COACHCARE | SERVICE LINE STRATEGY

Cardiac Associates

An Adventist Medical Group cardiology practice — three Montgomery County offices, Medicare billing through Adventist Physician Services Inc, alongside two Adventist HealthCare hospital campuses

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as a margin-positive standalone P&L under the Physician Fee Schedule — and, because the same corporation owns the practice and the hospitals, as the mechanism that turns every avoided admission under Maryland's hospital global budget into margin the enterprise keeps

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the cardiovascular service-line leadership of Adventist HealthCare and Adventist Medical Group. It assembles the group's public footprint and enrolled structure, its CY2024 Medicare service record and panel profile, the Maryland payment environment as it stands in the first performance year of the state's new all-payer arrangement, the Montgomery County market, and a modeled financial forecast into a single argument: the fee-schedule business case for remote care is fully valid in Maryland, and this is the rare account where the same corporate entity books the revenue and keeps the avoided cost.

All facts are drawn from public sources current to August 2026 and cited in the References section. All financial projections are illustrative and modeled in the CoachCare Value Analysis (MAC locality auto-resolved for ZIP 20850 — Maryland, locality 12202-01) — verify against practice data before budgeting.

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

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Executive Summary

Cardiac Associates is a Montgomery County cardiology group of more than forty-five years' standing — its own archived copy from 2001 already described two decades of Maryland practice — and it is no longer a standalone billing operation. **Every physician of the group who resolves in the current CMS Doctors and Clinicians file bills Medicare through ADVENTIST PHYSICIAN SERVICES INC**, organizational PAC ID 4284631540, an entity carrying **142 enrolled clinicians** and nineteen enrolled practice addresses, all of them in Montgomery or Prince George's County.[1] The same file holds **zero rows for Cardiac Associates, P.C.**, while peer cardiology organizations of similar size in the same county do appear in it. All three of the group's published offices are enrolled practice locations of the Adventist entity. Archived captures of Adventist HealthCare's own physician-profile pages date the rebrand to **between January and September 2022**, with an Adventist Medical Group employment badge appearing by October 2025.[2] **This report is therefore written for a health-system-owned cardiology group, and the economic buyer is Adventist HealthCare**. The practice's public homepage still presents the group in the terms it used before 2022; that copy predates the integration and is contradicted by federal enrollment data.

Three facts define this report.

1. **Maryland's global budget does not break the business case — it is the business case.** Maryland entered **Performance Year 1 of the AHEAD Model on January 1, 2026**, as the sole Cohort 1 state, succeeding the Total Cost of Care Model that ended December 31, 2025.[3] A Maryland reader will assume the fee schedule works differently here. It does not. **Hospital global budgets bind hospitals, not physician office billing** — the state regulator's own scope statement is that it regulates hospital rates, and the model's physician-facing component is voluntary and limited to primary care.[4] Remote monitoring and care management are paid under the ordinary Physician Fee Schedule at the Maryland locality. **And because Adventist owns both the hospitals and this practice, the same corporation captures the global-budget savings from every avoided admission and books the Part B care-management revenue.**
2. **The market is unusually favourable to a fee-for-service model.** Montgomery County's Medicare Advantage penetration is **22.57%** — 44,742 of 198,254 eligibles — against **51.69% nationally**, leaving roughly **153,500 traditional fee-for-service beneficiaries** in the county.[5] Maryland ranks fifth lowest of fifty-three jurisdictions on plan penetration. The usual caveat that most of the local

[1] CMS Doctors and Clinicians National Downloadable File (PECOS), dataset mj5m-pzi6, file vintage June 26, 2026. ADVENTIST PHYSICIAN SERVICES INC, organizational PAC ID 4284631540, 142 enrolled clinicians across nineteen practice addresses, all in Montgomery or Prince George's County, Maryland; specialty mix includes 87 cardiology records across 31 distinct cardiology identifiers, plus nurse practitioners, physician assistants, physical medicine, psychiatry, cardiac electrophysiology and vascular surgery. A separate query of the same file for Cardiac Associates, P.C. (PAC 8022005834) returns zero rows, while peer county cardiology organizations do appear.

[2] The group's own website (cardiacassociates.org: home, locations, providers, services and affiliations pages) and the separately branded venous service line, retrieved August 3, 2026; archived captures of the group's original domain from March 2001; and archived captures of Adventist HealthCare's physician-profile pages from September 2019, January 2022, September 2022, October 2025 and February 2026, which date the rebrand to between January and September 2022 and the medical-group employment badge to between September 2022 and October 2025. Adventist's live site blocks automated retrieval, so the branding evidence rests on archived captures and search metadata and should be confirmed directly.

[3] CMS Innovation Center AHEAD Model page, last modified July 9, 2026, and the Amended and Restated AHEAD Model Maryland State Agreement published by the Maryland Health Services Cost Review Commission. Maryland is the only Cohort 1 state; the pre-implementation period ran July 1, 2024 to December 31, 2025; the implementation period began January 1, 2026; Performance Year 1 runs through December 31, 2026; the model ends December 31, 2035 for all cohorts. Cohorts 2 and 3 begin performance January 1, 2028. The predecessor Maryland Total Cost of Care Model ended December 31, 2025.

[4] Maryland Health Services Cost Review Commission, retrieved August 3, 2026 — the regulator's own statement of scope is that it regulates hospital rates, and its published programme list includes the Readmission Reduction Incentive Program, Maryland Hospital Acquired Conditions, Quality Based Reimbursement and the Potentially Avoidable Utilization savings policy. CMS describes Hospital Global Budgets as covering inpatient and outpatient services for hospitals, with the separate physician-facing component, Primary Care AHEAD, voluntary and limited to primary care practices.

[5] CMS Medicare Advantage state / county penetration file, July 2026: Montgomery County, Maryland (FIPS 24031), 198,254 eligibles, 44,742 enrolled in a plan, 22.57% penetration; Maryland statewide 1,200,276 / 298,364 / 24.86%; national 69,221,715 / 35,779,621 / 51.69%. Maryland ranks fifth lowest of fifty-three jurisdictions. The national figure excludes Connecticut and Alaska, which the July 2026 file omits for recoding reasons.

Medicare population sits in a plan where remote-monitoring reimbursement is contract-dependent is, in this county, a minor footnote rather than a load-bearing qualification.

3. **The panel is exactly the population these benefits were written for.** Across the ten providers whose CMS-reported practice address is a confirmed Cardiac Associates location, the CY2024 Medicare panel runs at an average beneficiary age of **77.6**, with **heart failure at 29.5%, atrial fibrillation at 34.6%, chronic kidney disease at 31.4%**, hypertension at 75.0%, ischemic heart disease at 46.9% and diabetes at 39.0%, at an average HCC risk score of **1.472**.[6] Meanwhile **no remote physiologic monitoring, chronic care management or principal care management programme is marketed anywhere on the group's public site** — stated as absence of evidence, not proof of absence.

The central argument

1. Standalone value, and it leads here. TCM + RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based dollar — modeled at **$4,542,396** of net reimbursement and **$1,927,693** net to the practice over 24 months, a **42.44% practice margin** (net to the practice ÷ net reimbursement). It depends on no reconciliation, no shared-savings determination and no model selection. Illustrative, modeled — verify against practice data.

2. Connective tissue. One shared engine — enrollment, connected devices, 24/7 alerting and triage, nurse navigation, billing capture and analytics — simultaneously serves the standalone P&L, the hospital global-budget position of two Adventist campuses, the post-discharge window, referral durability in a four-system county, and procedural and device-clinic throughput. Build once, use everywhere.

The inversion is the whole argument, and it is worth stating slowly. In an ordinary fee-for-service market, a readmission generates incremental hospital revenue, so the hospital's enthusiasm for a programme that prevents readmissions is a matter of strategy rather than of arithmetic. **Under a global budget the hospital's revenue is set prospectively and does not move with volume**, so a readmission consumes budgeted capacity and produces nothing, and an avoided admission is margin retained rather than revenue lost. Maryland then layers explicit penalties on top of that: the state regulator operates a Readmission Reduction Incentive Program, a Maryland Hospital Acquired Conditions program, Quality Based Reimbursement, and a Potentially Avoidable Utilization savings policy.[7] **Readmissions are unfunded and penalised at the same time**. A remote care service line that keeps a heart failure patient out of the hospital is therefore not a cost the hospital tolerates for the sake of the physician group; it is a direct contributor to the hospital's own budgeted margin — and the physician group and the hospital are the same company.

[6] Same file and vintage: mean across the ten address-confirmed providers of the CMS chronic-condition prevalence fields and the average HCC risk score — average beneficiary age 77.6, hypertension 75.0%, ischemic heart disease 46.9%, diabetes 39.0%, atrial fibrillation 34.6%, chronic kidney disease 31.4%, heart failure (non-ischemic) 29.5%, COPD 17.0%, average HCC risk score 1.472.

[7] Maryland Health Services Cost Review Commission, published programme list, retrieved August 3, 2026: the Readmission Reduction Incentive Program, Maryland Hospital Acquired Conditions, Quality Based Reimbursement and the Potentially Avoidable Utilization savings policy. Under the state's current arrangement Maryland is additionally accountable for statewide Medicare total cost of care, not only for hospital spending.

The honest caveat on that argument, stated up front

If any Cardiac Associates site now bills provider-based — that is, as hospital outpatient under an Adventist campus — the global-budget interaction changes the model. Freestanding office billing runs on the Physician Fee Schedule and is unaffected by the hospital global budget; services billed at a provider-based location sit inside a different economic frame. This is the single largest modelling risk in the account and it is a contracting question rather than a clinical one. *Resolve the site-of-service status of all three offices before budgeting.*

On mandatory models, one line and no more. No mandatory federal payment model bears on this group or on its admitting hospitals — which makes the timing pure upside: the service line is built for its own economics, and it is the same asset that would answer a mandatory obligation if selection maps change.

The accountable care position is recorded fact, and a commercial file has it wrong. A widely used commercial firmographic record reports no accountable care affiliation for this account. That is incorrect. **ADVENTIST PHYSICIAN SERVICES INC was a participant in Adventist HealthCare ACO, LLC (A5374) in PY2024 and PY2025**, and in the PY2026 Shared Savings Program files that ACO does not exist: seven of its nine PY2025 participant organizations, this one among them, appear instead in **Kettering Physician Partners Accountable Care LLC (A5062)**, whose service area expanded to Maryland and Ohio effective January 1, 2026.[8] The movement of the participating organization is documented in the CMS files. *Whether it reflects a corporate combination between the two systems is an inference and is not confirmed by any announcement located in this research* — it is the highest-value single question to ask in discovery, because it determines whether procurement is a Maryland decision or a two-state one.

The clinical starting position is a group that already runs the hard part. The group's own services page publishes a staffed **anticoagulation clinic**, a **pacemaker and defibrillator clinic**, an arrhythmia clinic, named heart failure and blood-pressure management clinics, and Holter, event and loop-recorder monitoring.[9] Those are protocol-driven chronic-management and transmitted-data-triage operations — the exact staffing muscle a remote care service line runs on. What is not published anywhere on the site is remote physiologic monitoring, chronic care management or principal care management; there is also no patient portal link, no online scheduling, and telemedicine is requested by emailing a general inbox. **Two readings follow, and both should be carried into the first conversation**: the digital baseline is genuinely low, which means no incumbent vendor to displace at the practice level; and because billing runs through the Adventist entity, the relevant question is whether *Adventist* already operates an enterprise remote-care programme this practice sits inside. That was not determinable from public sources.

The timing is specific. The CY2026 Physician Fee Schedule expanded remote monitoring in ways that suit this group: **99445** pays the monthly device-supply amount for 2–15 days of data where 16 or more were previously required, which makes short post-discharge and post-procedure windows billable for the first time, and **99470** pays for the first 10 minutes of monthly management time where the floor had been 20. Maryland's performance year began January 1, 2026. A service line chartered in late 2026 is operating at census inside the first performance year rather than after it.

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[8] CMS Medicare Shared Savings Program participant and organization public use files for PY2024, PY2025 and PY2026. ADVENTIST PHYSICIAN SERVICES INC appears as a participant in Adventist HealthCare ACO, LLC (A5374, Maryland) in PY2024 and PY2025. A5374 does not appear in the PY2026 files; seven of its nine PY2025 participant organizations, this one included, appear in Kettering Physician Partners Accountable Care LLC (A5062), an Ohio-headquartered BASIC track Level E, low-revenue, retrospective-assignment organization with an agreement start of January 1, 2022 and a PY2026 service area of Maryland and Ohio. Cardiac Associates, P.C.'s own tax identification number is not a participant in any year checked.

