SERVICE LINE STRATEGY · Connected Care, by CoachCare.

MarinHealth Cardiovascular Medicine

A UCSF Health Clinic: a Larkspur cardiology hub with clinics in Novato, Petaluma and Sonoma, 22 cardiologists and four physician assistants, one Epic record shared with MarinHealth Medical Center, and a Medicare panel of about 12,200 patients

Cardiovascular Service Line Optimization Report

2026 Strategy Report

A scalable, profitable remote care service line for MarinHealth Cardiovascular Medicine: transitional care after discharge, remote monitoring and principal care management, run inside the shared Epic record, staffed by CoachCare, and built for the two mandatory Medicare models that now reach the heart program

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the leadership of MarinHealth Cardiovascular Medicine and the MarinHealth heart program. It makes one case at report length: a single remote care service line that pays for itself under Medicare fee-for-service and carries MarinHealth into the Ambulatory Specialty Model, which names nine of its heart-failure clinicians from January 2027, and into TEAM, which already holds MarinHealth Medical Center accountable for the 30 days after a bypass.

MarinHealth already follows about 1,200 patients' implanted devices remotely and already bills transitional care after discharge. What its claims do not show is home blood pressure and weight between visits, or monthly care management for the heart-failure care plan. This report shows what that service line returns at Marin County's Medicare rates, who does the work, how fast it can enroll, and how it starts at Larkspur.

Prepared by CoachCare for discussion with MarinHealth. © 2026 CoachCare.

Table of Contents

Executive Summary 3
1. Why Now: Two Mandatory Models and the Months Between Visits 4
2. MarinHealth Cardiovascular Medicine Today 5
2.1 A Larkspur hub, three clinics, 26 clinicians 5
2.2 What the CY2024 claims say 5
2.3 What MarinHealth already runs, and the gap 6
2.4 The hospital: five stars, average heart-failure readmissions 6
2.5 The market, and the rate basis 7
3. The Service Line: Discharge, Monitoring, Care Management 8
3.1 The clinical and billing stack 8
3.2 Transitional care: a workflow MarinHealth already runs 8
3.3 The care team, and the hours it keeps 9
3.4 One service line, every lever 9
3.5 Build versus partner 10
4. Epic: The Program Lives in the Shared Record 10
4.1 The five integration pillars 11
4.2 From a flag in the chart to a claim 11
4.3 What MarinHealth sees every month 11
5. Clinical Governance & Escalation 12
5.1 One escalation engine, and the emergent floor 12
5.2 Three-way routing, on business hours 12
5.3 The post-discharge cadence 13
6. Value Analysis: The 24-Month Forecast 13
6.1 The headline economics 13
6.2 Where the patients come from 13
6.3 The ramp, month by month 14
6.4 Enrollment capacity sets the pace 14
6.5 Starting at Larkspur 16
6.6 What the program produces clinically and operationally 16
6.7 Published results from CoachCare cardiology programs 16
7. The Ambulatory Specialty Model: Nine Heart-Failure Clinicians 16
7.1 What the model scores 17
7.2 How the service line maps to the heart-failure measures 17
7.3 Working with referring primary care 17
8. TEAM: The 30 Days After a Bypass 18
9. Procedural Growth: Structural Heart, Rhythm, Renal Denervation 18
10. Policy Watch: The CY2027 Proposed Rule, Repriced on This Forecast 19
11. Implementation Roadmap 20
11.1 Who runs what 20
11.2 The model inputs 20
11.3 The first 90 days at Larkspur, and after 20
11.4 What we would confirm together 21
12. Recommendations 21
About CoachCare 22
References & Data Sources 22

Executive Summary

MarinHealth Cardiovascular Medicine, A UCSF Health Clinic, is the cardiology group of the MarinHealth system: 22 cardiologists and 4 physician assistants, 20 of the physicians based at the Larkspur clinic on Bon Air Road, with clinics in Novato, Petaluma and Sonoma. Its physicians cover electrophysiology, interventional and structural cardiology, advanced heart failure, imaging, hypertension and renal denervation, and they admit to MarinHealth Medical Center in Greenbrae, a five-star hospital that launched a comprehensive cardiothoracic surgery program in 2025. Hospital and clinics share one Epic record.[1]

The group's CY2024 Medicare claims describe the panel: traditional-Medicare patients **averaging 78 years old, with a weighted risk score of 1.41** against a national 1.00. Ischemic heart disease runs at 50%, atrial fibrillation 44%, heart failure 32% and chronic kidney disease 29%, and hypertension sits at CMS's 75% reporting cap. The group already reads remote device transmissions for about 1,200 patients and billed transitional care after discharge for 332. **No remote physiologic monitoring or principal care management program appears at meaningful scale**.[2]

The observation this report is built on

One service line is the connective tissue for both mandatory models: build it once, use it everywhere.

Nine of the group's heart-failure clinicians are named on CMS's final CY2027 participant list for the Ambulatory Specialty Model, posted October 5, 2026, under the billing entity Regents of the University of California (UCSF). From January 2027 their Medicare Part B payments move with a heart-failure score. MarinHealth Medical Center has been a mandatory TEAM hospital since January 2026, accountable for Medicare spending in the 30 days after each bypass. Both models reward the same work: a call within two business days of discharge, daily readings at home, and a care manager on the heart-failure care plan every month. That work also pays for itself under Medicare fee-for-service before either model pays a dollar.

What the Value Analysis returns

Contribution margin to MarinHealth	Year 1	Year 2	24 months
Unique patients in remote monitoring or care management, end of period	937	2,139	2,139
Recurring line: remote monitoring and principal care management	**$329,077**	**$1,383,378**	**$1,712,455**
Transitional care: episodes above today's volume	$12,774	$20,598	$33,372
Combined	**$341,851**	**$1,403,976**	**$1,745,827**

CoachCare Value Analysis: a Medicare panel of 12,200 across the network, 26 referring clinicians, one CoachCare-funded on-site enrollment specialist, CY2026 California locality 52 (Marin County) amounts. Contribution margin is what MarinHealth keeps from the service line. The transitional care line counts only episodes above the 332 patients the group already reached in CY2024.

1. **Positive from month 2, with nobody hired.** Contribution margin runs slightly negative in month 1 while the program ramps; every month after is positive, and the monthly figure climbs with the census to $151,315 by month 24. CoachCare delivers 24,044 care-team hours over 24 months, about 11.6 full-time-equivalent years, with 6 care managers at month 12 and 13 at month 24.

[1] mymarinhealth.org cardiovascular medicine, location and provider pages, retrieved October 30, 2026. CMS Medicare provider enrollment (PECOS reassignments, October 2026), Quality Payment Program eligibility (2024 to 2026) and Doctors and Clinicians (July 2026): 22 physicians and four physician assistants at the cardiology sites, 20 of the physicians at Larkspur.

[2] CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024, the 21 clinicians with claims at the cardiology sites: average age 78.4; HCC risk 1.41; ischemic heart disease 49.8%; atrial fibrillation 44.3%; heart failure 31.8%; CKD 28.5%; hypertension and high cholesterol at the 75% cap. Device patients counted once across 93294, 93295 and 93298.

2. **The binding constraint is enrollment capacity, not the size of the panel.** With one on-site enrollment specialist and 26 clinicians referring, neither program reaches its ceiling in 24 months: remote monitoring has 1,921 of its 2,288 ceiling enrolled at month 24, principal care management 728 of 2,074. Across the panel sizes MarinHealth's claims support, 10,600 to 16,700, 24-month contribution margin moves only from $1,695,778 to $1,759,358.
3. **A second on-site enrollment specialist is the largest lever.** It cannot raise the ceilings, but reaches them sooner: remote monitoring fills in month 21, and 24-month contribution margin rises from $1,712,455 to $2,390,126, $677,671 more. We recommend scoping it; the forecast of record keeps one.
4. **Start at Larkspur.** Larkspur alone, with its 22 clinicians and a panel of about 10,100, returns $1,559,214 of the $1,712,455; Novato, Petaluma and Sonoma join on the same Epic record and the same protocols (Section 6.5).
5. **Extend the discharge workflow MarinHealth already runs.** The group billed transitional care for 332 patients in CY2024. With the CoachCare care team making the two-business-day call, half of the hospital's eligible cardiac discharges reach a transitional care visit, about 8 more episodes a month, and each one is the front door to monitoring and care management.
6. **Build for the Ambulatory Specialty Model and TEAM on the same rails.** Heart-failure monitoring, guideline-therapy follow-through and a monthly note to the referring primary-care physician map to the model's heart-failure measures (Section 7); the post-discharge cadence after a bypass is the layer the hospital's TEAM episodes depend on (Section 8).
7. **The CY2027 proposed rule takes $291,358 off the 24-month contribution margin.** A 20.7% cut to device supply leaves $1,421,097 on the recurring line instead of $1,712,455, with enrollment held constant (Section 10).

