COACHCARE | SERVICE LINE STRATEGY

Cabrillo Cardiology Medical Group

Cabrillo Cardiology Medical Group, Inc. · Oxnard and Camarillo, Ventura County, California — an independent, physician-owned California professional medical corporation

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as a margin-positive, recurring professional-fee service line billed under the practice's own TIN — and as the operating layer beneath readmission defence, referral durability and procedural throughput

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the physician leadership of Cabrillo Cardiology Medical Group, Inc. It assembles the practice's public footprint, its CY2024 Medicare service record, its county's payer structure, the 2026 payment environment, the care-coordination resources already available to it through its clinically integrated network, and a modeled financial forecast into a single argument: this group already runs a remote-data workflow in cardiac rhythm, and the physiologic layer sitting directly beside it — the one CMS pays for separately, and the one that determines what happens between visits — is currently neither staffed nor billed.

All facts are drawn from public sources current to August 2026 and cited in the References section. All financial projections are illustrative and modeled in the CoachCare Value Analysis (MAC locality auto-resolved for ZIP 93030 — California, locality 01182-17) — verify against practice data before budgeting.

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

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Executive Summary

Cabrillo Cardiology Medical Group, Inc. is an independent, physician-owned California professional medical corporation operating from two offices — Oxnard and Camarillo — in Ventura County. CMS enrollment records show the group holding its own Medicare group-practice enrollment under PAC ID 5890693279, with an enrollment record dating to December 2003, and **ten clinicians reassigning benefits to the group's own TIN — nine physicians and one nurse practitioner**; the practice's own site adds two physician assistants, giving the twelve-clinician referral bench used in the financial model.[1] No health system, foundation, management-services organisation or private-equity sponsor appears in any public record, and a twenty-four-month news sweep surfaced no transaction. The group's own account of its history places its founding in 1971 and its clinicians at the origin of the county's first coronary care unit and first coronary stent implantations — a self-reported history, but one consistent with a 2003 PECOS record and roughly fifty-five years in the same market.

Three facts define this report, and all three come from public records rather than from anything the practice has said.

1. **The group already runs a remote-data workflow — in rhythm.** The practice's own electrophysiology pages describe insertable cardiac monitors, mobile cardiac telemetry explicitly characterised as transmitting arrhythmias wirelessly to clinicians, fourteen-day ambulatory patch monitoring, Holter and symptom-triggered event recorders, and implanted-device checks on a three-to-six-month cadence.[2] Whoever reviews those transmissions today is already doing the hard part of a remote programme: triage, escalation, documentation and follow-up on data that arrives between visits. **The concept needs no selling here.**
2. **The physiologic layer beside it is empty, and so is the care-management layer.** No physiologic remote monitoring — blood pressure, weight, pulse oximetry — and no time-based care management appears anywhere in the public record: no programme page, no named device or monitoring vendor, no care-coordinator or chronic-care nurse posting, and no code-set evidence.[3] *This is an absence of evidence rather than a proof of absence, and it is the first thing to confirm directly* — but nothing found in this research suggests a physiologic programme exists.
3. **The panel is textbook for the programme.** Across the eight rendering NPIs with CY2024 traditional-Medicare billing, hypertension runs at **75% — the CMS published cap, meaning 75% or more** — with heart failure at **24% to 56%**, atrial fibrillation at **34% to 74%**, chronic kidney disease at 29% to 45%, diabetes at 35% to 53% and ischemic heart disease at 44% to 61%. The electrophysiology panel alone runs **56% heart failure and 74% atrial fibrillation**.[4] Essentially every one of these patients carries two or more chronic conditions, and the heart-failure and hypertension cohort is the population remote physiologic monitoring was written for.

[1] CMS Revalidation Clinic Group Practice Reassignment file, dataset modified July 14, 2026; queried on group legal business name, all rows carrying group PAC ID 5890693279. Ten clinicians - nine physicians and one nurse practitioner. Two physician assistants are named on the practice's own site and do not appear in the reassignment file, which is expected: physician assistants are typically employed rather than reassigned. The NPPES registry API was DNS-unresolvable from the research environment for the entire session, so attribution was established from the PECOS-derived reassignment file rolled up on group PAC ID rather than by NPPES name and postcode matching - a method that proves the reassignment relationship rather than inferring affiliation from geography.

[2] The practice's own electrophysiology services page and patient-resources page, retrieved August 3, 2026. The implanted-device check cadence is quoted from the practice's own wording. Whether these transmissions are billed, on which platform they are reviewed, and by whom, is not disclosed in any public source and is carried to the discovery agenda.

