hospitals, professional fees for the practice.

4. An Operating System for Service Line Performance

A service line is only as good as its scorecard. The recommendation is a single monthly review — clinical, operational, financial, and partnership measures on one page — owned by the practice administrator with physician sponsorship.

4.1 The balanced scorecard

Domain	Example measures	Cadence
Clinical	BP control rate in monitored cohort; GDMT optimization %; HF decompensations intercepted before the ED; time-from-alert-to-clinical-action	Monthly
Remote Care Service Line operations	Enrolled census by program (RPM/CCM/PCM); time-to-first-billable-enrollment; 16-day data-capture rate; alert-response time	Weekly ramp reviews for the first 6 months, then monthly
Financial	Net reimbursement; claims capture rate; revenue per enrolled patient per month; margin vs. the 51.0% modeled benchmark	Monthly
Hospital partnership (TEAM)	% of routed episode discharges contacted within 2 business days; TCM visit completion within code windows; 30-day readmissions among monitored episode patients	Monthly, shared with hospital episode teams
Patient	Enrollment consent rate; device adherence; patient-reported experience	Monthly

4.2 TEAM-partnership readiness checklist

Capability	Detail	Build window
Episode-discharge identification feed	Daily discharge notification for practice-attributed and hospital-routed patients from Memorial and Flagler case management	Months 1–3
Two-business-day contact standard	Protocolized interactive contact (meets the TCM requirement) for every routed discharge	Months 1–2
TCM visit slots	Reserved scheduling templates for 7- and 14-day face-to-face visits at both offices	Months 1–2
First-14-day RPM window	Device kit shipped/handed at discharge; 99445 short-window billing live (new CY2026 code)	Months 2–4
Titration & escalation pathway	Standing GDMT/diuretic titration protocols; same-day escalation to APP/physician; ED-avoidance decision support	Months 2–4
Shared outcome reporting	Monthly readmission and episode-touch reporting to both hospitals' episode teams; data-sharing agreement	Months 3–6

4.3 Ambulatory levers that compound the scorecard

- **Same-week post-discharge access:** hold protected slots so the TCM visit window is never missed — the visit is the billing trigger and the clinical anchor.
- **GDMT titration as a production process:** protocol-driven, APP-executed, RPM-verified — the highest-yield clinical intervention in heart failure, run as a system rather than an art.
- **BP-control program:** a named hypertension cohort with home BP monitoring — the scorecard's fastest-moving clinical measure and the renal-denervation substrate (Section 6).
- **Device-clinic capture:** every Holter/event/ILR/pacemaker/ICD encounter screens for RPM/CCM/PCM eligibility at check-in (Section 6).

5. Powering TEAM Episodes: The 30-Day Post-Discharge Pathway

This is the operational product the practice offers Memorial and Flagler. It is one pathway, run identically for both hospitals — and, critically, for the practice's own discharges regardless of episode status. TEAM patients are a routing rule, not a separate program.

5.1 The pathway, step by step

1. **Identify.** Daily discharge feed flags cardiac-relevant discharges — CABG and cardiac comorbidity within other episode categories — plus the practice's own patients discharged from any facility.
2. **Contact within 2 business days.** CoachCare-supported outreach completes the interactive contact; medication reconciliation begins; red-flag symptoms screened.
3. **See within the code window.** Face-to-face TCM visit inside 7 days (99496, high complexity) or 14 days (99495) at the office across the street from Memorial or on the Flagler campus — geography the practice already owns.
4. **Monitor the first 14 days.** Connected BP cuff and scale from day of discharge; the new CY2026 short-window code (99445) makes a 2–15-day monitoring window billable — the exact window where episode spending is won or lost.
5. **Intervene early.** 24/7 alert-and-triage escalates weight gain, hypotension, or arrhythmia symptoms to the practice's APPs for same-day titration — the admission avoided is the hospital's episode dollar saved.
6. **Close and report.** Day-30 episode summary: touches delivered, readmission status, medication changes — reported monthly to the hospital episode team.
7. **Graduate.** Patients with qualifying chronic disease transition from the episode window into longitudinal RPM + CCM/PCM — the episode pathway feeds the standalone P&L.

5.2 What each side gets

> **The hospitals get:** a documented, measurable 30-day post-discharge management pathway for the episode spending they now own; readmission interception; a cardiology partner whose EP lab leadership and campus presence they already trust.
>
> **The practice gets:** billable TCM and RPM on every routed patient, deepened referral flow from two hospitals with new reasons to route cardiac patients its way, and first-mover position as the episode partner — before any competing arrangement forms.