The ask is a working session: confirm the Medicare chart count by payer, agree on the heart-failure and hypertension flag criteria, scope the build inside the shared Epic record, and set enrollment staffing for Larkspur before the first patient enrolls.

1. Why Now: Two Mandatory Models and the Months Between Visits

Cardiology is managed in the months between appointments, and from 2026 Medicare measures those months for MarinHealth directly. Four changes arrive together, and each lands on the same patients: the heart-failure patient whose weight climbs in week three, the hypertensive patient whose new agent needs a second dose change, the bypass patient sent home on a Friday.

The shift	What it means for MarinHealth
1. Heart failure is scored from January 2027	Nine of the group's clinicians are named on CMS's final CY2027 participant list for the Ambulatory Specialty Model. Their Part B payments for 2029 move up or down by as much as 9% on a 2027 score built half on heart-failure quality, including cardiovascular admissions among their heart-failure patients, and half on the cost of those patients' care.[3]
2. The 30 days after a bypass	MarinHealth Medical Center is a mandatory TEAM hospital from 2026 to 2030. For each coronary bypass it is accountable for Medicare Part A and Part B spending through 30 days after discharge, the cardiology follow-up and any readmission included.[4]
3. Guideline therapy as a titration process	Therapy for heart failure with reduced ejection fraction spans four drug classes, each started low and stepped toward a target dose over several adjustments a few weeks apart. Home blood pressure, heart rate and weight tell the cardiologist when the next step is safe, and the monthly call catches the patient who stopped a drug because of dizziness. Two of the model's five heart-failure quality measures ask whether these drugs are prescribed.

[3] CMS Ambulatory Specialty Model final CY2027 participant list, posted October 5, 2026, matched by NPI: nine heart-failure rows under REGENTS UNIV OF CALIFORNIA UCSF, seven in CBSA 42034 (San Rafael) and two in CBSA 42220 (Santa Rosa-Petaluma). 42 CFR §§ 512.725, 512.730, 512.750.

[4] CMS TEAM participant list, hospitals as of August 18, 2026: CCN 050360, MarinHealth Medical Center, mandatory, CBSA 41860, participation January 1, 2026 to December 31, 2030.

The shift	What it means for MarinHealth
4. Codes for the work between visits	Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for shorter months such as the first weeks after a discharge. Principal care management pays for care-team time on a disease-specific plan for one high-risk condition such as heart failure. At Marin County's CY2026 rates one heart-failure patient on both (99454, 99457 and 99426) is **$221.32 a month** in Medicare allowed charges.

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

2. MarinHealth Cardiovascular Medicine Today

2.1 A Larkspur hub, three clinics, 26 clinicians

Clinic	Clinicians	What it means for this program
Larkspur **2 Bon Air Road, Suite 100**	20 of the 22 physicians and 2 physician assistants; electrophysiology, imaging, interventional and structural cardiology, hypertension, women's heart health	**The launch site.** Most of the panel is seen here, on the same road as the hospital, so the discharge call, the enrollment conversation and the follow-up visit all run from one clinic
Novato **75 Rowland Way**	A physician assistant, with physicians rotating in from Larkspur	Same flags, devices and care team as Larkspur; enrollment status visible at the front desk
Petaluma **335 South McDowell Boulevard**	Inside the multispecialty clinic that opened in November 2024; a physician assistant and rotating physicians	Sonoma County patients enroll here without a trip to Marin
Sonoma **651 First Street West**	2 physicians and a physician assistant	The second county; its patients join on the same protocols

mymarinhealth.org location pages, retrieved October 30, 2026; site assignment from CMS provider files. Clinicians rotate across sites, so counts are by primary location.

The bench covers general and preventive cardiology, electrophysiology through the MarinHealth Arrhythmia Center, interventional and structural cardiology (transcatheter valve replacement and repair, left atrial appendage closure), advanced heart failure, cardiac imaging including cardiac MRI since June 2024, cardiac rehab, a hypertension program and renal denervation, offered since December 2023. The hospital launched a cardiothoracic surgery program in May 2025, so bypass and valve surgery stay in Greenbrae.[5]

2.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for every clinician with claims at the cardiology sites, 21 in all. The profile is the traditional-Medicare panel those clinicians saw.[6]

Panel	CY2024	Condition	Share
Medicare allowed	$7,145,704	**Hypertension**	**75% (at the cap)**
Average age	**78**	High cholesterol	75% (at the cap)
Weighted HCC risk score	**1.41**	**Ischemic heart disease**	**50%**
Dual-eligible share	About 12%	**Atrial fibrillation**	**44%**
Remote interrogation of implanted devices	**About 1,200 patients**	**Heart failure**	**32%**

[5] mymarinhealth.org cardiovascular medicine program, arrhythmia center, renal denervation and news pages, retrieved October 30, 2026 (cardiothoracic surgery program announced May 20, 2025; Petaluma clinic opened November 19, 2024).

[6] CMS by Provider and by Provider and Service (92396110), CY2024, queried by NPI: 25,643 beneficiary-clinician pairs, 12,919 established-visit pairs, $7,145,704 allowed; prevalence weighted by beneficiaries.

Panel	CY2024	Condition	Share
Ambulatory rhythm monitoring	About 1,920 patients	Chronic kidney disease	29%
Echocardiograms	6,359 services	Diabetes	23%
Initial hospital visits	**1,826 services**	Depression	20%
Transitional care after discharge	**332 patients**	COPD · dementia	14% · 9%
Remote physiologic monitoring, principal care management	No program at meaningful scale		

CMS Medicare Physician & Other Practitioners, CY2024, 21 clinicians with claims at the cardiology sites. Device and rhythm patients are counted once across their codes; echocardiograms and hospital visits are services. CMS caps published prevalence at 75%, so hypertension and high cholesterol are floors, and suppresses lines under 11 beneficiaries.

This is the panel remote care is built for: hypertension in nearly every chart, heart failure in almost one patient of three, atrial fibrillation in more than two of five. The forecast treats 85% of the panel as eligible for principal care management and 75% for remote monitoring. MarinHealth sees these patients often and images them thoroughly, and in CY2024 **no remote physiologic monitoring or principal care management line appears at meaningful scale under any of its clinicians**.[7]

2.3 What MarinHealth already runs, and the gap

What exists	Status	What it means for this program
Epic (APeX, UCSF Health's instance)	**Live since August 2022, one record**	The program's host: flags, orders, readings, care documents and claims (Section 4)
Remote follow-up of implanted devices	**About 1,200 patients in CY2024**	Credited and kept. Transmissions report rhythm and device function, not blood pressure or daily weight; device patients with heart failure add a cuff and a scale
Transitional care after discharge	332 patients in CY2024 (209 at 99495, 123 at 99496), across 11 clinicians	A workflow to extend, not replace: the care team takes the two-business-day call so more discharges reach the visit (Section 3.2)
Nurse-navigator complex care management	Runs across MarinHealth's clinics, not cardiology-specific	Kept as it is; who it serves and how it bills is on the confirmation list
Imaging, stress and ambulatory rhythm monitoring	6,359 echocardiograms; about 1,920 rhythm patients	Findings become enrollment flags; rhythm patients stay on home heart rate after the monitor comes off
Remote physiologic monitoring, principal care management	No program at meaningful scale	Devices, daily readings, monthly care management and business-hours alert triage come from CoachCare

The gap is specific. Device transmissions report rhythm and device function. Nothing tracks home blood pressure or weight for the third of the panel with heart failure, and no one is assigned to that care plan every month between visits.