[3] A public-source sweep across the practice's own website, CMS billing data, reachable job boards and vendor material, August 2026. No programme page, no named monitoring or device vendor, no care-coordinator or chronic-care nurse posting and no code-set evidence was found. CMS suppresses provider/HCPCS lines with fewer than 11 beneficiaries, a programme launched in 2025 or 2026 would not yet appear in published data, and Medicare Advantage and commercial activity are excluded from Medicare fee-for-service files by construction. This is absence of public evidence, not proof of absence.

[4] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (file MUP_PHY_R26_P05_V10_D24_Prov.csv, dataset modified May 21, 2026), queried by each of the ten reassigned NPIs; eight carry CY2024 records. CMS publishes these chronic-condition percentages with a cap at 75%, so a panel reported at 75% may be higher. Figures are per-rendering-NPI shares of each physician's own Medicare panel.

The central argument

1. Standalone value — and on this account it leads. TCM + RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based upside and dependent on no reconciliation, no shared-savings determination and no hospital agreement — modeled at **$4,032,643** of net reimbursement and **$1,720,841** net to the practice over 24 months, a **42.67% practice margin** (net to the practice ÷ net reimbursement). Illustrative, modeled — verify against practice data.

2. Connective tissue. One shared engine — enrollment, connected devices, 24/7 alerting and triage, nurse navigation, billing capture and analytics — simultaneously produces the standalone P&L, the readmission-driven avoided cost the group's hospital partners can see, the referral durability that keeps a monitored patient attached to this practice, and the monitored discharge pathway that makes procedural throughput possible. Build once, use everywhere.

The market backdrop is favourable, and it is the opposite of what most people assume about coastal Southern California. Ventura County Medicare is **58.3% traditional fee-for-service and 41.7% Medicare Advantage** as of CY2025 — below the national Medicare Advantage average and far below the state's most penetrated counties. More usefully, **the fee-for-service pool is growing in absolute terms**: 97,537 beneficiaries in 2019 against 101,650 in 2025, even as the Advantage share crept up from 34.9% to 41.7% on a county Medicare population that grew 16.2%.[5] Because TCM, RPM and PCM are fee-for-service benefits, their economics work best where the fee-for-service pool is deep — and here it is deep, and it is not eroding. **The honest counterweight** is that the Advantage slice is real and rising roughly half a point a year, and whether the county's Advantage plans pay these codes at all is not publicly discoverable. Treat the traditional-Medicare book as the addressable base and the Advantage book as a second, separate conversation.

The revenue base is larger than the commercial data suggests, and the direction of the error matters. A widely used commercial firmographic file reports Medicare allowed charges of **$7,534,472** for this group. The CY2024 CMS Medicare Physician and Other Practitioners file, queried NPI by NPI, sums to **$12,207,641** across the eight rendering NPIs with CY2024 billing — **62% higher**. Excluding entirely the one physician whose CMS-registered CY2024 practice address is a Los Angeles academic medical centre rather than an Oxnard office, the floor is still **$10,873,144**.[6] Whatever the cause — an older vintage, a subset of NPIs, or a TIN-level rather than rendering-NPI-level roll-up — the practical consequence is that any sizing anchored on the commercial figure understates this practice by at least 44%.

[5] CMS Medicare Monthly Enrollment, April 2026 release, dataset modified July 23, 2026, queried on county FIPS 06111 (Ventura County, California), annual figures 2019 through 2025.

[6] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026), summed across the eight rendering NPIs with CY2024 records: $12,207,641 allowed across 6,142 beneficiary relationships. The $10,873,144 floor excludes the one physician whose CMS-registered CY2024 practice address is a Los Angeles academic medical centre and who carries two employer associations, so an unknown share of his volume belongs to that centre. The $7,534,472 comparison figure is from a widely used commercial firmographic file, vintage July 1, 2026.

The one thing to know before the first meeting

Cabrillo is a listed member location of **SCICN-VC** (Southern California Integrated Care Network – Ventura County), a physician-led clinically integrated network, and of the Dignity Health Care Network directory. **SCICN-VC already runs a named, RN-staffed Ambulatory Care Coordination Programme for its member physicians** — targeted at patients with two or more chronic conditions, high-risk medication burden, repeat emergency-department visits or hospitalizations and social barriers, with physician referral plus the network's own analytics-driven case-finding — alongside a separate transitional-care resource for member practices.[7]

That is a real programme and a genuine asset to the practice, and this report treats it as one. It is also **scoped differently** from what is proposed here: it serves an attributed, high-utilization sub-population rather than the whole panel; **the practice bills nothing for it**, because the coordinator's time is the network's cost and the network's economics are shared-savings; and neither published page describes physiologic monitoring or the monthly care-management codes. The network's own transitional-care material, by contrast, tells member practices to work with their coding and billing staff so that the practice bills the service itself — which is precisely the logic this report extends to the rest of the panel. Section 5 sets the two side by side.