[9] The group's own services page, retrieved August 3, 2026: the anticoagulation clinic, the pacemaker and defibrillator clinic, the arrhythmia clinic, heart failure management, blood pressure management, and Holter, event and loop-recorder monitoring, together with the statement that telemedicine visits are booked by email. The same page carries no reference to remote physiologic monitoring, chronic care management or principal care management, and no remote device-monitoring vendor is named anywhere on the site.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **7,879-patient in-scope base across 15 referring providers** — *a discovery-stage estimate to validate against the group's own chart counts* — with RPM and PCM only. It projects net reimbursement of **$1,152,508** in Year 1 and **$3,389,888** in Year 2 (**$4,542,396** over 24 months — RPM $3,338,027, PCM $1,204,369); **$1,927,693** net to the practice after CoachCare fees; 314,024 physiologic readings; approximately **199 avoided hospitalizations**; and 33,751 care-team hours delivered, about **16.2 full-time equivalents** of clinical labour nobody has to hire. Month 1 is modeled at −$3,683 and every month from month 2 onward is net-positive. *All figures are illustrative, modeled — verify against practice data.*

2026–2027 Priority Recommendations

1. **Charter the Remote Care Service Line at Adventist Medical Group level, with its own P&L.** TCM at discharge, then RPM, then PCM, across heart failure, uncontrolled and resistant hypertension, atrial fibrillation and anticoagulation management, and post-procedure windows. Name a physician lead from the cardiology bench and pair them with the medical group's ambulatory operations lead. Target the first billable enrollment within 90 days.
2. **Settle the site-of-service question before anything else.** Whether each of the three offices bills freestanding or provider-based determines whether the fee-schedule model in Section 2.2 applies cleanly or interacts with the hospital global budget. It is a one-week finance question and it gates the entire business case (Sections 3.1 and 5).
3. **Put the hospital economics in the same business case as the practice economics.** This is the unusual feature of the account: the avoided-admission value and the professional-fee revenue accrue to one corporation, so the two do not have to be negotiated between parties. Build one financial model that shows both lines, and measure the readmission delta against an unenrolled comparison panel from month one (Section 5).
4. **Start with the cohorts the group already touches every month.** The anticoagulation clinic, the pacemaker and defibrillator clinic, and the Holter, event and loop-recorder population are the highest-confidence enrollable groups in the account: the patients are already conditioned to remote review and the staff already triage transmitted data. Physiologic monitoring is a distinct benefit over distinct data (Section 9.3) — this is an attach, not a re-sell.
5. **Confirm the clinical record platform before scoping integration.** A commercial file reports one ambulatory platform; direct inspection of the group's public site found no fingerprint of any platform and no patient portal of any kind, and billing runs through the Adventist entity. This report deliberately specifies the integration generically for that reason (Section 8).
6. **Ask directly whether a remote-care programme already exists anywhere in the enterprise.** Nothing is publicly marketed by the practice, but the practice site says nothing about Adventist's enterprise capability, and Adventist's own site blocks automated retrieval. A national or enterprise agreement would change this from a practice engagement into a different kind of conversation entirely.
7. **Write the attribution policy before the first enrollment.** Only one practitioner may bill RPM for a given patient in any 30-day period, and the billing entity sits inside an accountable care organization whose primary-care participants share this panel. Settle in writing which patients the cardiology service line manages and which stay with a primary-care wrapper, with one shared care plan and explicit task ownership (Section 2.1).
8. **Treat the plan book as additive and unpriced, but do not over-weight it.** Every figure in this report is a fee-for-service figure. In this county that is 77.4% of the Medicare population, so unlike most US markets the fee-for-service model captures the great majority of the opportunity rather than a minority slice of it.

1. Footprint & Operating Model

1.1 The entity: a practice brand, a system billing organization, and why it decides this

The distinction between the practice brand and the enrolled billing organization is not a technicality on this account; it decides who signs, who budgets, and which side of the ledger the value lands on. Six independent lines of evidence resolve it the same way.

Evidence	What it shows
CMS enrollment — the strongest	Every physician of the group who resolves in the CMS Doctors and Clinicians National Downloadable File bills under ADVENTIST PHYSICIAN SERVICES INC, organizational PAC ID 4284631540, 142 enrolled clinicians — and under no other organization
The zero-row result	That same file holds no rows at all attributed to Cardiac Associates, P.C. (PAC 8022005834), while peer cardiology organizations of comparable size in the same county do appear in it. A group still billing under its own enrollment would be visible there
The addresses	All three published offices are enrolled practice locations of Adventist Physician Services Inc — 15225 Shady Grove Road with 21 records, 19735 Germantown Road with 17, and 12501 Prosperity Drive with 13
The hiring pattern	Two physicians presented on the group's current provider page appear under the Adventist entity only, with no reassignment to the P.C. at all. The P.C.'s own reassignment roster is composed entirely of longer-tenured clinicians — the signature of an entity that has stopped enrolling new physicians under itself
The footprint history	Between April 2019 and December 2021 two offices were closed and one opened, realigning the footprint onto Adventist's two hospital campuses immediately before the rebrand window
The surviving shell	Cardiac Associates, P.C. remains separately enrolled with 24 active reassignments and a June 30, 2026 revalidation date, and most individuals carry two employer associations — consistent with dual reassignment rather than with a dissolved entity

CMS Doctors and Clinicians National Downloadable File (PECOS), dataset mj5m-pzi6, file vintage June 26, 2026; CMS PECOS Revalidation Clinic Group Practice Reassignment file, vintage July 1, 2026; the group's own website and archived captures of Adventist HealthCare's physician-profile pages, retrieved August 3, 2026. Adventist's own site brands the group within its medical group, but the live site blocks automated retrieval, so that particular evidence is weaker and should be confirmed directly. The precise legal instrument — asset purchase, employment, or a professional services agreement — is not established from public sources and is listed as an open item.

The dating is unusually precise for this kind of question. Archived captures of Adventist HealthCare's own physician-profile pages show the practice listed as a plain external affiliation in September 2019 and still in January 2022; by **September 2022 the same page carries the Adventist-branded practice name**, and an Adventist Medical Group employment badge is present by October 2025.[10] The rebrand therefore happened **between January and September 2022**. No transaction announcement, press release or terms were located in any source reached during this research, and Adventist's newsroom archive carries cardiology items only from the early 2000s. *That is absence of evidence: the rebranding window is established, the deal structure is not.*

What this changes about the sale, stated plainly. It changes the buyer, the budget and the argument. A practice-level conversation about a practice's own P&L is the wrong conversation here, because the P&L in question consolidates into Adventist Medical Group and the avoided-cost value lands on Adventist HealthCare's hospital side. **The right conversation is a single-entity one**, and it is a better

[10] Archived captures of Adventist HealthCare's physician-profile pages, September 18, 2019; January 25, 2022; September 30, 2022; October 8, 2025; and February 11, 2026, together with an Adventist content-delivery asset for the co-branded practice first archived February 16, 2022. The live Adventist site returns an automated-access block, so this evidence rests on archived captures and search metadata and should be confirmed directly.

conversation: there is no cross-party negotiation to have about who pays for a programme whose benefits land somewhere else, because both sets of benefits land in the same place.

1.2 The operating model: three offices inside a county cardiology enterprise

Footprint. Three published patient-facing offices, not the five a commercial file reports — **Rockville** at 15225 Shady Grove Road, Suite 201 (the main office, at that address continuously since at least 2001), **Germantown** at 19735 Germantown Road, Suite 190, and **White Oak** at 12501 Prosperity Drive, Suite 300 in Silver Spring.[11] The commercial count of five is a historical artifact rather than an error: the group published five offices in earlier years, and dropped its Olney and Laurel sites while adding White Oak between April 2019 and December 2021. CMS billing data also shows practice activity at 15215 Shady Grove Road, an adjacent building on the same medical campus.

Roster source	Count	How to read it
Commercial firmographic file	9 physicians / 11 group members	Understates the group. The same file's location count and accountable-care field are both wrong on this account, so its roster figure should not anchor anything
The group's own provider page	**11 physicians + 4 advanced practice providers**	**The best current estimate of actively practising, publicly presented clinicians — and the 15 referring providers used in the modeled funnel**
CMS reassignments to the P.C.	17 physicians + 7 nurse practitioners	An upper bound. Reassignment rosters lag departures, so a 24-name list includes clinicians who may be part-time, unlisted or gone
Adventist cardiology, countywide	31 cardiologists across nine sites	The enterprise unit of sale. Three of those nine sites are this group's own offices; the others include the system's Rockville medical campus and Germantown, Silver Spring and Fort Washington locations

Commercial firmographic export, vintage July 1, 2026; the group's own provider page, retrieved August 3, 2026; CMS PECOS Revalidation Clinic Group Practice Reassignment file, vintage July 1, 2026; CMS Doctors and Clinicians National Downloadable File, vintage June 26, 2026. All three counts conflict, and the report uses the group's own published roster as the modelling basis. One physician on the provider page appears in no CMS Maryland file and returned no CY2024 Medicare billing, which is consistent with retirement or de-enrollment — unverified, and a discovery item.

Clinical range, from the group's own service pages. Interventional and invasive cardiology covers diagnostic and interventional catheterisation, percutaneous coronary intervention, carotid stenting, and peripheral angioplasty and stenting. Electrophysiology covers pacemakers, implantable defibrillators, bi-ventricular pacing, atrial fibrillation and flutter ablation, ventricular tachycardia ablation, accessory-pathway ablation and loop recorders. Vascular and venous work runs through a dedicated venous service line offering endovenous radiofrequency and laser ablation, micro-phlebectomy and ultrasound-guided sclerotherapy. Non-invasive imaging covers echocardiography, stress and dobutamine stress echocardiography, and exercise and pharmacologic nuclear stress testing.[12] *Two absences are worth recording rather than glossing*: no cardiac computed tomography or coronary CT angiography is advertised anywhere on the site, and no renal denervation programme is advertised — the second of which is treated as whitespace in Section 7 rather than as an existing capability.

[11] The group's own locations page, retrieved August 3, 2026, cross-checked against archived captures of its homepage from 2001, 2017, April 2019 and December 2021, which show the Olney and Laurel offices dropped and White Oak added between April 2019 and December 2021. CMS practice-address rows additionally place group activity at 15215 Shady Grove Road, an adjacent building on the same medical campus.

[12] The group's own services page and its separately branded venous service line site, both retrieved August 3, 2026, cross-referenced against CMS primary-specialty descriptors in the Doctors and Clinicians National Downloadable File. No cardiac computed tomography or coronary CT angiography, and no renal denervation, appears anywhere in the site's published service list.

The hospital relationship is not an affiliation list; it is the operating model. Members of the group hold named directorships across the system's Rockville campus — the cardiac catheterisation laboratory, the electrophysiology laboratory, the acute chest pain centre, inpatient cardiac services and cardiac rehabilitation — and the group also supplies the director of interventional cardiology and the catheterisation laboratory at a competing county hospital.[13] **One member of the group is simultaneously Adventist HealthCare's cardiovascular service line director**, which is the practical reason a service line proposed here can be decided at enterprise level rather than escalated to it. *No individual is named anywhere in this document*; the point is structural, and it is that the practice bench and the system's cardiovascular leadership are the same people.

One structural carve-out worth knowing about. The venous service line trades under its own brand and its own domain, is a Cardiac Associates, P.C. property by its own site metadata, is staffed by a single dual-board-certified vascular physician of the group, and carries **no Adventist branding of any kind**. It appears not to have been folded into the 2022 rebrand. *Whether it retains separate economics and separate purchasing authority is an inference from branding rather than from any ownership document* — but if a practice-level rather than an enterprise-level decision is ever needed on this account, that is the most plausible route to one.