2.4 The hospital: five stars, average heart-failure readmissions

MarinHealth Medical Center carries CMS's top Overall Hospital Star Rating, five stars. Its heart-failure readmission rate is average: 22.0% over July 2023 to June 2025, which Care Compare rates no different from the national rate. Heart failure is also the hospital's largest cardiac cohort in Medicare's readmissions program, 496 eligible discharges. The goal is to defend the five-star standing and convert the hospital's heart-failure care into the heart-failure results the Ambulatory Specialty Model will score.[8]

[7] CMS by Provider and Service, CY2024: no remote physiologic monitoring (99453 to 99458, 99091) or principal care management (99424 to 99427) line at or above CMS's 11-beneficiary reporting floor for any of the 21 clinicians.

[8] CMS Care Compare, Hospital General Information and Unplanned Hospital Visits (copies dated September 9, 2026), CCN 050360: overall rating 5; 30-day readmission, July 1, 2023 to June 30, 2025, heart failure 22.0%, heart attack 13.1%, CABG 10.5%, COPD 19.3%, pneumonia 17.9%, hip and knee

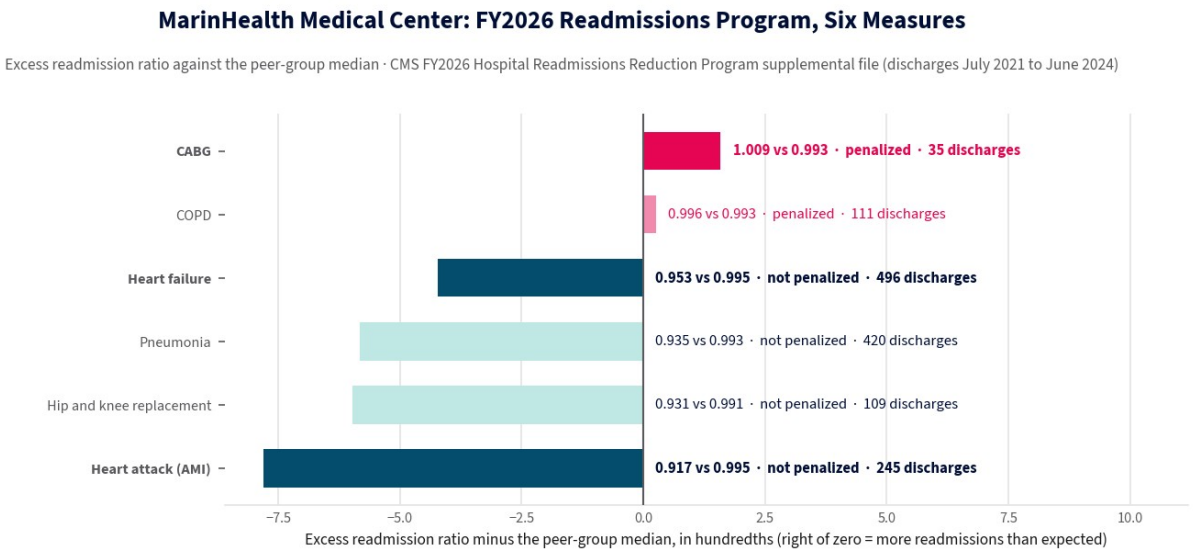


Figure 1. MarinHealth Medical Center in Medicare's FY2026 Hospital Readmissions Reduction Program: each measure's excess readmission ratio against its peer-group median. Heart failure and heart attack run better than peers; CABG is the one ratio above 1.0.

Medicare's payment file tells the same story more precisely. In FY2026 heart failure ran 0.953 against a peer-group median of 0.995 and heart attack 0.917, and neither was penalized. Of six ratios, one exceeds 1.0: CABG, at 1.009, and with COPD it accounts for the hospital's 0.02% readmissions adjustment. That is the TEAM episode, and Section 8 takes it up.[9]

2.5 The market, and the rate basis

Marin County had 65,281 Medicare-eligible residents in October 2026, and 45.28% of them were in a Medicare Advantage plan. Most of that enrollment sits in a closed-panel plan whose members see that plan's own cardiologists, so the Medicare panel in this report counts traditional Medicare plus only the Medicare Advantage plans open to MarinHealth's clinicians: about 12,200 patients across the network, 10,100 of them at Larkspur.[10]

Larkspur and Novato sit in California locality 52 (San Francisco-Oakland-Berkeley, Marin County) under Noridian, the Medicare administrative contractor, and every rate in this report is priced at those CY2026 non-facility amounts. The clinics bill as physician offices: 99.4% of the group's outpatient visits in CY2024 carried the office place of service.[11]

6.6%, each no different than the national rate.

[9] CMS FY2026 Hospital Readmissions Reduction Program supplemental data file (discharges July 2021 to June 2024), CCN 050360: payment adjustment factor 0.9998; penalty indicators Y for CABG (35 eligible discharges) and COPD, N for heart failure, heart attack, pneumonia and hip and knee replacement.

[10] CMS Medicare Advantage State/County Penetration, October 2026: Marin 45.28% (29,558 of 65,281), Sonoma 53.66%. CMS MA enrollment by contract, July 2026, for the open-network share (Marin 14.17%, Sonoma 20.48%). Panel: CY2024 established-visit beneficiaries for the 21 clinicians (12,919), de-duplicated at 70% (9,043), grossed up for the open-network Medicare Advantage share, plus the three physicians who joined in 2026 at the median physician panel.

[11] CY2026 Physician Fee Schedule, Noridian carrier 01112, California locality 52, ZIP 94939: geographic indices work 1.095, practice expense 1.410, malpractice 0.459; conversion factor $33.4009. CY2024 outpatient visits: 24,248 office against 136 facility services.

3. The Service Line: Discharge, Monitoring, Care Management

3.1 The clinical and billing stack

One discharge code and two monthly programs, with one enrollment conversation, one care team and one billing pipeline inside Epic. The sequence follows the patient: transitional care at discharge, a short first month of monitoring on the new 2026 codes, then monitoring and principal care management for as long as the condition needs it.

Program	What it does clinically	Who it fits on this panel
Transitional care management (TCM)	Contact within two business days of discharge, medication reconciliation, a visit within 14 days (99495) or 7 days at high complexity (99496)	Cardiac patients discharged home from MarinHealth Medical Center, heart failure and bypass first
Remote physiologic monitoring (RPM)	Cellular cuffs and scales send readings between visits against thresholds the cardiologists set; 99453, 99454 or 99445, 99457, 99458, 99470	Heart failure and uncontrolled hypertension first, then atrial fibrillation, coronary disease after a stent, renal denervation follow-up and kidney disease
Principal care management (PCM)	A disease-specific care plan and at least 30 minutes of clinical staff time a month for a patient with one high-risk condition; 99426, 99427	Heart failure on guideline therapy, resistant hypertension, atrial fibrillation on anticoagulation

Codes	What they pay for	CY2026, California locality 52
99495 · 99496	Transitional care, visit within 14 days · within 7 days	$275.07 · $373.53
99453	Remote monitoring setup and education, once	$29.98
99454 · 99445	**Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)**	**$73.15 · $73.15**
99457 · 99458	Treatment management, first 20 minutes · each additional 20	$65.31 · $50.71
99470	**Treatment management, 10 to 19 minutes (new in CY2026)**	**$32.84**
99426 · 99427	Principal care management, clinical staff, first 30 minutes · each additional 30	$82.86 · $67.24

How the rates apply

CY2026 non-facility amounts, California locality 52 (Noridian, carrier 01112), ZIP 94939. One device code (99454 or 99445), one first-tier management code (99457 or 99470) and principal care management bill for a patient in a given month; transitional care bills once per discharge alongside them. One heart-failure patient on 99454, 99457 and 99426 is $221.32 a month in Medicare allowed charges.