5.3 Build once, reuse everywhere

The pathway above is not TEAM-specific plumbing. The same contact standard, device logistics, and titration protocols serve every practice discharge, every device-clinic patient, and every hypertension enrollee. The episode use case simply gives the build a 2026 deadline and two motivated hospital partners — the infrastructure it justifies is the same engine that produces the Section 2 economics.

6. Device-Clinic Modernization & Procedural Growth

6.1 The funnel the practice already owns

Every Holter, event monitor, implantable loop recorder, pacemaker, and ICD the practice manages is a patient already consented to the idea that their heart is monitored from home. That makes the device population the lowest-friction RPM/CCM/PCM enrollment funnel available — no cold outreach, no concept-selling. The recommended motion: eligibility screening at every device-clinic touch, with enrollment offered in the same visit. (The current state of remote follow-up for the implanted-device population is not publicly documented; discovery should confirm it, and the service line formalizes and scales whatever exists.)

6.2 EP growth

Dr. Greene's EP laboratory leadership at Memorial is a growth engine: post-ablation and post-implant patients routed into short-window RPM (99445) get documented early-rhythm surveillance, and referring physicians get visible follow-through — the kind of closed loop that compounds referral confidence. Monitored stability also replaces a share of routine in-person checks, freeing clinic capacity for new procedures.

6.3 Hypertension program and the renal denervation whitespace

Effective October 28, 2025, CMS national coverage determination 20.40 covers renal denervation for uncontrolled hypertension under coverage with evidence development (CED). The procedure sits squarely in interventional cardiology — and its entire care model is remote-monitoring-dependent: patient selection requires documented resistant hypertension on optimized therapy; CED evidence requirements demand longitudinal BP data before and after. A BP-monitored RPM cohort is therefore both a standalone revenue engine today and the on-ramp to a procedural whitespace tomorrow. This report frames renal denervation as an option the service line creates, not a commitment — the practice's interventional capability (coronary and peripheral) makes it credible; the monitored cohort makes it operational.

A note on honesty in scope: the practice does not operate a structural heart program, and none is assumed anywhere in this report. Growth here is framed on what exists — EP, interventional, diagnostics — extended by monitoring infrastructure.

7. Implementation Playbook

7.1 Goals and scope

- Stand up the Remote Care Service Line across both offices under one protocol set, one scorecard, one enrollment funnel.
- Reach RPM census ceiling (~396 patients) by month 12 and CCM ceiling (~385) by month 13; keep PCM growing through month 24 (~371 modeled, ceiling 385 — headroom remains).
- Launch the TEAM episode pathway with Memorial and Flagler inside the first two quarters.

7.2 Target populations

Cohort	Source	Program mapping
Heart failure	Practice panel; hospital discharges	TCM at discharge → RPM (weight + BP) + PCM
Hypertension (incl. resistant HTN)	Practice panel; referring PCPs	RPM (BP) + CCM where multi-morbid; renal-denervation evidence cohort
Arrhythmia / device patients	Device clinic: Holter, event, ILR, pacemaker/ICD	RPM; CCM/PCM by comorbidity profile
Post-procedure / post-discharge	EP lab, cath lab, TEAM-routed episode discharges	TCM → first-14-day RPM window (99445) → graduation to longitudinal programs

7.3 Staffing model

CoachCare's full-service model supplies the labor the practice would otherwise have to hire: an on-site enrollment specialist (**funded by CoachCare — this cost sits inside CoachCare's fees and is never netted against the practice's margin**), 24/7 monitoring and alert-triage staff, telephonic clinical outreach, device logistics, and billing-capture operations. The practice contributes clinical oversight at top of license: APPs execute protocols and physicians adjudicate escalations. The model's 24-month labor contribution is equivalent to ~8.2 FTE-years the practice does not recruit, onboard, or manage.

7.4 Technology, data, and billing architecture

- **EMR integration:** Veradigm confirmed as the practice's EMR vendor (FollowMyHealth patient portal in production); CoachCare integrates with the Veradigm ambulatory suite — exact product and version confirmed in contracting. Integration setup is already reflected in the month-1 economics.
- **Devices:** cellular-connected BP cuffs, weight scales, and pulse oximeters — no patient Wi-Fi dependency; shipped or handed at enrollment.
- **Billing capture:** program-aware claims engine enforcing the coordination rules (CCM/PCM exclusivity, RPM stacking, TCM windows, 16-day and 2–15-day supply thresholds) with an audit trail per claim.

- **Analytics:** census, capture-rate, and outcome dashboards feeding the Section 4 scorecard and the monthly hospital episode reports.