1.3 Design principles for the 2026 service line

Principle	What it means for this group
Longitudinal by default	Every heart failure, uncontrolled-hypertension, atrial-fibrillation and post-discharge patient leaves the encounter enrolled in monitoring or monthly management — not merely scheduled for a return visit a quarter later
One entity, one ledger	The professional-fee revenue and the avoided-admission value accrue to the same corporation. Build the business case as a single P&L that shows both lines, and measure the hospital-side contribution rather than asserting it (Section 5)
Settle site-of-service before design, not after	Freestanding office billing and provider-based billing sit in materially different economic frames under a hospital global budget. This is a finance question with a one-week answer and it gates everything downstream
Confirm the record platform, then scope the integration	The ambulatory platform is not established from public sources and there is no patient portal on the group's website at all. The integration is specified generically in this report on purpose (Section 8)
Start at the discharge, not at the office visit	Every cardiac discharge from an Adventist campus opens a transitional-care window, and every ablation, device implant and catheterisation opens a post-procedure window that 99445 now makes billable
One front door	A single enrollment, consent and device-logistics workflow; referral to the service line is one order inside the chart clinicians already use, with enrollment status visible in real time
The partner carries the load	The group supplies clinical direction and supervision; the partner supplies enrollment, devices, monitoring, documentation and claims. No care-management headcount has to be created to start
Separate the two remote programmes cleanly	Implanted-device interrogation and patient physiologic monitoring are different benefits over different data. Define the boundary, the data source and the documentation for each before launch, so neither service is at risk (Section 9.3)
Single scorecard	Clinical, operational and financial metrics reviewed monthly by the physician lead and the medical group's operations lead, and mapped explicitly to the readmission and avoidable-utilization measures the hospitals are already scored on (Sections 5 and 9.5)

[13] The group's own provider page, retrieved August 3, 2026. The hospital directorships are single-sourced to that page and are self-reported; one listed chairmanship refers to a facility that no longer operates as an acute-care hospital, which is a reminder that the page is not maintained closely. The system's own site independently identifies a member of the group as its cardiovascular service line director.

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

Chartering, concretely, means four things. A named physician lead drawn from the cardiology bench, with the authority to set alert thresholds and the escalation protocol rather than accept vendor defaults. A single P&L line at medical-group level, so the revenue and the cost sit together and neither disappears into an overhead pool. A defined target population with a written attribution policy agreed with the primary-care side before the first enrollment. And a monthly scorecard with a standing review, mapped to the readmission and avoidable-utilization measures the hospitals are already accountable for. **Two facts have to be established before any of that is worth doing**: whether each office bills freestanding or provider-based, and which clinical record the clinicians actually document in. Both are internal questions with fast answers, and both are load-bearing for everything that follows.

2. The Remote Care Service Line — The Operating Spine

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

2.1 What it is: the cardiology clinical & billing stack

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

Programme	Core codes	What it does	Where it lands at this group
TCM — Transitional Care Management *(identified, not modeled)*	99495 / 99496	The 30-day post-discharge transition: interactive contact within two business days, face-to-face visit within 14 or 7 days depending on complexity	Every cardiac discharge from the two Adventist campuses opens one. Deliberately excluded from every financial figure in this report, which makes it a separate and additive decision the enterprise can take on its own merits
RPM — Remote Physiologic Monitoring	99453; 99454 / 99445; 99457 / 99470; 99458	Cellular blood-pressure cuffs, weight scales and pulse oximeters; daily physiologic data; 24/7 review and alert triage; monthly clinical management time	The between-visit layer for heart failure (weight and blood pressure) in a panel running 29.5% heart failure, for uncontrolled and resistant hypertension in a panel running 75.0% hypertension, and — via the new short-window code 99445 — for the 2–15 day post-discharge and post-procedure windows
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Heart failure and resistant hypertension as the qualifying conditions, and the monthly chassis for guideline-directed therapy titration. In a cardiology panel the single dominant condition genuinely is the cardiac one — the clinical situation PCM was written for

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

The one coordination rule

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

The practical rule here: the cardiology service line owns the transitional-care window at discharge and owns RPM plus PCM on the cardiac condition; the patient's primary-care physician owns any longitudinal primary-care wrapper; both work from **one shared care plan** with explicit task ownership. This is not hypothetical housekeeping in this account — the billing entity sits inside an accountable care organization whose primary-care participants share patients with this panel, and a duplicate-billing denial there is also a referral-relationship problem.

And a boundary specific to this group: implanted-device interrogation (93294–93298) and patient physiologic monitoring (99453 onward) are different benefits over different data — the device's own telemetry versus patient-generated physiologic readings from a separate connected device. The same distinction applies to the Holter, event and loop-recorder work the group already does, which is diagnostic and time-limited rather than longitudinal. The rule to design around is that the same data stream is not billed twice. *Confirm the specific pairings with the payer and with billing counsel before launch.*

2.2 Standalone value: a margin-positive service line

This is the lead layer on this account, not the supporting one. Before any avoided-cost argument and before any conversation about the hospital side of the enterprise, the service line stands on four layers of value:

1. **Direct professional-fee revenue.** Recurring monthly billing on a population the group already manages clinically, delivered at top-of-license staffing under general-supervision rules. Modeled at $4,542,396 of net reimbursement over 24 months, $1,927,693 of it net to the practice, at a 42.44% practice margin. This layer depends on no reconciliation and no model determination — it is fee schedule revenue, and Section 3.1 establishes that the fee schedule works normally in Maryland.
2. **Avoided cost, and here it is retained margin rather than lost revenue.** Modeled at approximately 199 avoided hospitalizations over 24 months — on the order of $3.0 million at an illustrative $15,000 per admission. Under a hospital global budget that value is not revenue the hospital forgoes; it is capacity and cost the hospital keeps, inside the same corporation that books the professional fee (Section 5).
3. **Referral durability and procedural throughput.** Montgomery County is a contested four-system market with 133 cardiology clinicians. A monitored census with structured monthly reporting back to referring physicians is the cheapest referral-retention mechanism there is, and a monitored discharge pathway is what converts a post-procedure bed-day into a same-or-next-day discharge (Sections 6 and 7).
4. **Strategic position and readiness.** A built, billable, hospital-facing post-discharge capability is an asset the enterprise can point at when a payer asks what changed, when the state's quality programmes reconcile, and when the next payment model arrives. Building it once, centrally, is cheaper than assembling a separate response to each.

The CY2026 billing stack

Service / code	Type	~CY2026 magnitude	Notes
TCM — 99495 / 99496 *(not modeled)*	Per discharge	~$200 / ~$280	Moderate / high complexity. Interactive contact within two business days; face-to-face within 14 or 7 days — upside beyond every financial figure in this report

Service / code	Type	~CY2026 magnitude	Notes
RPM — 99453	One-time setup	~$20	Device setup and patient education; requires qualifying data days
RPM — 99454 / 99445	Monthly	~$52	99454 = 16–30 days of data; 99445 = new 2026 short-window code (2–15 days) at the same magnitude — post-discharge and post-procedure windows now billable
RPM — 99457 / 99470	Monthly	~$52 / ~$26	First 20 minutes of management time / new 2026 first-10-minute code
RPM — 99458	Monthly	~$41	Each additional 20 minutes
PCM — 99424 / 99425	Monthly	~$79 / ~$57	Physician or qualified health professional: first 30 minutes / each additional 30
PCM — 99426 / 99427	Monthly	~$60 + ~$50 addl	Clinical staff under supervision: first 30 minutes / each additional 30 — the workhorse codes for a full-service care team

Rates are illustrative — and the local payer factor cuts the usual way round

The figures above are illustrative national non-facility magnitudes for CY2026. Actual payment is locality-adjusted. The financial model in this report uses MAC-locality rates auto-resolved for ZIP 20850 in the CoachCare Value Analysis — Maryland, locality 12202-01. Verify against the current CY2026 Physician Fee Schedule and the applicable Maryland locality files before budgeting, and note that CMS rulemaking for CY2027 is in progress: remote-monitoring code values are subject to change inside the 24-month window modeled here.

The plan-book caveat belongs here, and on this account it is genuinely small. Every figure in this report is a Medicare fee-for-service figure, and inside a Medicare Advantage plan these benefits are paid according to the plan contract rather than the fee schedule. In most US markets that qualification governs the majority of the Medicare population. **In Montgomery County it governs 22.57% of it** — roughly 44,700 of 198,254 eligibles — so the fee-for-service model captures the great majority of the addressable population rather than a minority slice. Treat the plan book as additive and unpriced; do not treat it as the main event.

Modeled economics

The companion Value Analysis prices an RPM + PCM programme on the group's Medicare base. The modeled population is an estimated **7,879-patient in-scope base across 15 referring providers**, all of it in scope in Year 1. *This is a discovery-stage estimate and should be validated against the group's own chart counts before budgeting.* It is derived from the CY2024 claims record rather than assumed: the sum of per-provider beneficiary counts across the ten address-confirmed providers is 18,001, a figure that contains substantial duplication because a patient seen by two cardiologists in the group is counted twice.[14] Applying a duplication factor to that anchor gives a fee-for-service ambulatory panel on the order of 7,000–9,000 unique patients, and because fee-for-service is 77.4% of the county's Medicare population the all-payer Medicare panel is only about 1.3 times that — roughly 9,000–11,500. **The modeled 7,879 therefore sits inside the fee-for-service range and excludes the plan book entirely.**

Enrollment builds bottom-up from **15 referring providers at eight referrals per provider per month with 80% patient acceptance**, supported by **one on-site enrollment specialist** at approximately 80 enrollments per month — **staffed at CoachCare's expense: embedded value, never deducted from the practice's margin**. Programme eligibility is modeled at 75% of the in-scope population for RPM (5,909 patients) and 85% for PCM (6,697), with acceptance of 35% and 30% respectively, and monthly

[14] The in-scope estimate applies a stated intra-group duplication factor to the CY2024 beneficiary-instance anchor of 18,001 across ten address-confirmed providers. It is an analyst estimate derived from a disclosed method, not a CMS-published figure, and it should be replaced with the group's own chart counts before budgeting. The all-payer gross-up applies the county's 77.4% fee-for-service share from the CMS Medicare Advantage penetration file, July 2026.

attrition of 1.5%. Revenue is reported as **net** reimbursement — gross allowed amounts less a 5% realization discount for payer mix and collection, as configured in the model.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$1,152,508	$3,389,888	**$4,542,396**
CoachCare fees (incl. setup & integration)	—	—	$2,614,703
Net to the practice	**$483,222**	**$1,444,471**	**$1,927,693**
Practice margin	**41.93%**	—	**42.44%**
Net reimbursement by programme	RPM $861,178 · PCM $291,329	RPM $2,476,849 · PCM $913,039	RPM $3,338,027 · PCM $1,204,369
Claims / billed units	—	—	74,234
Physiologic readings collected	—	—	314,024
Hospitalizations avoided (modeled)	—	—	~199 (≈$3.0M at an illustrative $15,000 each)
Care-team hours delivered	—	—	33,751 (≈16.2 FTE)
Active programme enrollments at month 24	—	—	3,027 (RPM 2,068 · PCM 959)
Unique patients (de-duplicated)	1,422 at month 12	2,356 at month 24	—

CoachCare Value Analysis, MAC locality MD 12202-01 (ZIP 20850), RPM and PCM only. Chronic care management is carried at zero eligibility. Transitional care management is excluded entirely. Fee-for-service rates only; Medicare Advantage volume is additive and unpriced. Unique patients are de-duplicated across programmes; active programme enrollments count each enrollment, so a patient on both RPM and PCM appears once in the first line and twice in the second. Illustrative, modeled — verify against practice data.

The margin, and how it is defined

24-month practice margin: 42.44% — net to the practice ÷ net reimbursement. Year 1 is **41.93%**, on $4,542,396 of net reimbursement and $1,927,693 net to the practice over the full 24 months.

Month 1 is modeled at **−$3,683** because one-time implementation lands there, and **every month from month 2 onward is net-positive**. By month 24 the programme is modeled at $324,967 of monthly net reimbursement and $138,708 of monthly net to the practice. The more useful way to describe the timing is this: no capital is at risk while the census builds, because CoachCare funds the enrollment engine, the devices and the monitoring staff.

The two arms behave differently, and it matters for planning. **RPM is ceiling-pinned**: it reaches its modeled ceiling of 2,068 enrolled patients at month 20 and holds there, so the last four months of Year 2 add RPM revenue only through retention, not through growth. **PCM is not** — it stands at 959 patients at month 24 against a modeled ceiling of 2,009, still climbing, limited by enrollment pace rather than by eligibility. **Month 24 is therefore not the programme's terminal size**. Raising referral throughput or opening a second enrollment pathway moves the PCM arm materially; it does very little for RPM once the ceiling is reached. With only 15 referring providers across three offices, the telephonic pathway — modeled at just 8% of conversions today — is the obvious second lane and the cheapest lever in the model.

Recurring-revenue mechanics

Each month's enrolled census re-bills, so revenue is a function of census and capture rate rather than of visit volume. Year 2 net reimbursement ($3,389,888) is 2.9× Year 1 ($1,152,508) on the same referral engine, purely from census accumulation. Unit economics are modeled at approximately $111.61 of net reimbursement per RPM patient-month and $101.64 per PCM patient-month, across 29,907 RPM and 11,849 PCM patient-months over 24 months.