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

3.2 Transitional care: a workflow MarinHealth already runs

MarinHealth already does this work for some patients: 11 clinicians billed transitional care for 332 traditional-Medicare patients in CY2024, about 28 a month. The hospital discharges about 59 traditional-Medicare cardiac patients a month (MS-DRGs 215 to 320), about 68 once open-network Medicare Advantage is counted. With the CoachCare care team making the two-business-day contact and the medication reconciliation, half of those

discharges reach a transitional care visit, which MarinHealth furnishes and bills: about 36 a month at steady state, 8 more than today.[12]

The forecast carries only those additional episodes, 150 over 24 months from month 4, worth $33,372 of contribution margin; the transitional care MarinHealth bills today is not in it. The line is small by design. Its value is the patient it hands on: the discharge call is the first enrollment conversation, and a short first month of monitoring on 99445 and 99470 carries the patient to the visit, then into monthly monitoring and care management past day 30.

3.3 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 6 care managers for the 937 unique patients at month 12 and 13 for the 2,139 at month 24. An on-site enrollment specialist on CoachCare's payroll works the Larkspur schedules beside the front desk and enrolls patients during the visit, telephonic outreach reaches the rest, and the cardiologists and physician assistants order from the chart. Devices are cellular, with no Wi-Fi, smartphone or pairing. Devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. Pacific, inside the hours the clinics keep. Patients are told at consent to call 911 for an emergency and the clinic for anything urgent.

3.4 One service line, every lever

The same infrastructure does the work for every lever MarinHealth has: one enrollment engine, one set of devices, one care team, one escalation protocol and one claims pipeline. Built once, it serves the fee-for-service programs, both mandatory models, the procedural programs and the hospital's quality standing.

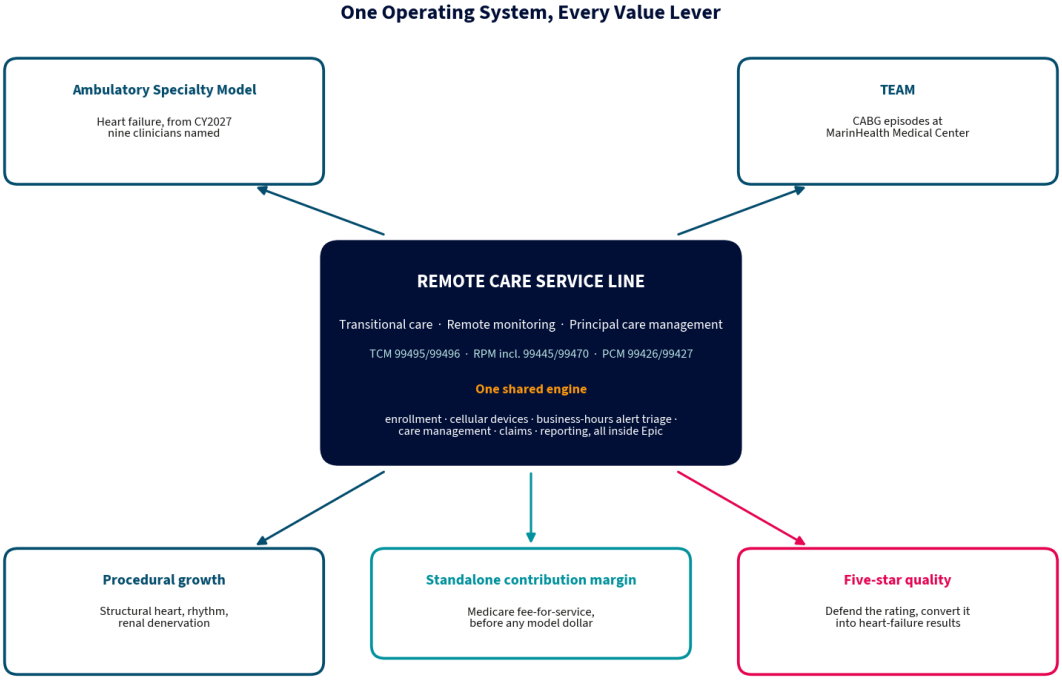


Figure 2. One service line, five levers. The shared engine runs inside Epic; each lever uses the same enrollment, devices, care team and claims.

[12] CMS Medicare Inpatient Hospitals by Provider and Service, CCN 050360, MS-DRGs 215 to 320 discharged alive (cells under 11 suppressed and counted as zero). CY2024 transitional care: CMS by Provider and Service, 99495 and 99496. CoachCare Value Analysis, transitional care layer: 50% capture of eligible discharges after a four-month ramp, 30% at high complexity, only episodes above the CY2024 volume counted.

Lever	What the shared service line does for it
Standalone contribution margin	Remote monitoring, principal care management and the additional transitional care episodes bill under Medicare fee-for-service from month 1 (Section 6)
Ambulatory Specialty Model heart failure, from CY2027	Home weight and blood pressure for heart-failure patients, guideline-therapy steps tracked monthly, cardiovascular admissions headed off, and a note back to each patient's primary-care physician (Section 7)
TEAM CABG at MarinHealth Medical Center	The two-business-day call, home readings and the follow-up visit inside the 30-day episode window (Section 8)
Procedural growth	Blood pressure, heart rate and weight before and after valve, appendage closure, ablation and renal denervation procedures (Section 9)
Five-star quality	Heart-failure patients watched between visits, in the hospital's largest cardiac cohort, and documented follow-up for every discharge the program touches

3.5 Build versus partner

MarinHealth has built part of the answer already. Its clinic staff run remote follow-up of implanted devices for about 1,200 patients, its clinicians bill transitional care, and its clinics offer a nurse-navigator complex care service. None of it supplies daily blood pressure and weight, monthly billable care management for the heart-failure care plan, or the staff to make the discharge call for every eligible patient. Building that in-house means hiring care managers, buying and replacing devices, writing protocols and building the Epic workflow before the first claim. CoachCare brings all of it.

- **MarinHealth keeps clinical governance, the patients and the revenue.** Its cardiologists set thresholds, routing and discharge criteria and sign the care plans; claims go out under the clinicians' own NPIs and billing entity, and MarinHealth keeps $1,712,455 of contribution margin over 24 months on the recurring line.
- **CoachCare supplies the program.** Devices, an on-site enrollment specialist, care managers, business-hours alert triage, monthly documentation and automated claims. None of it is MarinHealth headcount, inventory or software.
- **The device clinic and the complex care service stay as they are.** The program sits beside them, in the same record.

4. Epic: The Program Lives in the Shared Record

MarinHealth Medical Center and its clinics have run on APeX, UCSF Health's Epic, since August 8, 2022, with one medical record for the hospital and every clinic and MyChart for patients. CoachCare works inside Epic's own workflows, so cardiologists, physician assistants and staff do not learn a second system, and a discharge in Greenbrae and a flag at Larkspur land in the same chart.[13] A flagged patient begins services in under five days, and CoachCare is the only care-management application integrated with Epic that creates claims automatically.[14]

[13] MarinHealth APeX go-live announcement, August 8, 2022; mymarinhealth.org MyChart page, retrieved October 30, 2026: the medical center and the clinics are on a single medical record system.

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

4.1 The five integration pillars

Integration pillar	What happens in Epic at MarinHealth
Integrated enrollment	Enrollment flags and trigger ordering in the clinical workflow for patients who meet the cardiologists' criteria, such as heart failure on a loop diuretic, two office readings at or above 140/90, or a cardiac discharge from the hospital; enrollment status visible in the chart in real time
Exchange of health history	Diagnoses, ejection fraction, medications, vitals and labs pass to the care team at intake; the care plan comes back to the chart
Integrated discrete vitals	Home readings land as discrete vitals, not attachments, so trends sit beside office values at the next visit or in the in-basket
Compliance documentation and care summary	Evidence of care, vitals and the care plan documented monthly for every enrolled patient
Automated claim generation	Claims built for every patient, every month, once a code's requirements are met, for the billing team to reconcile and file

4.2 From a flag in the chart to a claim

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

No one builds a claim by hand, patient by patient, month by month. Over 24 months the recurring line produces 53,894 claims and billable units. The build happens inside UCSF Health's Epic instance, so its change-control path and timing are on the confirmation list in Section 11.4.