7.5 Clinical workflow

1. Identify & consent — eligibility screening at every visit, device-clinic touch, and discharge; enrollment specialist completes consent and setup same-day where possible.
2. Equip & train — device provisioning, first transmission verified before the patient leaves (or within 48 hours of shipment).
3. Monitor — daily readings into 24/7 triage; thresholds personalized per care plan.
4. Intervene — protocolized escalation to practice APPs; same-day titration; documentation flows to the Veradigm record.
5. Review & bill — monthly clinical review; time and claims captured automatically; scorecard updated.

7.6 The 12-month roadmap

1. **Months 1–2 — Foundation.** Contracting (confirm Veradigm product; validate the panel estimate against chart counts), integration build, protocol sign-off, staff orientation, first enrollments from the device clinic. One-time costs land here: month 1 is modeled at −$4,031; the program is margin-positive from month two.
2. **Months 3–6 — Ramp.** Device-clinic funnel at full screening cadence; TEAM episode pathway live with Memorial and Flagler; hypertension cohort launched; first shared outcome report delivered to both hospitals. Cumulative breakeven arrives by month three.
3. **Months 7–12 — Scale.** RPM census approaches and reaches its 396-patient ceiling (month 12); CCM close behind (ceiling month 13); run-rate reaches ~$97K/month net reimbursement.
4. **Months 13–24 — Optimize.** PCM continues growing (never saturates in the window); steady state reaches ~$113K/month net reimbursement and ~$39K/month practice profit; scorecard drives capture-rate and adherence tuning; renal-denervation evidence cohort matures.

7.7 Why CoachCare

CoachCare operates remote care programs for 500,000+ patients across 400+ managed conditions, supports 10,000+ providers, and has delivered 1,000+ implementations — with billing infrastructure that has generated over 5 million claims and a monitoring platform that has recorded over 100 million vitals and enabled 4 million+ care actions. For an independent practice, that maturity means the service line launches as an operating program, not an experiment.

> **Expected impact — the two-sentence version**
>
> Standalone: ~$1.86M in practice net reimbursement and ~$630K in practice profit over 24 months at a 51.0% margin, margin-positive from month two, with ~48 hospitalizations avoided. Strategic: the practice becomes the indispensable post-discharge partner for the TEAM episodes its two anchor hospitals now own — and reclaims, in modern form, the remote cardiac monitoring legacy its founder created. All figures illustrative, modeled — verify against practice data.

References & Data Sources

- Baker-Gilmour Cardiovascular Institute — practice website: about, providers, electrophysiology services, contact pages (bakerandgilmour.com; FollowMyHealth portal at bakerandgilmour.followmyhealth.com). Fetched July 27, 2026.
- NPPES provider registry and CMS Doctors & Clinicians national files — practice organization records, provider NPIs, group composition, hospital affiliations. Fetched July 27, 2026.
- CMS Innovation Center — Transforming Episode Accountability Model (TEAM): model overview and participant hospital list (cms.gov/priorities/innovation/innovation-models/team-model; cms.gov/team-model-participant-list). CBSA selection per FY2025 IPPS Final Rule (188 CBSAs). Participant verification performed July 27, 2026 against published list renditions dated August 2024, with CCN identities anchored to the CMS Care Compare hospital dataset; re-confirm CCNs 100179 and 100090 against the current CMS file in discovery.
- CMS Care Compare hospital dataset (data.cms.gov/provider-data) — hospital CCN identity confirmation. Fetched July 27, 2026.
- CMS CY2026 Medicare Physician Fee Schedule — care-management and remote-monitoring code rates for Florida carrier 09102, locality 99 (e.g., 99457 $51.12; 99490 $65.97; 99426 $67.57). National non-facility magnitudes shown where locality rates were not pulled. Verify with the practice's Medicare Administrative Contractor.
- CMS National Coverage Determination 20.40 — Renal Denervation for Uncontrolled Hypertension, effective October 28, 2025, coverage with evidence development.
- Definitive Healthcare — practice Medicare allowed-charge volume and EMR vendor identification (Veradigm; crawl-verified), underlying the panel estimate. 2026 vintage.
- CoachCare Value Analysis workbook — Baker_Gilmour_Cardiovascular_Institute_CoachCare_Value_Analysis_2026.xlsx: all modeled economics, census ramps, ceilings, and clinical-operations values in Section 2 and Section 7.

Global caveat

This report was prepared from public sources and modeled estimates, each date-stamped above. Modeled financials are illustrative, computed at CY2026 Medicare rates for the practice's Florida locality against an estimated panel — verify every figure against practice data, current CMS files, and the practice's Medicare Administrative Contractor before relying on it. The Medicare panel size is an estimate presented with its method and range; validating it is the first discovery task. Hospital participation status should be re-confirmed against the current CMS TEAM participant file. CoachCare pricing shown at list; final terms set in contracting.