The two value streams compound rather than compete. The professional fee depends on no reconciliation and no shared-savings determination — while the same monitored census is what moves the readmission and avoidable-utilization results that the enterprise's hospitals are measured and paid on under Maryland's arrangement. *All figures are illustrative, modeled — verify against practice data.*

2.3 Connective tissue: one infrastructure, every lever

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

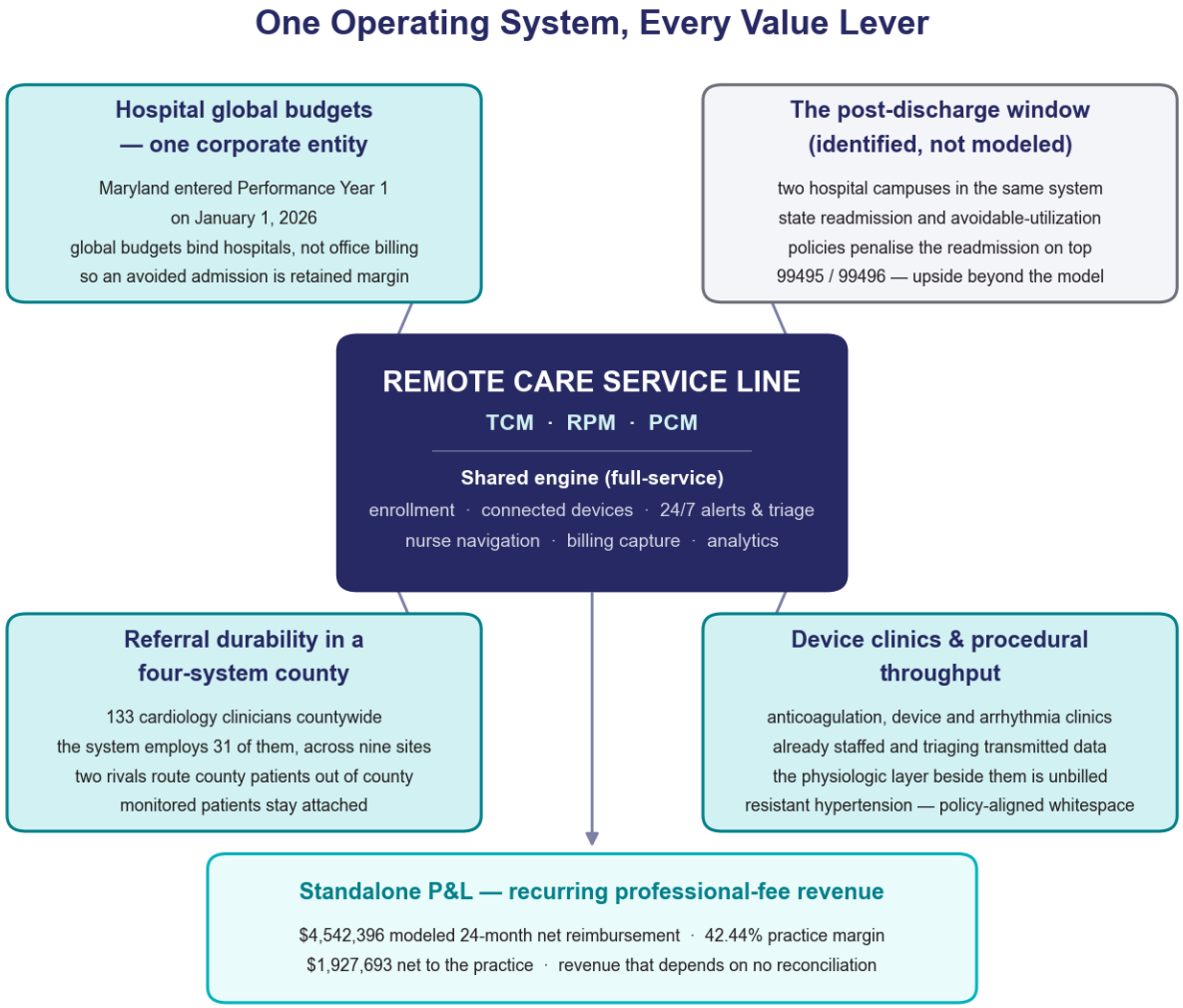

Figure 1. The Remote Care Service Line as connective tissue: one operating system powering the standalone P&L, the hospital global-budget position of two Adventist campuses, the post-discharge window, referral durability in a contested four-system county, and device clinic and procedural throughput.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Standalone P&L	Recurring professional-fee revenue under the Physician Fee Schedule, unaffected by the hospital global budget and dependent on no reconciliation; CY2026 code expansion (99445, 99470) widens what is billable	**$4,542,396 of modeled 24-month net reimbursement at a 42.44% practice margin**, $1,927,693 of it net to the practice. This is the lead layer on this account, not the supporting one
Hospital global budgets	Two Adventist campuses paid a prospectively set annual amount that does not move with volume, in the first performance year of the state's arrangement	Daily physiologic signal with 24/7 triage turns deterioration into a same-week outpatient intervention instead of an admission. Under a global budget the avoided admission is retained margin, and it is retained by the same corporation that books the professional fee (Section 5)
State readmission and quality programmes	A Readmission Reduction Incentive Program, a hospital-acquired-conditions programme, Quality Based Reimbursement and a potentially-avoidable-utilization savings policy, all administered by the state regulator	The same monitored census is the operational instrument for the readmission measure. Measured against an unenrolled comparison panel, the contribution is reportable rather than assertable
Transitional care *(identified, not modeled)*	Every cardiac discharge from the two campuses opens a 30-day transitional-care window	The same enrollment and monitoring engine covers that window; short-window RPM is billable today via 99445, and TCM remains a separate decision the enterprise can take on its own merits
Referral durability	133 cardiology clinicians in a four-system county, with two rival systems routing county patients to tertiary centres outside it	Structured monthly reporting back to referring physicians, and a patient in monthly contact with the cardiology service line, is the cheapest retention mechanism available (Section 6)
Device clinics and procedural throughput	Anticoagulation, pacemaker and defibrillator, and arrhythmia clinics already staffed; catheterisation, ablation and implant volume; resistant hypertension unaddressed	The triage muscle already exists; the physiologic layer beside it is unbilled. A monitored discharge pathway converts a post-procedure bed-day into a same-or-next-day discharge (Section 7)

Read that table one way and it is six separate problems, each with its own project plan, its own budget line and its own reason to be deferred. Read it the other way and it is **one asset, built once and paid for once, that answers all six**. The group already owns the hardest input to that asset — staffed clinics whose whole job is reviewing transmitted data and managing chronic therapy between visits. What it does not yet own is the physiologic data layer, the enrollment engine and the billing capture that turn that habit into a service line.

3. 2026 Policy & Payment Environment

Maryland is the only state in the country where a reader will assume, reasonably and incorrectly, that a fee-schedule business case does not apply. This section resolves that first, because everything downstream depends on it.

3.1 Maryland's global budget: what it binds, and what it does not

Maryland has operated under an all-payer hospital rate-setting arrangement continuously since 1977. The most recent instrument, the **Maryland Total Cost of Care Model, ended December 31, 2025**, and the state moved directly into the **AHEAD Model** — Achieving Healthcare Efficiency through Accountable Design — as its only Cohort 1 state.[15]

Fact	Value
Maryland cohort	Cohort 1 — the only Cohort 1 state
Pre-implementation period	July 1, 2024 – December 31, 2025
Implementation start	**January 1, 2026**
Performance Year 1	**January 1, 2026 – December 31, 2026 — Maryland is in it now**
Model end date	December 31, 2035 (all cohorts)
Other cohorts	Cohort 2 (Connecticut, Hawaii, Vermont) and Cohort 3 (Rhode Island, New York) begin performance January 1, 2028
Model components	Hospital Global Budgets; Primary Care AHEAD; Geo AHEAD; state cooperative-agreement funding
State regulator	Health Services Cost Review Commission — its own scope statement is that it regulates hospital rates

CMS Innovation Center AHEAD Model page, last modified July 9, 2026; the Amended and Restated AHEAD Model Maryland State Agreement published by the state regulator; the regulator's own website, retrieved August 3, 2026.

Does the Physician Fee Schedule work normally in Maryland? Yes — and that has to be said out loud

The global budget applies to hospitals, not to physician office billing. Three independent confirmations, none of them inferential:

1. The state regulator's own scope statement is that it regulates hospital rates. It does not set physician professional fees.
2. CMS describes Hospital Global Budgets as covering inpatient and outpatient services for *hospitals*; the model's separate physician-facing component, Primary Care AHEAD, is **voluntary and limited to primary care practices** — a cardiology specialty group is not eligible for it and is not bound by it.
3. Maryland physicians appear normally in the CMS Medicare Physician and Other Practitioners file with standard Physician Fee Schedule allowed amounts — including this group's own CY2024 figures, reproduced in Section 4.2.

The implication, stated plainly: 99453, 99454, 99445, 99457, 99470, 99458 and 99424–99427 are paid under the ordinary Physician Fee Schedule at the Maryland MAC locality. Nothing about the state's arrangement reduces, caps or globally budgets a physician practice's care-management billing.

[15] Amended and Restated AHEAD Model Maryland State Agreement, published by the Maryland Health Services Cost Review Commission, together with the CMS Innovation Center model page last modified July 9, 2026: Hospital Global Budgets, Primary Care AHEAD, Geo AHEAD and state cooperative-agreement funding as the model's components, with Cohort 2 (Connecticut, Hawaii, Vermont) and Cohort 3 (Rhode Island, New York) beginning performance January 1, 2028.

The caveat that has to be resolved before budgeting

If any of the three offices now bills as a provider-based hospital outpatient department under an Adventist campus, the global-budget interaction changes the model. Provider-based billing sits inside the hospital's rate-regulated environment; freestanding office billing does not. The two are materially different economic questions, and this report models the freestanding case throughout.

This is not a reason to discount the business case — it is a reason to establish one fact before the business case is signed. *Take the site-of-service status of all three offices to contracting and finance in the first week.*

3.2 The CY2026 fee schedule: remote care gets more billable

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

3.3 The market: the largest fee-for-service denominator in this batch

Geography	Medicare eligibles	Enrolled in a plan	Plan penetration
Montgomery County, Maryland	**198,254**	**44,742**	**22.57%**
Maryland statewide	1,200,276	298,364	24.86%
Prince George's County, Maryland	157,339	48,831	31.04%
Fairfax County, Virginia	187,071	59,478	31.79%
National	**69,221,715**	**35,779,621**	**51.69%**

CMS Medicare Advantage state / county penetration file, July 2026. The national figure excludes Connecticut and Alaska, which that file omits for recoding reasons. Approximately 153,500 Montgomery County beneficiaries — 77.4% — remain in traditional fee-for-service Medicare. Maryland ranks fifth lowest of fifty-three jurisdictions on plan penetration, a direct consequence of the state's all-payer environment.

This is the most fee-for-service-favourable market in this batch of accounts, and it inverts the usual caveat. In most metropolitan markets a fee-schedule model prices a minority of the local Medicare population and the plan book is the larger, unpriced opportunity. **Here the fee-schedule model prices roughly three-quarters of it**. The consequence for this report is that the modeled figures are close to the whole picture rather than a visible slice of it, and the honest qualification about contract-dependent reimbursement inside plans is a short note rather than a load-bearing condition. It should still be said: inside a plan, remote monitoring and care management are paid according to the plan contract, and may be paid at parity, bundled, or not separately paid at all.

The demographic backdrop supports aggressive enrollment assumptions. Montgomery County has a population of 1,065,949 with **17.0% aged 65 or older — about 181,300 people**. Median household income is **$132,450**, 64% above the national $80,734; **31.1% of households clear $200,000** against 13.4% nationally; families below the poverty line run 5.1% against 8.8%; and **60.6% of adults aged 25 and over hold a bachelor's degree or higher**, 25 points above the national figure.[16] For a programme whose enrollment depends on patient coinsurance tolerance and on device onboarding, that is close to a best-case environment. The one figure that does not flatter is a 7.0% uninsured rate against Maryland's 6.3% — immaterial for a Medicare-focused programme.

3.4 The accountable care position, and a correction to the commercial record

A widely used commercial firmographic file reports no accountable care affiliation for this account. The CMS Shared Savings Program public use files say otherwise, and they also record a structural change that took effect at the start of this year.

Program year	Participant organization	Accountable care organization	ID	Service area
PY2024	Adventist Physician Services Inc	Adventist HealthCare ACO, LLC	A5374	MD
PY2025	Adventist Physician Services Inc	Adventist HealthCare ACO, LLC	A5374	MD
PY2026	**Adventist Physician Services Inc**	**Kettering Physician Partners Accountable Care LLC**	**A5062**	**MD, OH**

CMS Medicare Shared Savings Program participant and organization public use files, PY2024, PY2025 and PY2026. Cardiac Associates, P.C.'s own tax identification number is not a participant in any year checked, which is consistent with the group's accountable-care exposure running entirely through the Adventist entity.