4.3 What MarinHealth sees every month

Report	What it shows	At month 12 in this forecast
Operational outcomes for clinic leadership	Unique patients active; new enrollments by program, clinic and physician; reading days per patient; escalations by route; discharges reached within two business days	**937 unique patients; 842 remote-monitoring and 317 principal care management enrollments**
Clinical outcomes for the physicians	Hypertensive patients at goal on home averages; heart-failure weight trends, diuretic changes and admissions; guideline-therapy steps completed; alerts by type and time to resolution	Built from the same chart data every month
Claims batch for the billing team	Claims created for every patient whose codes were met that month	Reconciled in the billing work queue

5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so MarinHealth never carries surveillance it did not agree to. Thresholds and routing are set with the cardiologists, for each clinic, before the first patient enrolls.[15]

5.1 One escalation engine, and the emergent floor

Branch	The rule	Why
Critical value	**Escalate to the clinic, regardless of symptoms**	No clinic preference can suppress it. A critical reading on its own goes to the clinic, not to 911
Out of range, not critical	Retake, then a structured symptom check	Most out-of-range readings resolve here, which keeps in-baskets usable
Trend	**Three consecutive blood-pressure readings an hour or more apart; three heart-rate readings out of range within seven days; weight gain past the threshold the cardiologists set for heart failure**	A confirmed trend escalates like a single threshold breach
Patient unreachable	Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding

The emergent floor, stated as such

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

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

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

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

5.2 Three-way routing, on business hours

Route	What goes there	Who sees it
Emergency	Active emergent symptoms reported on a call	911 with the patient on the line; the clinic notified
Needs the clinic	A critical reading, or an out-of-range reading or trend confirmed after a retake	The clinician or nurse each clinic designates, in the Epic in-basket, with the readings and a recommended next step
Stable or resolved	**Worked, retaken and resolved**	**Documented as an FYI in the chart, without paging anyone**

Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. Pacific, so escalations land while the clinics are open. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is the clinic's own line, or 911. Patients average 78 years old, so every call is made by phone and no patient has to learn an app.

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

5.3 The post-discharge cadence

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

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

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers remote monitoring and principal care management across a Medicare panel of 12,200 at the CY2026 California locality 52 amounts, with 26 referring clinicians and one CoachCare-funded on-site enrollment specialist at 80 enrollments a month, plus transitional care episodes above today's volume as their own line. No value-based payment is in these numbers.[16]

Contribution margin to MarinHealth	Year 1	Year 2	24 months
Unique patients in remote monitoring or care management, end of period	937	2,139	2,139
Recurring line: remote monitoring and principal care management	**$329,077**	**$1,383,378**	**$1,712,455**
Transitional care: episodes above today's volume	$12,774	$20,598	$33,372
Combined	**$341,851**	**$1,403,976**	**$1,745,827**

Enrollment builds through the first year, so the program enters the second with 937 unique patients and ends it with 2,139. Year two returns **$1,383,378 of the $1,712,455 recurring-line contribution margin**. The transitional care line adds $33,372 over the same 24 months, for $1,745,827 combined.

6.2 Where the patients come from

Program	Active enrollments, month 12	Active enrollments, month 24	Ceiling
Remote physiologic monitoring	842	**1,921**	2,288, not reached by M24
Principal care management	317	**728**	2,074, not reached by M24
Unique patients	**937**	**2,139**	

Remote monitoring is the larger program: 1,921 enrollments at month 24, still growing, and it produces the readings, alerts and avoided admissions. Principal care management reaches 728, also still growing. The **2,649 active program enrollments at month 24 belong to 2,139 unique patients**, because most care-management patients are also monitored.

[16] CoachCare Value Analysis for MarinHealth Cardiovascular Medicine, 2026, the source of all Section 6 figures; the transitional care line is a separate episodic layer on the same Medicare rates; sensitivity runs change one input at a time on the same workbook.

6.3 The ramp, month by month

Contribution margin runs −$5,178 in month 1 while the program ramps, on 22 enrollments. It is positive from month 2, with $3,229 on 54 enrollments, and cumulative contribution margin is above zero by the end of month 3. New patients join faster each month as referrals build, reaching about 146 a month by month 12, so the monthly figure climbs every month to $151,315 at month 24. Cumulative contribution margin passes $49,916 at month 6, $329,077 at month 12 and $1,712,455 at month 24.

Month	Active enrollments	Monthly contribution margin	Cumulative contribution margin
M1	22	**−$5,178**	−$5,178
M2	54	$3,229	−$1,949
M3	103	$6,212	$4,262
M6	348	$20,552	$49,916
M12	1,159	$67,155	$329,077
M18	1,972	$113,069	$896,783
M22	2,437	$139,335	$1,415,724
M24	2,649	**$151,315**	**$1,712,455**

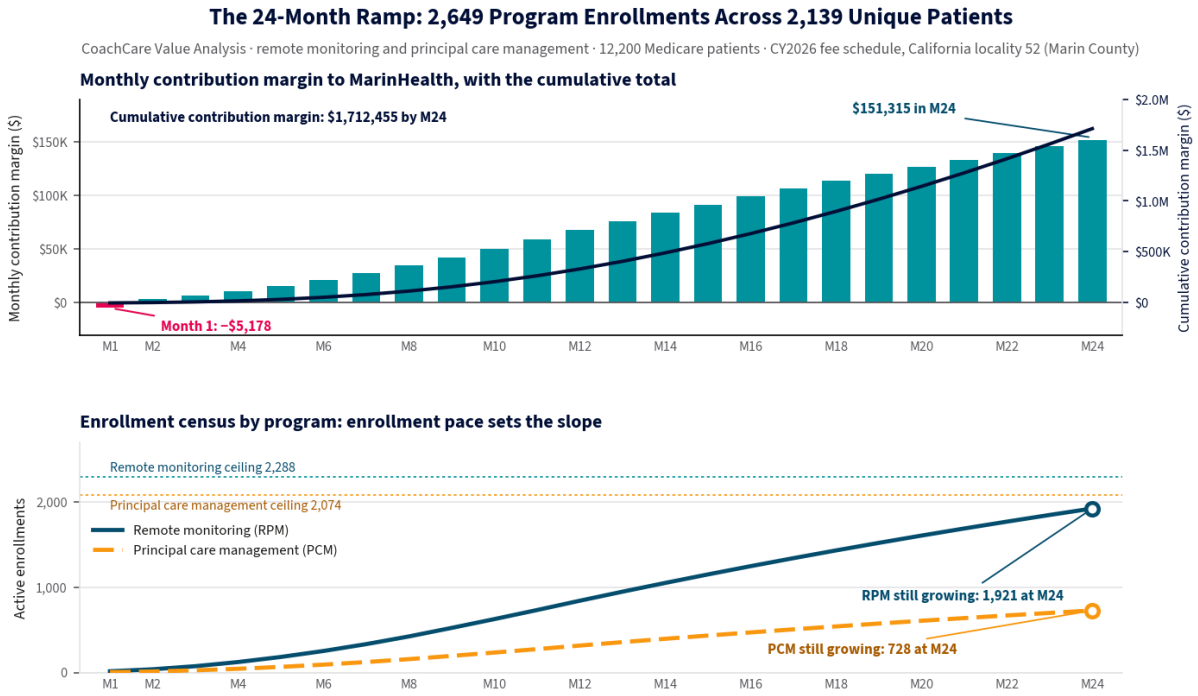


Figure 3. Monthly contribution margin with the cumulative total, and the enrollment census by program: both programs are still growing at month 24, below their eligible ceilings. CoachCare Value Analysis, recurring line.