The timing is clean, and worth stating precisely because it is a positive rather than a deadline. The CY2026 Physician Fee Schedule expanded remote monitoring in ways that suit a procedural cardiology 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. On the model side there is **no mandatory model exposure — pure-upside timing, and prepared if selection maps change**.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **7,307-patient in-scope base across 12 referring clinicians** — *a discovery-stage estimate to validate against the practice's own chart counts* — with RPM and PCM only. It projects net reimbursement of **$1,011,459** in Year 1 and **$3,021,184** in Year 2 (**$4,032,643** over 24 months — RPM $2,963,136, PCM $1,069,507); **$1,720,841** net to the practice after CoachCare fees; 282,352 physiologic readings; approximately **179 avoided hospitalizations**; and 30,479 care-team hours delivered, about **14.7 full-time equivalents** of clinical labour the practice does not have to hire. Month 1 is modeled at −$4,037 and every month from month 2 onward is net-positive. *All figures are illustrative, modeled — verify against practice data.*

2026–2027 Priority Recommendations

1. **Charter the Remote Care Service Line as a named programme with its own P&L.** TCM at discharge, then RPM, then PCM, across heart failure, uncontrolled and resistant hypertension, post-ablation and post-implant windows, and post-structural-heart recovery. Name a physician lead and pair them with the practice's administrative lead on operations. Target the first billable enrollment within 90 days.
2. **Start with the heart-failure and atrial-fibrillation cohort, because it is already identified.** The electrophysiology panel runs 56% heart failure and 74% atrial fibrillation, and heart failure runs to 56% across the group. That cohort can be populated from the practice's own record in weeks rather than quarters, and it is the population in which weight and blood-pressure trend between visits changes what happens next (Sections 4.1 and 6).
3. **Map the boundary with the rhythm-monitoring workflow before anything is enrolled.** Implanted-device and rhythm monitoring and patient physiologic monitoring are different benefits over different data. Identify who reviews rhythm transmissions today, on which platform, and

[7] SCICN-VC (Southern California Integrated Care Network - Ventura County): the network's care-coordination page for physicians, its transitional care management page and its location listing for this practice; and the Dignity Health Care Network location directory. All retrieved August 3, 2026. Programme description is quoted from the network's own published wording; pricing, and this practice's actual use of the programme, are not disclosed publicly.

whether that team has capacity — then define the documentation boundary so neither service is ever at risk (Sections 2.1 and 9.3).

4. **Position the service line explicitly alongside the network's care-coordination programme, not against it.** Establish in discovery whether the practice actually uses the network's RN coordinators, how many patients they touch, and whether any exclusivity, preferred-vendor or data-sharing terms would constrain a third-party service. Then write one attribution policy so no patient is touched twice for the same purpose (Section 5).
5. **Structure the commercial agreement as a services and technology agreement at fair market value.** California's corporate practice of medicine doctrine and the fee-splitting provisions of the Business and Professions Code make a percentage-of-collections model a non-starter with a California professional medical corporation. A flat or per-enrolled-patient fee, with the group retaining clinical control and billing the codes itself, is the structure this engagement is designed around (Section 3.4).
6. **Confirm the payer mix before budgeting on any figure in this report.** Traditional Medicare against Medicare Advantage as a share of patients, and whether any Advantage volume is capitated or paid fee-for-service off an independent practice association's fee schedule. Nothing public answers this, and every number downstream moves with the answer (Section 3.2).
7. **Plan bilingual enrollment and monthly outreach from day one.** This programme runs on monthly outbound telephone contact. In Ventura County, 30.2% of residents speak Spanish at home and 14.9% speak English less than “very well”.[8] Bilingual care-management staffing is a design requirement here rather than an enhancement — and a real differentiator where it is delivered (Section 9.2).

[8] U.S. Census Bureau, American Community Survey 2024 five-year estimates, profiles DP02 and DP05 for Ventura County, California, retrieved August 4, 2026 and cross-checked against ACS detail tables. County-level figures only; Oxnard-city figures were not separately retrieved, and the practice's own patient language mix was not measured.