What is recorded fact and what is inference, kept apart. Recorded fact: Adventist HealthCare ACO, LLC does not appear in the PY2026 files at all, and seven of its nine PY2025 participant organizations — including the entity this group bills through — appear instead in Kettering Physician Partners Accountable Care LLC, an Ohio-headquartered accountable care organization whose service area expanded to Maryland and Ohio effective January 1, 2026. That entity is a BASIC track Level E, low-revenue, retrospective-assignment organization with an agreement start of January 1, 2022, and its own public reporting page lists the Adventist entity as a participant.[17] **Inference**: that this reflects a corporate combination or a shared population-health platform between two Adventist-affiliated systems. *No announcement, transaction record or terms were located in this research, and both systems' newsrooms blocked automated retrieval — so the combination is unconfirmed and is presented here as a question, not a finding.* It matters commercially because it determines whether a purchasing decision is made in Maryland or across two states, and because the receiving organization's published governing body currently shows no Maryland representative.

Two related items, closed for completeness. The Maryland Primary Care Program and the model's Primary Care AHEAD component are both primary-care programmes; a cardiology specialty group is not eligible for either, and neither bears on this account. And no evidence was found either way on Medicare Advantage risk contracts held by the enterprise — which, given 22.57% county penetration, is a structurally smaller question here than it would be almost anywhere else.

[16] U.S. Census Bureau, American Community Survey 2024 five-year estimates, profiles DP02, DP03 and DP05, retrieved August 4, 2026 direct from data.census.gov; income and population figures cross-checked against detail tables B19013, B19113 and B01003. Five-year and one-year ACS products differ; the figures used here are five-year throughout, for Montgomery County, Maryland and the United States alike.

[17] CMS Medicare Shared Savings Program PY2026 organizations file and the receiving organization's own public reporting page, which lists ADVENTIST PHYSICIAN SERVICES INC as a participant. The organization is headquartered in Ohio, reports a PY2026 service area of Maryland and Ohio, and its published governing body shows no Maryland representative. No corporate transaction between the two systems was located in any source reached during this research.

4. Performance Snapshot: The Starting Position

4.1 The panel: elderly, comorbid, and heart-failure heavy

The clinical case for this programme does not depend on any commercial argument. The panel is old, comorbid and cardiac by definition, and it is the population these benefits were written for.

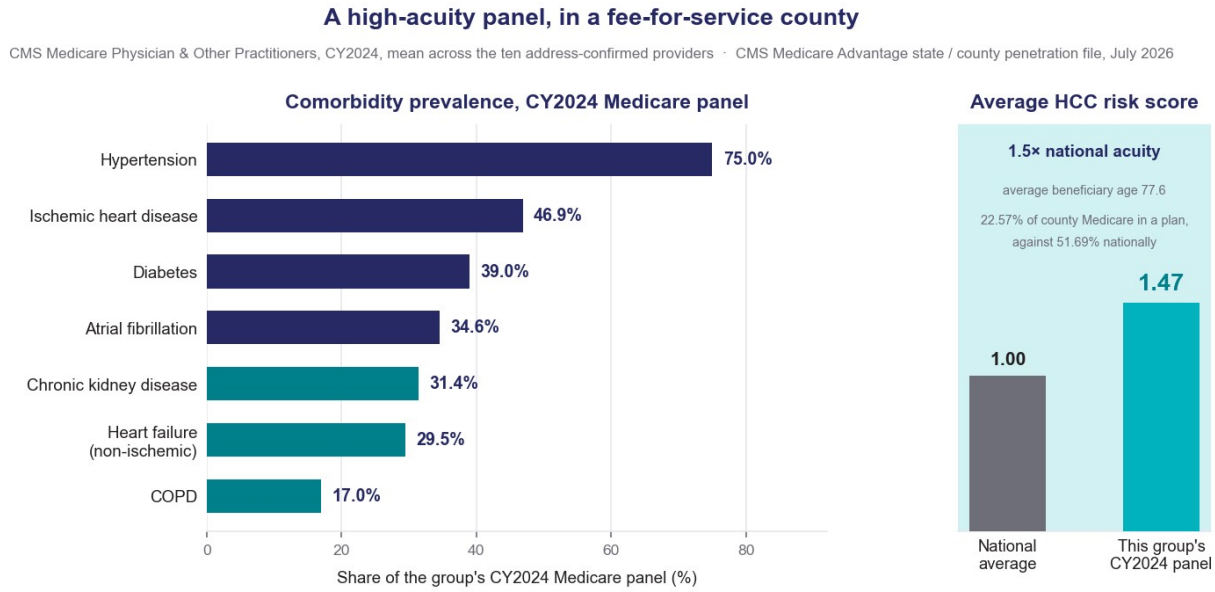

Figure 2. The group's CY2024 Medicare panel: mean comorbidity prevalence across the ten providers whose CMS-reported practice address is a confirmed Cardiac Associates location, and average HCC risk score against the national average beneficiary. Mean beneficiary age is 77.6. The county's Medicare Advantage penetration of 22.57%, against 51.69% nationally, leaves roughly 153,500 fee-for-service beneficiaries in the local denominator.

Measure, CY2024 mean across the ten providers	Value	Why it matters here
Average beneficiary age	**77.6**	An older panel than a typical cardiology practice, and the age band where between-visit deterioration turns into an admission fastest
Hypertension	75.0%	The blood-pressure RPM denominator. Three-quarters of the panel qualifies clinically
Ischemic heart disease	46.9%	The procedural and secondary-prevention population
Diabetes	39.0%	Compounds heart failure and kidney risk, and raises the value of monthly structured contact
Atrial fibrillation	**34.6%**	Unusually high, and it maps directly onto the anticoagulation clinic the group already runs
Chronic kidney disease	31.4%	Diuretic titration in heart failure is a kidney-function problem as much as a cardiac one — weight and blood-pressure data change the titration decision
Heart failure (non-ischemic)	**29.5%**	**The core RPM and PCM population, and the readmission population the hospitals are measured on**
COPD	17.0%	Pulse-oximetry monitoring where it overlaps with heart failure
Average HCC risk score	**1.472**	About 1.5 times the national average beneficiary — a heavily comorbid panel, not a screening population

CMS Medicare Physician & Other Practitioners — by Provider, CY2024 (file released May 21, 2026), mean across the ten address-confirmed providers. Prevalence figures are CMS chronic-condition percentages of each provider's Medicare panel.

The clinical read, stated without embellishment. A panel averaging 77.6 years of age with heart failure near 30%, atrial fibrillation near 35%, chronic kidney disease above 30% and hypertension at 75% is a population where the clinically correct intervention — measured weight and blood pressure between visits, with someone reviewing it and acting on it — is also the billable one. **Guideline-directed medical therapy titration is the specific work this enables**: titration against a measured response on a schedule, with principal care management as the monthly billing chassis for the time it takes, rather than titration attempted in a 20-minute visit three months apart.

4.2 The Medicare footprint, independently verified

A commercial firmographic file reports $5,121,094 of Medicare allowed charges for this group. Unusually, that figure is accurate. Querying the CY2024 CMS provider-level file per NPI and restricting to providers whose CMS-reported practice address is a confirmed Cardiac Associates location returns **$5,217,742 of allowed charges across 18,001 beneficiary-instances for ten providers** — corroborating the commercial figure to within about 2%.[18]

Practice address	Providers	Beneficiary-instances	Allowed
15225 Shady Grove Road, Rockville (main office)	8	16,300	$4,743,068
19735 Germantown Road, Germantown	1	965	$268,362
15215 Shady Grove Road, Rockville (adjacent campus building)	1	736	$206,312
Total	**10**	**18,001**	**$5,217,742**

CMS Medicare Physician & Other Practitioners — by Provider, CY2024 (file MUP_PHY_R26_P05_V10_D24_Prov, released May 21, 2026), queried per NPI. Beneficiary instances are per provider and double-count a patient seen by more than one physician in the group; they are not unique-patient counts.

Caution	The mechanism	What follows
The beneficiary count double-counts	18,001 is the sum of per-provider beneficiary counts. A patient seen by two cardiologists in the group is counted twice	The true unique-patient panel is materially lower and has to be derived rather than assumed. The modeled in-scope base of 7,879 is a deduplicated estimate, not a CMS-published figure
Five roster identifiers were excluded	Five clinicians on the practice's reassignment roster returned CY2024 practice addresses outside Maryland — in Virginia, Texas, New Jersey and South Carolina. Either these are common-name identifier collisions or the clinicians relocated	They are excluded from the total above, which makes the $5.2 million figure conservative rather than inflated. Flagged for verification
Fee-for-service only — but here that is most of the book	The CMS file sees only traditional Medicare. In this county that is 77.4% of the Medicare population rather than the 40-50% typical of major metros	**Grossing up for the plan book raises the Medicare-funded professional book by only about 30%, not by 2-3×. The visible number is close to the real one**

[18] CMS Medicare Physician & Other Practitioners — by Provider, CY2024, file MUP_PHY_R26_P05_V10_D24_Prov, released May 21, 2026, queried per identifier and restricted to providers whose CMS-reported practice address is a confirmed Cardiac Associates location: ten providers, 18,001 beneficiary-instances, $5,217,742 of allowed charges. Beneficiary instances are per provider and double-count patients seen by more than one physician in the group; they are not unique-patient counts. Five further identifiers from the practice's reassignment roster returned CY2024 addresses outside Maryland and are excluded.

The framing conclusion is the opposite of the usual one. In most accounts the public fee-for-service figure understates the enterprise badly and the modeled revenue has to be defended as conservative against an invisible plan book. **Here the public figure is close to the whole figure**, which makes the modeled economics unusually easy to reconcile against something the finance team can independently verify. It also means the growth argument has to come from programme design and census, not from an unpriced payer segment.

4.3 What the group already runs, and what it does not publish

No code-level screen of this group's CY2024 remote-monitoring and care-management billing was run for this report, so nothing here asserts a zero. What the public record does establish is what the group publishes about itself, and the gap between the two lists is the argument.

Published on the group's own services page	What it is, operationally
Anticoagulation clinic	A staffed, protocol-driven chronic-management clinic with recall, monitoring and dose adjustment — directly analogous in workflow to monthly care management, and sitting on top of a panel running 34.6% atrial fibrillation
Pacemaker and defibrillator clinic	Device follow-up infrastructure, which means the staffing and review habits for transmitted device data already exist
Arrhythmia clinic; heart failure management; blood pressure management	Named specialty clinics on exactly the three conditions a cardiology remote care programme enrolls from
Holter, event and loop-recorder monitoring	The group already receives, triages and acts on transmitted ambulatory cardiac data. This is diagnostic and time-limited monitoring, distinct from longitudinal physiologic monitoring (Section 9.3) — but the triage muscle is the same muscle
Telemedicine visits	Offered, and booked by emailing a general practice inbox

Not found anywhere on the public site	Finding
Remote physiologic monitoring	No mention anywhere on the public site
Chronic care management or principal care management	No mention anywhere on the public site
A named remote device-monitoring vendor	None named, though a pacemaker and defibrillator clinic exists — so remote device checks are almost certainly happening under some vendor and simply are not publicised
Patient portal	No portal link, login or portal branding anywhere on the site
Online scheduling	None. Telemedicine is requested by email
Care-coordinator or remote-monitoring nurse postings	Not found — and not searched exhaustively, so this is the weakest line in the table

Stated as required: absence of evidence, not proof of absence

The group may run remote monitoring or care management without advertising it. Nothing above refutes an existing programme; it establishes only that none is publicly marketed. *Confirm current-state programmes directly in discovery — this is the single most important question to ask.*

And a second-order caveat that matters more here than the first. Because clinical and billing operations run through the Adventist entity, the practice's own website says very little about the capability actually available to these patients. **The relevant question is whether Adventist HealthCare operates an enterprise remote-care programme** — which this research could not determine, because the system's site blocks automated retrieval. Do not conclude 'no programme here' from the practice site alone.

The digital baseline is genuinely low, and it cuts both ways. For an eleven-physician cardiology group in one of the wealthiest, most educated counties in the United States, having no patient portal of any kind, no online scheduling, and a telemedicine pathway that runs through a general email inbox is a low starting point in 2026. The favourable reading is that **there is no incumbent remote-care vendor to displace at the practice level** and no portal-based workflow to re-engineer. The unfavourable one is that enrollment cannot lean on a digital front door that does not exist — which is precisely why the modeled funnel in Section 9.1 is built on an on-site enrollment specialist and a referral engine rather than on patient self-service.