6.4 Enrollment capacity sets the pace

Program	Eligible share of the 12,200	Acceptance	Ceiling	Reached
Remote physiologic monitoring	75%, 9,150 patients	25%	**2,288**	**Not by M24 (1,921 enrolled)**
Principal care management	85%, 10,370 patients	20%	**2,074**	**Not by M24 (728 enrolled)**

Say the constraint out loud

At a Medicare panel of about 12,200, enrollment capacity sets the pace, not panel size. One on-site specialist, 26 referring clinicians and telephonic outreach take remote monitoring to 1,921 of its 2,288 ceiling and principal care management to 728 of its 2,074 by month 24. A second on-site enrollment specialist cannot raise the ceilings, but reaches them sooner: remote monitoring fills in month 21, and 24-month contribution margin rises from $1,712,455 to $2,390,126, $677,671 more. The forecast holds new enrollment to what one care team can onboard well: no more than 1,500 new patients a year. With no on-site specialist the forecast falls to $970,854.

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

Panel size moves this forecast far less than enrollment capacity does. Across 10,600 to 16,700 patients, the panel sizes MarinHealth's claims support, 24-month contribution margin moves by $63,580; a second specialist adds $677,671 at the same 12,200. Referring clinicians are the other pace lever: the 19 physicians with CY2024 claims return $1,482,587, the 22 physicians alone $1,581,102, and 27 clinicians $1,745,293.

Scenario	24-month contribution margin	Unique patients at M24	RPM ceiling reached
Base: network panel 12,200, 26 clinicians, one enrollment specialist	**$1,712,455**	**2,139**	**Not by M24**
No on-site enrollment specialist	$970,854	1,248	Not by M24
A second on-site enrollment specialist	**$2,390,126**	**2,622**	**M21**
Panel 10,600	$1,695,778	2,121	Not by M24
Panel 16,700	$1,759,358	2,191	Not by M24
Larkspur alone: panel 10,100, 22 clinicians	$1,559,214	1,945	Not by M24
The 19 physicians with CY2024 claims	$1,482,587	1,841	Not by M24
The 22 physicians alone	$1,581,102	1,969	Not by M24
27 referring clinicians	$1,745,293	2,182	Not by M24

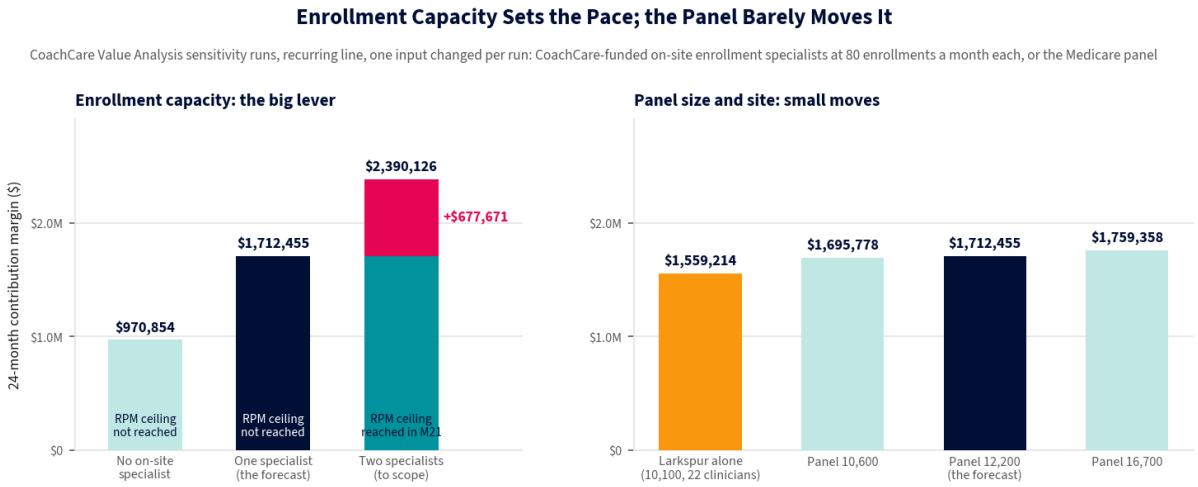


Figure 4. 24-month contribution margin with zero to two CoachCare-funded on-site enrollment specialists (left), and across panel sizes and the Larkspur-only run (right). CoachCare Value Analysis sensitivity runs, recurring line.

6.5 Starting at Larkspur

Larkspur is where the program starts. 20 of the 22 physicians are based there, two physician assistants work from it, and about 10,100 of the network's 12,200 Medicare patients are seen there. Run on Larkspur alone, with 22 referring clinicians and the same single enrollment specialist, the service line returns $1,559,214 of contribution margin over 24 months for 1,945 unique patients, against $1,712,455 and 2,139 for the whole network.

That gap is small because enrollment capacity, not geography, sets the pace. Novato, Petaluma and Sonoma join without a second build: the same Epic record, the same flags, the same care team and the same protocols. A Larkspur start proves the workflow where most of the panel is seen, and the network inherits it.

6.6 What the program produces clinically and operationally

Output over 24 months	Volume	What it represents
Physiologic readings received	**227,685**	Blood pressure, heart rate and weight values arriving between visits
Claims and billable units	**53,894**	Created in Epic for the billing team
Care-team hours	**24,044**	**About 11.6 full-time-equivalent years of work MarinHealth does not employ**: 107,788 care-management tasks and 16,168 patient conversations over 898 hours of call time
Transitional care episodes above today's volume	**150**	About 150 care-team hours of discharge calls and medication reconciliation

24-month totals. The recurring line also avoids about 145 hospitalizations at the workbook's 20% annual admission rate; at a 40% annual admission baseline, realistic for a heart-failure panel with an average risk score of 1.41, it is about 289.

6.7 Published results from CoachCare cardiology programs

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

7. The Ambulatory Specialty Model: Nine Heart-Failure Clinicians

Nine heart-failure clinicians in this group are named on CMS's final CY2027 participant list for the Ambulatory Specialty Model, which CMS posted on October 5, 2026. They bill under Regents of the University of California (UCSF), the entity under which MarinHealth's cardiologists bill Medicare; seven are in the San Rafael CBSA and two in Santa Rosa-Petaluma. The model is mandatory for them. The first performance year is CY2027, and it sets their payments in 2029.[20]

[17] Cardiac Solutions case study, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more.

[18] Cardiac Solutions readmissions case study: 7% against 15% across 26,689 patients.

[19] Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.

[20] CMS, Ambulatory Specialty Model final CY2027 participant list (posted October 5, 2026), matched by NPI to the group's clinicians: nine heart-failure rows, billing entity REGENTS UNIV OF CALIFORNIA UCSF, CBSA 42034 (7) and 42220 (2). The preliminary list carried the same nine.

7.1 What the model scores

Each named clinician receives a 0 to 100 score, half quality and half cost, with improvement activities and interoperability able only to subtract, and is compared with heart-failure peers. The score sets a payment adjustment of −9% to +9% in the first two performance years, rising to −12% to +12% by the last, applied to the clinician's Medicare Part B professional services as a whole, not only to heart-failure visits.[21]

Heart-failure measure	How it is collected	What the service line does
Q492 · Cardiovascular admissions among heart-failure patients	Calculated by CMS from claims	Daily weight and blood pressure, and a care manager who sees a gain before it becomes an admission
Q008 · Beta-blocker for reduced ejection fraction	Reported by the clinician	Heart rate and blood pressure from the cuff show when the dose can go up; the monthly call finds the patient who stopped it
Q005 · ACE inhibitor, ARB or ARNI for reduced ejection fraction	Reported by the clinician	Principal care management tracks each patient's place on guideline therapy and schedules the next step
Q236 · Controlling high blood pressure	Reported by the clinician	Home averages give an accurate picture of control and a monthly chance to act on it
Q377 · Functional status assessment	Reported electronically only	Structured symptom and function questions on the monthly call, documented in Epic
Cost · Heart-failure episode-based cost measure	Calculated by CMS from claims	Admissions headed off lower Medicare spending in the clinician's attributed heart-failure episodes

ASM heart-failure quality set, 42 CFR § 512.725(b); cost measure, § 512.730. Q377 is collected only as an electronic clinical quality measure, which the shared Epic record supports.