Read together, the two tables above describe a specific and unusual starting position. This is not a group that has to be persuaded that between-visit management is real work — it already staffs three clinics whose entire purpose is managing patients between visits and acting on data those patients send in. It is a group that does that work **without a billing chassis under it**. Anticoagulation management, arrhythmia follow-up and device review are today delivered as uncompensated infrastructure attached to office visits; remote physiologic monitoring and principal care management are the Medicare benefits that pay for exactly that pattern of care. The programme described in this report is therefore less a new capability than a monetisation and an extension of one the group has already proved it will run.

5. The Global-Budget Inversion: An Avoided Admission Is Retained Margin

The correct statement first, because it is the one that is usually got wrong. Maryland's hospital global budget does not reach this practice's professional billing. The state regulates hospital rates; the physician fee schedule operates normally; and the model's physician-facing component is voluntary and limited to primary care (Section 3.1). **Everything in this section is therefore additive to the standalone P&L in Section 2.2, not a substitute for it**.

What the global budget does change is the economics on the other side of the same corporation. Under a global budget an Adventist hospital receives a fixed, prospectively set annual revenue amount that does not move with volume. That inverts the ordinary fee-for-service incentive in a way that is worth setting out side by side.

	Ordinary fee-for-service market	Maryland under a hospital global budget
A readmission	Generates incremental hospital revenue	**Consumes budgeted capacity and produces no incremental revenue**
An avoided admission	Is revenue the hospital forgoes	**Is margin the hospital retains**
Penalty exposure	Federal readmission programmes	State-administered on top: a Readmission Reduction Incentive Program, a hospital-acquired-conditions programme, Quality Based Reimbursement, and a potentially-avoidable-utilization savings policy
Who benefits from prevention	The payer, and the hospital only through contract or model design	**The hospital directly — and here, the same corporation that employs the cardiologists and books the professional fee**

Maryland Health Services Cost Review Commission programme list and scope statement, retrieved August 3, 2026; CMS Innovation Center model documentation. Under the state's arrangement Maryland is additionally accountable for statewide Medicare total cost of care, not only for hospital spending.

Why this is the cleanest single-entity return story available

In almost every other account, the practice revenue argument and the avoided-cost argument point at **two different balance sheets**, and the deal has to be negotiated between them: who funds the programme, who captures the savings, how the value is shared. That negotiation is where most remote-care business cases die.

Here there is no negotiation, because there are not two parties. Adventist HealthCare owns the hospitals that hold the global budget and owns the entity that employs these cardiologists and bills their professional fees. **The same corporation books $4,542,396 of modeled 24-month net reimbursement and keeps the margin on approximately 199 avoided admissions** — on the order of $3.0 million at an illustrative $15,000 per admission. Both lines land in the same place.

One point of precision on that $3.0 million. Under a global budget, what an avoided admission retains is the *cost* the admission would have consumed, not a revenue line that would otherwise have been collected — the revenue is fixed either way. The $15,000 figure is an illustrative cost-of-admission proxy and should be replaced with Adventist's own variable cost per cardiac admission before it goes into a budget. *All figures are illustrative, modeled — verify against practice data.*

The two campuses this runs through

Hospital	What is established	Relevance
Adventist HealthCare Shady Grove Medical Center, Rockville	266 licensed beds; a state-designated cardiac interventional centre with a primary percutaneous-intervention waiver; American College of Cardiology	The group's main office sits on the same medical campus, and members of the group direct its catheterisation laboratory, electrophysiology laboratory, chest pain

The admitting split is the number to verify first on the hospital side. A commercial file reports that roughly 73% of this group's hospital volume goes to the Rockville campus and roughly 9% to White Oak. *That figure is unverified — no claims-level source was available in this research — and it should not be used in a budget until Adventist confirms it from its own data*. The direction is what matters for the argument: the great majority of this group's admissions land inside the same corporation's global budget, which is what makes the single-entity return story real rather than theoretical.

There is precedent for the mechanism at state scale. The predecessor Maryland model is frequently reported to have generated on the order of $689 million in Medicare savings alongside a 16.8% reduction in preventable admissions.[19] *That is a secondary source and directional only* — it is cited here as evidence that admission avoidance is the mechanism Maryland's payment environment rewards, not as a forecast of what this programme would produce. The programme's own modeled contribution is the 199 figure above, and it should be measured against an unenrolled comparison panel from month one rather than asserted.

What the service line actually does in the window

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

Everything in that table depends on the first cell. Knowing which patients were discharged yesterday, from which campus, is the single most common point of failure in a post-discharge programme. It is an ordinary integration problem when the ambulatory and inpatient records are the same system and a design problem when they are not — and on this account the ambulatory platform is not established at all. Section 8 is about that specific gap.

Proving it rather than asserting it

The weakest version of this argument is a slide claiming that remote monitoring reduces readmissions. The strong version is a measurement design agreed before launch, so that by month nine the enterprise is reading its own numbers rather than a vendor's. Five things make that possible, and none of them is expensive:

- **An unenrolled comparison panel, defined at the start.** Patients who meet the enrollment criteria but are not yet enrolled, tracked on the same measures. Without it, every result is confounded by the fact that enrolled patients are selected patients.

[19] Reported in secondary analysis of the predecessor Maryland model — approximately $689 million in Medicare savings and a 16.8% reduction in preventable admissions. This is a secondary source and is cited as directional evidence about the mechanism the state's payment environment rewards, not as a forecast for this programme.

- **Readmission measured at the campus, not at the practice.** The outcome that matters under a global budget is an admission that did not happen at an Adventist hospital. That data sits on the hospital side of the enterprise and has to be joined to the enrolled census deliberately.
- **Time from discharge to first physiologic reading, reported per campus.** This is the single best leading indicator of whether the programme is actually operating in the window where a readmission is preventable, and it is available from week one.
- **Alert-to-contact time and escalation outcome.** The mechanism by which monitoring becomes an avoided admission is a same-week outpatient intervention. If alerts are being generated and not converted into contacts, the programme is producing data rather than results.
- **A variable-cost-per-admission figure from Adventist's own finance team.** The illustrative $15,000 used in this report should be replaced with the enterprise's own number before anything goes into a budget. Under a global budget the relevant figure is cost avoided, not revenue forgone.

One condition on any cross-entity arrangement

Where a hospital supports, subsidises or co-invests in physician-practice services — even inside a single enterprise, and even where both sides are commonly owned — the arrangement must be structured to comply with the physician self-referral and anti-kickback rules, and with Maryland's corporate-practice-of-medicine framework. *Take the structure to healthcare counsel before it is proposed, not after.*

6. Referral Durability in a Four-System County

Montgomery County is an unusually contested market: four health systems plus a closed-panel plan, 133 unique cardiology clinicians practising across 296 practice-location records, and no single dominant referral relationship to defend. That is the competitive frame a remote care service line operates in here, and it is a second, non-financial reason to build one.

Organization	Cardiologists in the county	Organization size	Status
Adventist Physician Services Inc	**31**	**142**	**Employed — the dominant cardiology employer in the county**
Johns Hopkins Community Physicians	16	760	Employed
Johns Hopkins University (Suburban / Bethesda)	14	2,891	Employed
CardioCare LLC (Chevy Chase)	**13**	**17**	**The largest independent group in the county**
MedStar Medical Group II LLC	11	3,729	Employed
Kaiser Foundation Health Plan of the Mid-Atlantic States	8	1,964	Closed staff model — structurally unavailable
MedStar Heart Institute LLC	7	319	Employed
Associates in Cardiology, P.A. (Silver Spring)	6	6	Independent
Ten further independent entities and solo clinicians	~37	1–6 each	Fragmented — most with one to four physicians

CMS Doctors and Clinicians National Downloadable File, vintage June 26, 2026, enumerated for Montgomery County: 133 unique cardiology clinicians across 296 practice-location records. Organization size is total enrolled clinicians nationally, not in the county.

Three structural facts follow, and each of them is a reason the monitored census matters. First, **Adventist is the dominant cardiology employer in the county** — 31 employed cardiologists, about 2.4 times the largest independent group, across nine sites concentrated on the I-270 corridor, three of which are this group's own offices.[20] That scale is the reason the unit of sale is the enterprise rather than the three-office practice. Second, **one of the four systems employs no cardiologists in the county at all**: a full scan of the Maryland cardiology file found no employing entity for it, and its cardiac interventional centre is staffed entirely through affiliated and independent groups — one of which is this one, since a member of the group directs its interventional cardiology and catheterisation laboratory. **That makes it the most open referral target in the county, and it also makes those referral relationships the most exposed**. Third, the closed-panel plan — 750,551 members across Maryland, Virginia and the District as of March 31, 2026, across 41 medical offices — is structurally unavailable, and should be subtracted from any market-size arithmetic rather than counted in it.[21]

The leakage dynamic is the specific thing a monitored census defends against. Two of the four systems route county patients to tertiary centres outside the county — to Baltimore and to the District.

[20] CMS Doctors and Clinicians National Downloadable File, vintage June 26, 2026: the nine Montgomery County practice sites of ADVENTIST PHYSICIAN SERVICES INC carrying cardiology clinicians, by record count — 9901 Medical Center Drive (29), 15225 Shady Grove Road (13), 15215 Shady Grove Road (12), 19735 Germantown Road (11), 12501 Prosperity Drive (10), 19801 Observation Drive (7), 1500 Forest Glen Road (4), 299 Hurley Avenue (4) and 11890 Healing Way (2). Three of the nine are this group's own published offices.

[21] Kaiser Permanente published fast facts as of March 31, 2026: 750,551 members across Maryland, Virginia and the District of Columbia and 41 medical offices. The county cardiology census of 133 unique clinicians across 296 practice-location records is from the CMS Doctors and Clinicians National Downloadable File, vintage June 26, 2026.

Every one of those transfers is a referral relationship weakening in slow motion, and it is not won back with a marketing campaign. **It is won back by being the practice the patient hears from every month**. A patient enrolled in monitoring has a named clinical contact, a device in their kitchen that belongs to this service line, and a monthly touch; a patient seen once a quarter has an appointment card. The first is a durable relationship and the second is a transaction.

What the service line does for referring relationships specifically

- **Structured monthly reporting back to the referring physician.** A short, standard summary of what was monitored, what changed and what was adjusted — delivered every month rather than at the next consultation. It is good practice, it is a referral-retention mechanism, and it is the artifact that keeps the attribution policy honest where a primary-care practice shares the patient.
- **A written attribution policy with the primary-care side.** Only one practitioner may bill RPM for a patient in any 30-day period, and the billing entity sits inside an accountable care organization with primary-care participants. Settling that in writing prevents the denial and, more importantly, prevents the relationship damage that follows a denial.
- **A visible answer to the leakage question.** When a referring physician asks what happens to their patient after the cardiology visit, the answer is a documented monitoring and management programme rather than a follow-up interval. That is a materially better answer in a county where the alternative referral targets are four systems deep.
- **A retention mechanism that survives clinician turnover.** Referral patterns in a fragmented county follow individual relationships, which makes them fragile. A programme the patient is enrolled in is an institutional relationship rather than a personal one.

7. Procedural Throughput, Device Clinics and the Hypertension Whitespace

Remote care is usually sold as a chronic-disease programme. In a group with this procedural and device profile it is also a throughput multiplier, and the mechanism is specific: **a monitored discharge pathway is what lets a post-procedure patient go home on the same or next day instead of occupying a bed overnight**. Under a global budget, a freed bed-day is not forgone revenue — it is capacity released inside a fixed budget, which is the only way capacity gets created at all.