7.2 How the service line maps to the heart-failure measures

Three things decide whether the service line moves these scores. First, which billing opens and attributes a heart-failure episode: principal care management and transitional care management are trigger codes for the heart-failure cost measure, and remote monitoring is not. Monitoring billed alone neither opens a heart-failure episode nor counts toward a clinician's attribution. This service line pairs monitoring with principal care management and builds on the transitional care the group already bills, so its heart-failure patients carry trigger codes.[22]

Second, the admissions. Q492 and the cost measure both run on hospitalizations among heart-failure patients, and the hospital already does better than its peers on heart-failure readmissions; the service line reaches the admissions that start at home. Third, the reporting. Q008, Q005 and Q236 need documented therapy and control, and the monthly care-management note is that documentation, in the same Epic record the clinicians report from.

7.3 Working with referring primary care

The model also asks each participant to connect patients to primary care and to send relevant information back to the primary-care physician after a visit. The service line can send each enrolled patient's primary-care physician a monthly summary of home readings and care-plan changes, from the shared record. Any collaborative care arrangement the model contemplates is between the participating clinician and the primary-care practice; CoachCare is not a party to it, and the summary works the same with or without one.[23]

---

[21] 42 CFR part 512, subpart G: §§ 512.725 (quality), 512.730 (cost), 512.735 (improvement activities), 512.745 (final score), 512.750 (payment adjustment; risk levels 9% in payment years 2029 and 2030, rising to 12% in 2033).

[22] CMS, proposed operational list of care episode and patient condition codes, June 2026, heart-failure tab: principal care management (99424, 99426) and transitional care management (99495, 99496) are among the outpatient trigger codes; the remote monitoring family (99453, 99454, 99457, 99458, 99445, 99470, 99091) is not.

[23] 42 CFR § 512.735 (improvement activity IA-1: confirming access to primary care and communicating relevant information back to the beneficiary's primary-care physician; IA-2: at least one collaborative care arrangement) and § 512.771(a)(2) (an arrangement is exclusively between the

The nine named clinicians bill under a billing entity that spans more than MarinHealth's cardiology clinics, so how that entity organizes its response to the model, and where MarinHealth's clinics fit in it, is on the confirmation list.

8. TEAM: The 30 Days After a Bypass

TEAM, the Transforming Episode Accountability Model, began on January 1, 2026, and MarinHealth Medical Center (CCN 050360) is a mandatory participant through December 31, 2030. For each episode TEAM holds the hospital accountable for total Medicare Part A and Part B spending from the admission through 30 days after discharge, against a target price. Of TEAM's five episode types, one is cardiac: coronary artery bypass graft. The other four (joint replacement, hip fracture, spinal fusion and major bowel procedures) are not cardiology's.[24]

Bypass is also where the readmissions program flags the hospital: CABG is the one measure with an excess readmission ratio above 1.0, on a small volume (35 eligible discharges over three years), which means each readmission weighs heavily. The hospital launched a comprehensive cardiothoracic surgery program in May 2025, and its bypass patients come back to the cardiologists in this group.

Days after a bypass discharge	What the service line does	What it means for the episode
Day 1–2	The call: symptoms, wound, medications reconciled, follow-up visit booked	Medication problems caught before they become an emergency visit
Day 2–30	Daily blood pressure, heart rate and weight on a cellular cuff and scale, with business-hours alert triage	Fluid, rate and pressure problems routed to the cardiologist early
Day 7–14	The follow-up visit, billed as transitional care; cardiac rehab referral confirmed	The visit and the rehab start inside the episode window
Day 30 on	Monthly monitoring and care management where the patient qualifies	The patient stays connected past the episode

TEAM lets each hospital name collaborators for its episodes, and a documented post-discharge program, with its cadence, escalations and monthly reports, is what that conversation needs. TEAM does not change what Medicare pays the cardiologists, and the Value Analysis carries no TEAM dollars. The same call, devices and care team serve the bypass patient, the heart-failure patient and the patient after a valve procedure.

9. Procedural Growth: Structural Heart, Rhythm, Renal Denervation

MarinHealth runs a full procedural program, and every procedure has a before and an after that happen at home. In CY2024 the group's clinicians billed these procedures for traditional-Medicare patients:[25]

Procedure (CPT)	CY2024 services	Where remote care fits
Transcatheter aortic valve replacement (33361)	64	Weight, blood pressure and heart rate through recovery; heart-failure patients stay on monitoring
Left atrial appendage closure (33340)	85	Rate and blood pressure while anticoagulation changes
Coronary stent, single vessel (92928)	124	Blood pressure and heart rate while new medications settle
Atrial fibrillation ablation (93656)	151	Home heart rate after the procedure, beside the device and rhythm follow-up

participant and the primary care practice).

[24] CMS, Transforming Episode Accountability Model final rule and participant list (hospitals as of August 18, 2026): CCN 050360, mandatory, CBSA 41860 San Francisco-Oakland-Fremont, January 1, 2026 to December 31, 2030.

[25] CMS by Provider and Service, CY2024, the 21 clinicians: professional services for 33361, 33340, 92928 and 93656. Traditional Medicare only.

Renal denervation. MarinHealth has offered renal denervation for uncontrolled hypertension since December 2023. Medicare covers it under national coverage determination 20.40, effective October 28, 2025, with coverage with evidence development. The same cuff that finds uncontrolled hypertension documents it before the procedure and tracks the response after, on readings the care team already collects.[26]

None of this is in the forecast. The forecast counts the monthly programs and the additional transitional care episodes; the procedural value is what the same care team adds when the patients it already watches are the ones going to the cath lab and the hybrid operating room.

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

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in the recurring line was repriced at California locality 52 on MarinHealth's own billing mix, with enrollment held constant.[27]

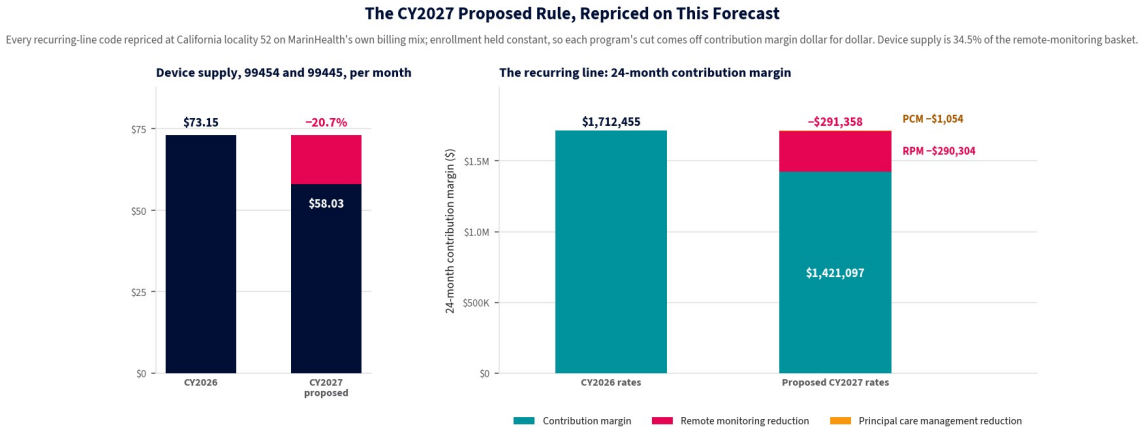


Figure 5. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then the recurring line's 24-month contribution margin at CY2026 and proposed CY2027 rates, with the reduction from each program. Enrollment held constant.

Level	CY2026 rates	Proposed CY2027 rates	What changes
Device supply, 99454 and 99445	$73.15 a month	**$58.03 a month, −20.7%**	The code CMS proposes to cut
Remote monitoring, change in contribution margin		**−$290,304**	Device supply is 34.5% of the remote monitoring basket
Principal care management, change in contribution margin		−$1,054	Routine rate changes only (−0.1%); not targeted
Recurring line, 24-month contribution margin	**$1,712,455**	**$1,421,097 (−$291,358)**	Enrollment held constant, so the repricing passes through dollar for dollar

[26] mymarinhealth.org renal denervation page, retrieved October 30, 2026; CMS National Coverage Determination 20.40, Renal Denervation for Uncontrolled Hypertension, effective October 28, 2025.

[27] CMS-1848-P, published July 2026. CoachCare repricing at California locality 52, conversion factor $32.8409 against $33.4009: device supply 34.5% of the remote monitoring basket; remote monitoring 75.2% of the line.

With enrollment held constant, every dollar of repricing comes off contribution margin: $290,304 from remote monitoring and $1,054 from principal care management, which barely moves, leaving $1,421,097 over 24 months. Section 1848(c)(7) of the Act limits how far a code's relative value can fall in one year. CoachCare will rerun the forecast at the final rates before MarinHealth commits to anything.

11. Implementation Roadmap

11.1 Who runs what

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

11.2 The model inputs

Input	Value in this forecast
Medicare panel	**12,200 patients across the network, all in scope; about 10,100 at Larkspur**
Referring clinicians	26: 22 cardiologists and 4 physician assistants
Programs	Remote monitoring and principal care management (the recurring line); transitional care episodes above the CY2024 volume as a separate line
Eligibility and acceptance	Remote monitoring 75% eligible, 25% accept; principal care management 85%, 20%; 5 referrals per clinician a month at 70% acceptance; 70% of care-management patients also monitored; 3% monthly attrition; referrals and on-site enrollment build to full pace over the first 12 months
Transitional care	50% of eligible cardiac discharges from MarinHealth Medical Center after a four-month ramp, 30% high complexity; the CY2024 volume of 332 patients a year subtracted
Enrollment staffing	One CoachCare-funded on-site enrollment specialist at 80 a month, plus telephonic outreach
EMR	Epic (APeX), integrated as described in Section 4
Rates	CY2026 fee schedule, non-facility, California locality 52, ZIP 94939; every patient priced at the Medicare amount

11.3 The first 90 days at Larkspur, and after

Window	What happens	Result
Weeks 0–6 Integrate and charter	Epic workshop with clinic, billing and UCSF Health IT leads; chart counts and payer mix; today's transitional care workflow and the device clinic mapped; thresholds, routing and Larkspur staffing agreed	Integration path set, protocol signed, staffing decided
Weeks 6–12 Launch at Larkspur	Enrollment from the first week; remote monitoring and principal care management for heart failure and uncontrolled hypertension; the discharge call and post-discharge cadence live	22, 32 and 51 new enrollments in months 1 to 3

Window	What happens	Result
Months 3–12 **Bring in the network**	Novato, Petaluma and Sonoma on the same protocols; atrial fibrillation, post-procedure and device patients with heart failure added; care managers added as the census grows	1,159 enrollments, 937 unique patients at month 12
Months 13–24 **Grow toward the ceilings**	Remote monitoring grows to 1,921 of its 2,288 ceiling and principal care management to 728 of 2,074; the first Ambulatory Specialty Model year runs on these data	Year 2: $1,383,378 on the recurring line

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

11.4 What we would confirm together

1. **The Medicare chart count, by payer and clinic.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry heart failure, hypertension or atrial fibrillation. It sets both ceilings in Section 6.
2. **The heart-failure and hypertension flag criteria.** Ejection fraction, diuretic use, recent admissions and office readings: the rules that put a patient on the worklist.
3. **Who contracts, and the Epic path.** Which MarinHealth entity signs, how the program's claims flow under the clinicians' billing entity, and the change-control path and timing for building inside UCSF Health's Epic instance.
4. **Transitional care today.** Who makes the two-business-day contact now, how discharges reach the clinic, and how the care team's call joins that workflow without duplicating it.
5. **The device clinic and complex care.** How device patients with heart failure are co-managed with a cuff and a scale, and which patients the nurse-navigator complex care service already follows.
6. **The Ambulatory Specialty Model response.** How the billing entity is organizing for the model across its clinicians, and where the nine named clinicians and their primary-care partners fit.
7. **The billing practitioner and coinsurance.** Who bills for patients the physician assistants manage, and how the monthly Part B coinsurance is explained at enrollment.

12. Recommendations

1. **Launch at Larkspur, then bring in the network.** $1,712,455 of contribution margin over 24 months on the recurring line across the network, $1,559,214 from Larkspur alone, positive from month 2, with nobody hired.
2. **Scope a second on-site enrollment specialist.** Enrollment capacity sets the pace: a second specialist fills remote monitoring in month 21 and adds $677,671 of contribution margin.
3. **Pull the Medicare chart count by payer in week one.** It sets both ceilings.
4. **Start with heart failure and uncontrolled hypertension.** A cellular scale and cuff for the readings, principal care management for the care plan, and the follow-up visit as the enrollment conversation.
5. **Put the discharge call on the care team.** Extend the transitional care MarinHealth already bills to half of eligible cardiac discharges, $33,372 of contribution margin over 24 months on its own, and the front door to everything else.
6. **Build the heart-failure measures into the monthly work before January 2027.** Weight, blood pressure, therapy steps and functional status documented in Epic for the nine named clinicians' patients first.
7. **Offer the post-discharge cadence to the hospital's bypass episodes.** The same call, devices and care team, documented for TEAM.
8. **Keep clinical governance where it is.** MarinHealth's cardiologists decide; CoachCare does the work and documents it.

The Medicare panel MarinHealth already manages supports a service line that returns $1,712,455 of contribution margin over 24 months, $1,745,827 with the additional transitional care, on staff MarinHealth does not hire and devices it does not buy, before any model dollar. The same service line is what both mandatory models will measure.

About CoachCare

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

- **It builds on what MarinHealth already does.** Device follow-up for about 1,200 patients and transitional care after discharge stay, and the service line adds blood pressure, weight and the monthly heart-failure care plan.
- **It runs inside the record MarinHealth already shares.** Readings, documentation and claims live in Epic, visible at every clinic and at the hospital.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll, with no capital outlay.
- **Cardiologists stay in charge.** MarinHealth's physicians and physician assistants set the protocols, sign the care plans and make every clinical decision.
- **Published cardiology results.** A 29.1 mmHg drop in Stage 2 hypertension across 2,738 patients at Cardiac Solutions, half the 30-day readmission rate across 26,689 patients at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session to confirm the Medicare chart count by payer, agree on the heart-failure and hypertension flag criteria, scope the build inside the shared Epic record, and set enrollment staffing for Larkspur before the first patient enrolls.

Contact

Connor Knapp · VP, Commercial · CoachCare · connor.k@coachcare.com
Anthony Pappas · Director of Sales · CoachCare · anthony.p@coachcare.com

Prepared by CoachCare for discussion with MarinHealth. © 2026 CoachCare.

References & Data Sources

- **MarinHealth:** mymarinhealth.org, retrieved October 30, 2026, for clinics, services, the arrhythmia center, renal denervation, cardiac surgery, the Petaluma clinic and MyChart; the APeX go-live announcement, August 2022.
- **CMS provider and claims files:** NPPES; PECOS reassignments, October 2026; Doctors and Clinicians, July 2026; Quality Payment Program eligibility, 2024 to 2026; Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024; Medicare Inpatient Hospitals by Provider and Service.
- **CMS hospital files:** Care Compare Hospital General Information and Unplanned Hospital Visits; FY2026 Hospital Readmissions Reduction Program supplemental data file.
- **CMS models:** Ambulatory Specialty Model final CY2027 participant list (October 5, 2026) and 42 CFR part 512, subpart G; ASM heart-failure operational code list, June 2026; TEAM participant list (hospitals as of August 18, 2026); National Coverage Determination 20.40.

- **Medicare payment rules:** the CY2026 Physician Fee Schedule final rule, RVU file and California locality 52 geographic indices; CMS-1848-P, the CY2027 proposed rule.
- **Market:** CMS Medicare Advantage State/County Penetration, October 2026; CMS Medicare Advantage enrollment by contract, July 2026.
- **CoachCare:** Epic integration overview, 2026; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for MarinHealth Cardiovascular Medicine, 2026, with its transitional care layer, the source of every contribution margin, enrollment, clinical-output and operational figure in Sections 6 to 12.

Unique patients and program enrollments are different numbers. At month 24 the recurring line holds 2,649 active program enrollments belonging to 2,139 unique patients, because a patient may hold both a care-management and a monitoring enrollment. The 12,200-patient panel covers every MarinHealth cardiology clinic; the CY2024 claims profile is traditional Medicare only.