Line	What the group publishes	What the service line adds
Interventional and invasive cardiology	Diagnostic and interventional catheterisation, percutaneous coronary intervention, carotid stenting, peripheral angioplasty and stenting; members of the group direct the catheterisation laboratories at two county hospitals	A monitored discharge pathway after intervention, and a managed census afterwards. The freed bed-day and the additional case land on the same balance sheet as the professional fee
Electrophysiology and device implant	Pacemakers, implantable defibrillators, bi-ventricular pacing, atrial fibrillation and flutter ablation, ventricular tachycardia and accessory-pathway ablation, loop recorders; a named pacemaker and defibrillator clinic	Post-ablation and post-implant physiologic monitoring sits alongside — not inside — device interrogation. Blood pressure, weight and symptom data are patient-generated and distinct from the device's own telemetry (see the boundary rule in Section 2.1)
Device clinic modernization	A pacemaker and defibrillator clinic plus Holter, event and loop-recorder monitoring — but no remote device-monitoring vendor named anywhere on the site, and no patient portal	**The clinic already receives and triages transmitted data. What it does not have is a billing-grade documentation and claim-capture layer around it, or the physiologic stream beside it**. Modernising the device clinic and standing up physiologic monitoring is one project, not two
Anticoagulation management	A named anticoagulation clinic, on a panel running 34.6% atrial fibrillation	The closest existing analogue to monthly care management in the practice: recall, monitoring, dose adjustment, documented contact. The same team and the same cadence extend to principal care management on the cardiac condition
Advanced heart failure	One clinician on the reassignment roster carries the advanced heart failure and transplant cardiology specialty; named heart failure and blood-pressure management clinics are published	Weight and blood-pressure monitoring with 24/7 triage, and guideline-directed therapy titration against measured response, with PCM as the monthly chassis for the time it takes
Vascular and venous	A dedicated venous service line — endovenous radiofrequency and laser ablation, micro-phlebectomy, ultrasound-guided sclerotherapy — under a separate brand carrying no system branding	Post-procedure follow-up and a monitored hypertension and vascular-risk census. Also the one plausible route to a practice-level rather than enterprise-level decision (Section 1.2)
Resistant hypertension — whitespace	**No renal denervation programme is advertised anywhere on the group's site**, against a panel running 75.0% hypertension and an interventional bench that already does carotid and peripheral intervention	**Blood-pressure RPM is intrinsic to the renal denervation pathway** — for candidate identification, for pre-procedure documentation of uncontrolled pressure on maximal therapy, for titration, and for the evidence CMS national coverage determination 20.40 requires under Coverage with Evidence Development, effective October 28, 2025. Building the monitoring first is the correct order

The hypertension row is the one to read twice, because the order matters. In accounts that already perform renal denervation, the argument is that the monitoring infrastructure beneath an existing procedure is missing. Here the procedure is not advertised at all, which makes it clean whitespace — and the sequencing is favourable rather than awkward. **A group that builds blood-pressure monitoring first arrives at the procedure with a documented, protocolised resistant-hypertension population already identified**, which is exactly what the coverage conditions require. *Confirm whether any renal denervation capability exists at the enterprise level* — the system markets a structural heart programme, minimally invasive valve procedures and left atrial appendage occlusion, but those claims come from an archived capture of the system's own marketing pages with no announcement dates attached, and none of them is used as a fact in this report.

The atrial fibrillation line deserves its own sentence, because it is the least obvious and the most immediately actionable. A panel running 34.6% atrial fibrillation, managed by a group that already staffs an anticoagulation clinic and an arrhythmia clinic and already implants and follows devices, is a population in structured monthly contact with the practice for reasons that have nothing to do with remote monitoring. **The contact already happens; it is simply not billed as care management and not supported by physiologic data**. Adding blood-pressure and weight monitoring to that existing cadence consumes no new clinic slots, and it converts a recall list into an enrolled census. It is the shortest path from today's operation to a first billable enrollment, and it is why the implementation sequence in Section 9.1 starts there rather than with heart failure.

8. Record Integration & Technology Architecture

8.1 What is — and is not — established about the platform

This section is deliberately generic, and the reason is worth stating rather than hiding: **the ambulatory clinical record platform used by this group is not established from public sources**.

Line of evidence	What it shows
The commercial file	Reports one named ambulatory platform for this practice
Direct inspection of the group's site	**Contradicts nothing and confirms nothing**. The raw HTML of the home, patient-information, services, contact and frequently-asked-questions pages was fetched and searched for the fingerprints of every major ambulatory platform and portal host. Zero matches on every term, on every page
The portal	**There is no patient portal link of any kind on the website** — no login, no portal navigation item, no vendor portal branding. Practices on most major ambulatory platforms surface a portal link prominently, so this absence is itself informative
The outbound links	The only outbound links on any patient-facing page are to the group's own venous service line and to a professional society's patient-education library
The billing entity	**The operative record may not be a practice-owned system at all**. Clinical and billing operations run through Adventist Physician Services Inc, so the system's enterprise platform is at least as likely to be the record these clinicians document in. Adventist's enterprise platform was not identified in this research

Direct retrieval and inspection of the group's public website, August 3, 2026; commercial firmographic export, vintage July 1, 2026. The platform question is unresolved in both directions — neither confirmed nor refuted.

> **The discovery question, in one sentence**
>
> **"What are your clinicians documenting in today — your own system, or Adventist's?"** Everything about integration scoping, the discharge feed, the enrollment order and the documentation trail follows from that answer, and none of it can be scoped responsibly before it. This report therefore specifies what the integration must *do*, not which connector it uses.

8.2 What the integration does

Whatever the platform turns out to be, the requirements are the same, and they are the difference between a programme that runs inside the practice's workflow and one that runs beside it:

- **Enrollment inside the chart.** Referral to the service line is one order in the record the clinicians already use — not a separate system, a separate login or a paper form.
- **Enrollment status visible in real time.** Whether a patient is enrolled, which programmes they are on, and which device they hold — visible to the clinician at the point of the next decision rather than in a monthly report.
- **Structured clinical exchange.** Health history out; vitals, evidence of care and care plans back into the chart on a monthly cadence, so the record the group is audited on is the record it already keeps.
- **The discharge trigger.** A process or feed that surfaces yesterday's inpatient discharges from the two Adventist campuses to the ambulatory team on the day they happen, and starts the two-business-day clock automatically. If the ambulatory and inpatient records are different systems, this is the long pole in the build — design it deliberately rather than discovering it after the first missed window.

- **Automated claim generation.** The monthly per-patient claim is generated by the billing engine rather than assembled by hand.
- **A workable path if there is no portal.** With no patient portal in place today, enrollment, consent and education have to run through the on-site specialist and the telephonic pathway rather than through patient self-service. That is a design constraint, not a blocker — but it should be planned for rather than assumed away.

Scope note: integration capabilities are CoachCare-provided; confirm the platform, the connector, the product version and the delivery timeline in contracting, and confirm the hospital-side interface path separately.

8.3 Why automated claim generation matters here specifically

This is not a general benefit; it is the specific difference between a programme that runs at this scale and one that does not. At a modeled census of **3,027 active programme enrollments at month 24** across three offices and 15 billing providers, the monthly billing task is thousands of per-patient, per-code, time-documented claims — each one dependent on evidence that the monitoring days and the management minutes were actually met. **The model projects 74,234 billed units over 24 months.** No administrative layer assembles that by hand, and the failure mode is not a rejected claim; it is a programme that quietly stops billing what it delivers. Automated generation from the monitoring record is what makes the capture rate in Section 9.5 a real operating metric rather than an aspiration — and in a practice with no portal and no online scheduling, it is also the part of the workflow least likely to be absorbed by existing staff.

9. Implementation Playbook: Building the Remote Care Service Line

9.1 Goals, scope, and the modeled funnel

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

Model input	Value	Note
In-scope Medicare base	7,879	Discovery-stage estimate, deduplicated from 18,001 CY2024 beneficiary-instances across ten providers — validate against chart counts
Referring providers	15	The group's own published roster: 11 physicians and 4 advanced practice providers
Referrals per provider per month	8	With 80% patient acceptance
On-site enrollment specialist	1 (≈80 enrollments / month)	**CoachCare's expense — embedded value, never deducted from practice margin**
RPM eligibility / acceptance	75% (5,909) / 35%	Modeled ceiling 2,068 patients; reached at month 20
PCM eligibility / acceptance	85% (6,697) / 30%	Modeled ceiling 2,009; at 959 at month 24 and still climbing
Monthly attrition	1.5%	Discharge from programme
Telephonic conversion share	8%	The lowest-cost second enrollment lane, and the one with the most headroom given only three offices and 15 referring providers
Revenue basis	Net of a 5% realization discount	Payer mix and collection, as configured in the model
Payer scope	Medicare fee-for-service only	**77.4% of the county's Medicare population — so this is most of the opportunity, not a minority slice of it**

Target populations and clinical pathways

Population	Why it is first	Pathway
The anticoagulation-clinic cohort	A staffed, protocol-driven clinic already contacting these patients on a schedule, on a panel running 34.6% atrial fibrillation — the enrollment friction is already paid	Blood-pressure and weight RPM added to an existing recall cadence; PCM on the cardiac condition where a single dominant condition qualifies
Heart failure	29.5% of the panel, with chronic kidney disease at 31.4% on top — the population where between-visit deterioration turns into an admission, and the one the hospitals' readmission measures are built on	Daily weight and blood pressure with 24/7 triage; PCM as the monthly chassis; guideline-directed therapy titrated against measured response
Uncontrolled and resistant hypertension	75.0% of the panel carries hypertension, and no renal denervation programme exists to compete with — this is clean whitespace with a coverage pathway attached	Blood-pressure RPM; protocolised titration; candidate identification and coverage documentation for a future procedural pathway (Section 7)

Population	Why it is first	Pathway
The device-clinic cohort	A pacemaker and defibrillator clinic and Holter, event and loop-recorder monitoring already running — patients conditioned to remote review and staff conditioned to triage transmitted data	Add a connected cuff or scale to an already-monitored patient, documented as a distinct benefit over distinct data (Section 9.3)
Post-discharge cardiac	Every cardiac discharge from the two Adventist campuses opens a window that is both billable and, under a global budget, economically valuable to the same corporation	TCM 99495 / 99496 (not modeled) plus short-window RPM via 99445 / 99470, triggered by the daily discharge feed in Section 8.2
Post-procedure	Catheterisation, intervention, ablation and device implant volume, every case of which opens a short window that CY2026 made billable	Short-window RPM (99445), kept explicitly distinct from device interrogation

9.2 Staffing: nobody has to be hired

The model delivers **33,751 care-team hours over 24 months — approximately 16.2 full-time equivalents** — supplied by the partner under the group's protocols and clinical supervision, alongside 148,467 care-management tasks, 37,117 chart updates, 22,270 patient conversations and 1,237 hours of call time. **The on-site enrollment specialist is funded by CoachCare: embedded value, never deducted from the practice's margin, and never a practice cost line.** That matters here because a three-office group of fifteen clinicians has no spare clinical capacity to redeploy, and because it is not established whether the enterprise operates a centralised care-management capability that could be extended to a specialty group — that is an unverified gap rather than a confirmed absence.

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

9.3 “We already run monitoring clinics” — the answer

This objection is going to come up in the first meeting, and it should — the group genuinely does already run monitoring clinics. The answer is not to argue with it. It is to be precise about what is and is not already covered, because three different things are being called monitoring.

	Implanted-device monitoring (93294–93298)	Ambulatory diagnostic monitoring (Holter, event, loop)	Remote physiologic monitoring (99453 onward)
What is measured	The implanted device's own telemetry — lead integrity, arrhythmia episodes, device diagnostics	Cardiac rhythm over a defined diagnostic window	Patient-generated physiologic data from a separate connected device — blood pressure, weight, pulse oximetry
How long it runs	Ongoing, tied to the implanted device	Time-limited — days to a defined study period	Longitudinal, month after month, for as long as the condition is managed
What clinical question it answers	Is the device working, and has an arrhythmia occurred	What is the rhythm doing during this window	Is this patient decompensating, is the blood pressure controlled, is the titration working
Status at this group	A device clinic is published; no vendor is named and no volume is established here	Published and running	**Not marketed anywhere on the public site**

The three are different benefits over different data, and they answer different questions. The design rule is that the same data stream is not billed twice: a distinct device generating distinct physiologic data supports a distinct service, and the documentation has to make that distinction obvious on its face.

Confirm the specific code pairings with the payer and with billing counsel before launch. The larger point is the encouraging one: this group has already proved it will operate a remote-data workflow, three times over. It simply has not monetised the physiologic side of it — and the physiologic side is the one that moves readmissions.

9.4 Clinical workflow

1. **Identify.** Heart failure, uncontrolled and resistant hypertension, atrial fibrillation on anticoagulation, post-discharge and post-procedure. Seeded by the anticoagulation and device clinics and by the daily discharge list from the two campuses.
2. **Enroll.** One order in the clinical record. Consent, device selection and logistics handled by the partner; the on-site enrollment specialist rotates across the three offices, with a telephonic pathway carrying the rest.
3. **Monitor.** Daily physiologic data with 24/7 review and alert triage against thresholds the physician lead sets — not vendor defaults.
4. **Escalate.** A defined path from alert to nurse contact to same-week outpatient intervention, with the emergency department as the exception rather than the default. This is where the 199 modeled avoided admissions actually come from, and under a global budget it is where the hospital-side value comes from too.
5. **Titrate.** Guideline-directed therapy adjusted against measured response on a schedule, with PCM as the monthly billing chassis for the work. In a panel with chronic kidney disease at 31.4%, titration decisions depend on data the practice does not currently see between visits.
6. **Document and bill.** Time, readings and interventions captured as a by-product of care; claims generated automatically from the monitoring record (Section 8.3).
7. **Report back.** Structured monthly reporting to the referring physician — good practice, a referral-retention mechanism in a four-system county, and the artifact that keeps the attribution policy honest where a primary-care practice shares the patient.

9.5 KPI dashboard and expected impact

Domain	Metric	Why it is on the dashboard
Clinical	Blood-pressure control rate; weight-alert response time; heart failure admissions and 30-day readmissions among the enrolled census, measured against an unenrolled comparison panel	Readmission is the measure the state's programmes penalise and the measure the global budget makes expensive. Measured against a comparison panel, the contribution is reportable rather than assertable
Operational	Enrolled census by programme; enrollment conversion rate by pathway; device compliance (days with data); alert-to-contact time	Census is revenue. Days-with-data is what makes 99454 and 99445 billable in the first place. Conversion by pathway is how the telephonic lane gets sized
Transitions	Post-discharge reach rate within two business days, by campus; time from discharge to first physiologic reading	The measure that tells you whether the discharge feed in Section 8.2 was actually built, reported per campus so it can be acted on
Financial	Time to first billable enrollment; capture rate (billed ÷ eligible); net reimbursement per patient per month; net to practice	Modeled at ~$111.61 per RPM patient-month and ~$101.64 per PCM patient-month. Capture rate is the metric that quietly decides whether the modeled P&L is realised

Expected impact over 24 months, as modeled: $4,542,396 of net reimbursement and $1,927,693 net to the practice at a 42.44% margin; 2,356 unique patients and 3,027 active programme enrollments at

month 24; 314,024 physiologic readings; 74,234 billed units; approximately 199 avoided hospitalizations; and 33,751 care-team hours delivered. *All figures are illustrative, modeled — verify against practice data.*

9.6 Twelve-month roadmap

Phase	Months	What happens
Charter	0–1	Physician lead named; service line chartered with its own P&L at medical-group level; site-of-service status of all three offices confirmed with finance; target populations agreed; attribution policy written with the primary-care side before the first enrollment; the clinical record platform confirmed
Stand up	1–3	Record integration built against the confirmed platform; the daily discharge feed from the two campuses designed and tested — this is the long pole, not the connector; alert thresholds and escalation protocol set by the physician lead; on-site enrollment specialist placed across the three offices
First census	2–6	The anticoagulation-clinic and device-clinic cohorts enrolled first, then heart failure; first billable enrollment inside 90 days; month 2 is the first net-positive month in the model
Extend	6–9	Hypertension, post-discharge and post-procedure pathways added; the telephonic lane opened deliberately to move the PCM arm, which is enrollment-limited rather than eligibility-limited; the hospital-side readmission comparison begins reporting
Institutionalise	9–12	Monthly scorecard running; capture rate and post-discharge reach rate reported by campus; readmission delta against the unenrolled panel measured and taken to the hospital finance conversation; the transitional-care decision taken on its own merits

References & Data Sources

- **CMS Doctors and Clinicians National Downloadable File (PECOS)** (dataset mj5m-pzi6, file vintage June 26, 2026): the enrolled organization ADVENTIST PHYSICIAN SERVICES INC, organizational PAC ID 4284631540, 142 clinicians and nineteen Maryland practice addresses; the zero-row result for Cardiac Associates, P.C. (PAC 8022005834); the three office addresses as enrolled Adventist practice locations with 21, 17 and 13 records; the nine-site, 31-cardiologist county footprint; and the county cardiology census of 133 unique clinicians across 296 practice-location records.
- **CMS PECOS Revalidation Clinic Group Practice Reassignment file** (vintage July 1, 2026): Cardiac Associates, P.C., group PAC ID 8022005834, 24 active reassignments, revalidation due June 30, 2026, and the dual employer-association pattern. The file's group state code is a known unreliable field on this record and was not relied on.
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024** (file MUP_PHY_R26_P05_V10_D24_Prov, released May 21, 2026): $5,217,742 of allowed charges across 18,001 beneficiary-instances for the ten providers whose CMS-reported practice address is a confirmed Cardiac Associates location; the per-provider chronic-condition prevalence and HCC risk figures; and the five roster identifiers returning out-of-state addresses, which are excluded from the total.
- **CMS Innovation Center — AHEAD Model** (model page last modified July 9, 2026) and the Amended and Restated AHEAD Model Maryland State Agreement published by the Maryland Health Services Cost Review Commission: Cohort 1 status, the pre-implementation period of July 1, 2024 to December 31, 2025, the implementation start of January 1, 2026, Performance Year 1 running through December 31, 2026, the model end date of December 31, 2035, and the model components including Hospital Global Budgets and the voluntary, primary-care-only Primary Care AHEAD. The predecessor Maryland Total Cost of Care Model ended December 31, 2025.
- **Maryland Health Services Cost Review Commission** (retrieved August 3, 2026): the regulator's own scope statement that it regulates hospital rates, and its programme list — the Readmission Reduction Incentive Program, Maryland Hospital Acquired Conditions, Quality Based Reimbursement, and the Potentially Avoidable Utilization savings policy.
- **CMS Medicare Advantage state / county penetration file, July 2026:** Montgomery County, Maryland (FIPS 24031) at 198,254 eligibles and 44,742 enrolled, a 22.57% penetration rate; Maryland statewide at 24.86%; the national rate of 51.69%; and the Prince George's and Fairfax County comparators. The national figure excludes Connecticut and Alaska, which that file omits for recoding reasons.
- **CMS Medicare Shared Savings Program public use files** — PY2024, PY2025 and PY2026 participant and organization files: ADVENTIST PHYSICIAN SERVICES INC in Adventist HealthCare ACO, LLC (A5374, Maryland) for PY2024 and PY2025; the absence of A5374 from the PY2026 files; and the same organization's appearance in Kettering Physician Partners Accountable Care LLC (A5062, service area Maryland and Ohio) for PY2026, corroborated by that organization's own public reporting page.
- **U.S. Census Bureau, American Community Survey 2024 five-year estimates** (profiles DP02, DP03 and DP05, retrieved August 4, 2026, with income and population cross-checked against detail tables B19013, B19113 and B01003): Montgomery County population 1,065,949, 17.0% aged 65 and over, median household income $132,450, 31.1% of households above $200,000, 5.1% of families below the poverty line, 60.6% of adults with a bachelor's degree or higher, and the Maryland and national comparators.
- **CMS — CY2026 Medicare Physician Fee Schedule:** TCM 99495 and 99496; RPM 99453, 99454, 99445, 99457, 99470 and 99458; PCM 99424–99427; and the concurrency rules under

which RPM and PCM stack. Locality-adjusted payment for this group is set under Maryland locality 12202-01.

- **CMS national coverage determination 20.40,** renal denervation for uncontrolled hypertension, effective October 28, 2025 under Coverage with Evidence Development.
- **CMS mandatory-model participant files, current published vintages** (retrieved August 3, 2026): searched in full by clinician identifier across all states with no state filter, by organization-name expression across every row, and separately for both of the group's admitting hospital campuses. **No match on any file**. No mandatory federal payment model bears on this group or on its hospitals, and no mandatory-model content appears anywhere in this report.
- **The group's own website** (cardiacassociates.org — home, locations, providers, services, affiliations and patient-information pages, plus the separately branded venous service line; retrieved August 3, 2026), together with archived captures of the group's original domain from 2001 and of Adventist HealthCare's physician-profile pages from 2019, 2022, 2025 and 2026: the three published offices, the published roster of 11 physicians and 4 advanced practice providers, the published clinical range and named clinics, the hospital directorships, the office footprint changes between April 2019 and December 2021, and the January-to-September 2022 rebrand window.
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 5, 8.3 and 9, including the 7,879-patient in-scope base, 75% / 85% RPM / PCM eligibility, 35% / 30% acceptance, 1.5% monthly attrition, a 5% realization discount, the 15-provider referral engine at eight referrals per provider per month with 80% acceptance, one on-site enrollment specialist at CoachCare's expense, and MAC-locality rates auto-resolved for ZIP 20850 (Maryland, locality 12202-01).

Items not independently verified

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

- **Whether any site bills provider-based.** This is the single largest modelling risk in the account. Freestanding office billing is unaffected by the hospital global budget; provider-based billing is a different economic question. Nothing in public data establishes the site-of-service status of the three offices. *Resolve this before budgeting.*
- **Whether any remote monitoring, chronic care or principal care management programme exists today** — at the practice or anywhere in the enterprise. Nothing is publicly marketed by the practice, but no code-level screen of the group's own billing was run for this report, and the system's website blocks automated retrieval, so its enterprise capability is unknown. *This is the single most important thing to ask directly.*
- **Whether the two systems combined.** The migration of the billing entity from a Maryland accountable care organization into an Ohio-headquartered one effective January 1, 2026 is documented in CMS files. The corporate transaction behind it is not. It determines whether procurement is a Maryland decision or a two-state one.
- **The clinical record platform.** A commercial file names one ambulatory platform; direct inspection of the group's site found no fingerprint of any platform, no portal host, and no patient portal link of any kind. The enterprise platform was not identified either. Integration cannot be scoped until this is answered.
- **The legal form and date of the Adventist relationship.** The rebrand window of January to September 2022 is established from archived captures. No acquisition or affiliation announcement, no terms and no transaction record were located in any source reached during this research. Asset purchase, employment and a professional services agreement are indistinguishable in CMS enrollment data and differ commercially.

- **The live roster.** Three sources give three different counts — 9 physicians in a commercial file, 11 physicians and 4 advanced practice providers on the group's own page, and 24 reassignments in CMS enrollment records. One physician on the group's page appears in no CMS Maryland file and returned no CY2024 billing. Confirm the current roster before any outreach that depends on it.
- **True unique-patient panel size.** The 18,001 CY2024 figure is beneficiary-instances and double-counts patients seen by more than one physician in the group. The modeled 7,879 in-scope base is a deduplicated estimate derived from a disclosed method, not a CMS-published figure.
- **Five out-of-state clinician records.** Five identifiers on the practice's reassignment roster returned CY2024 practice addresses in Virginia, Texas, New Jersey and South Carolina. Common-name identifier collisions or relocations — unresolved, and they affect both the roster and the revenue base.
- **The hospital admitting split.** A commercial file reports roughly 73% of hospital volume to the Rockville campus and 9% to White Oak. No claims-level source was available to verify it. Adventist can confirm it from its own data in an afternoon.
- **Hospital procedure volumes.** Reported open-heart and interventional cardiology volumes for the White Oak campus carry no data vintage and may predate the 2019 campus move. They are recorded here as unverified and are used nowhere in this report.
- **Enterprise structural-heart and procedural claims.** The system markets a structural heart programme, minimally invasive valve procedures and left atrial appendage occlusion, and claims a first-in-region intravascular lithotripsy capability. Those claims come from an archived capture of the system's marketing pages with no announcement dates attached and are not used as facts in this report.
- **Whether the venous service line retains separate economics.** It is a Cardiac Associates, P.C. property by its own site metadata and carries no system branding, which is suggestive but is inference from branding rather than from any ownership document.
- **Medicare Advantage contracts.** No public evidence either way on plan contracts held by the enterprise. Given 22.57% county penetration this is a smaller question here than in most markets, but the plan book remains additive and unpriced in every figure in this report.
- **Corporate registry filings.** Entity type, formation date, status and registered agent for the practice entity and for the venous service line could not be retrieved — the state's business entity search is a session-driven interface that could not be queried programmatically.
- **Hiring signals.** No care-coordinator, remote-monitoring-nurse or population-health postings were found, and the search was not exhaustive. Absence of a found posting is not evidence of absence.
- **Ratings, patient-satisfaction scores, awards and grievance history.** None are reported anywhere in this document because none were verified from a citable independent source. Vendor-hosted review scores and consumer aggregator listings were observed during research but are not relied on for any claim. A current-sanctions screen against the state medical board returned no hits for the group's physicians; historical or terminated actions were not searched, and malpractice and civil litigation were not checked because the state judiciary's case search blocks automated retrieval.

Global verification caveat

Facts in this report reflect public sources current to August 2026 and are cited above. Items flagged “CoachCare-provided,” “stated assumption,” “estimate,” “plausibly” or “confirm” were not independently verifiable from public sources. Reimbursement figures are illustrative national or modeled locality magnitudes — verify against the current CY2026 Physician Fee Schedule and the applicable Maryland locality files, and note that CY2027 rulemaking is in progress. Every modeled figure is a Medicare fee-for-service figure; Medicare Advantage, commercial and Medicaid volume is additive and unpriced. The Maryland payment environment is described as of Performance Year 1 of the state's current arrangement, which began January 1, 2026. All Value Analysis outputs are illustrative, modeled — verify against practice data.

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