1. Footprint & Operating Model

1.1 The practice

The legal entity is **Cabrillo Cardiology Medical Group, Inc.** — a California professional medical corporation, which under California law means its shares are held by licensed physicians. CMS records give the group its own PECOS group associate ID (PAC ID **5890693279**) and its own group enrollment identifier (O20031222000943, whose prefix indicates a December 2003 enrollment record), state of California, with a revalidation date of November 30, 2025 on file.[9] A California Secretary of State filing dated September 1971 is reported by a corporate-data aggregator but **could not be verified directly** — the Secretary of State's business-search endpoint blocks automated retrieval — so treat the 1971 date and the entity number as probable rather than confirmed, and do a manual lookup before any contractual use.

Office	Address	Status in CMS data
Oxnard (main)	2241 Wankel Way, Suite C, Oxnard, CA 93030	Corroborated — the CY2024 Medicare Physician file places seven of the eight rendering NPIs at this exact address
Camarillo	400 Camarillo Ranch Road, Suite 205, Camarillo, CA 93010	Published on the practice's own site, sharing the main telephone number; not separately resolvable as a distinct Medicare billing address in the CY2024 file
A third location — not evidenced	—	**A widely used commercial firmographic file reports three locations. Only two are publicly evidenced.** The most likely explanations are a hospital-based site of service, a legacy office, or a claims-derived third address: the CY2024 CMS record for one physician lists a Los Angeles academic medical centre as his practice address, which would present as a third address in any claims-derived dataset without being a Cabrillo clinic. Confirm in discovery

Roster, counted from CMS rather than from the website. The authoritative count is the set of clinicians who reassign Medicare benefits to the group's own PECOS group associate ID: **ten — nine physicians and one nurse practitioner**, as of the CMS file modified July 14, 2026. The practice's own site names two physician assistants who do not appear in the reassignment file, which is expected: physician assistants are typically employed rather than reassigned. **Twelve clinicians is therefore the right referral bench for planning**, and it reconciles cleanly against the commercial file's “nine physicians” and “eleven group practice members” — the first is exactly right, the second is a counting convention. *Stated as a caveat rather than glossed over*: reassignment records capture reassignment relationships, so they can lag a departure and will miss a hire made after the snapshot date.

A note on how these clinicians were identified, because the method matters. The NPPES registry API was unreachable throughout the research session — DNS failure from the research environment, not a CMS outage — so clinician-to-organisation attribution was established instead from the CMS Revalidation Clinic Group Practice Reassignment file, rolled up on the group's PAC ID. That is arguably the stronger method: it proves a reassignment relationship rather than inferring an affiliation from name and postcode proximity. It was independently corroborated by a third-party PAC-ID directory returning the identical nine-physician roster, and by the CY2024 Medicare Physician file placing seven of eight rendering NPIs at the Oxnard address.

[9] CMS Revalidation Clinic Group Practice Reassignment file (dataset modified July 14, 2026) for the group PAC ID and the California revalidation date; the group enrollment identifier O20031222000943 carries a prefix indicating a 2003-12-22 PECOS enrollment record. The September 1971 California Secretary of State filing date and entity number are reported by a corporate-data aggregator only: the Secretary of State's business-search endpoint returned HTTP 403 to every scripted request, so both are unverified and require a manual lookup before any contractual use.

Sub-specialty mix, from the practice's own published service pages

Service line	What is published	Why it matters to this programme
Interventional and coronary	Coronary angioplasty, cardiac catheterisation, atherectomy; five to six of the nine physicians describe interventional practice	A large post-procedure population, each case opening a short recovery window that CY2026 coding now makes billable
Structural heart	Transcatheter aortic valve replacement, patent foramen ovale closure, left atrial appendage occlusion	Post-discharge monitoring and structured anticoagulation follow-up are the difference between a bed-day and a same-or-next-day discharge (Section 7)
Electrophysiology	Complex ablation across atrial fibrillation, flutter, ventricular tachycardia, supraventricular tachycardia and premature ventricular complexes; pacemaker and defibrillator implant and generator change; lead extraction; insertable cardiac monitors	The panel behind it runs 56% heart failure and 74% atrial fibrillation — the highest-yield enrollable cohort in the practice
Non-invasive imaging	Electrocardiography, echocardiography, stress and exercise echo, nuclear cardiology, cardiac computed tomography	Explains the practice's extreme services-per-beneficiary ratio (Section 4.3) and confirms a technical-component-heavy revenue base
Peripheral vascular	Doppler and carotid imaging, endovascular intervention, varicose vein ablation	Additional post-procedure windows, and a hypertension-adjacent population
Clinical research	A named research page listing cardiovascular outcome trials, registries and heart-failure cell-therapy studies, with two named principal investigators	**Most listed trials date to 2012–2016 enrollment and current activity is unconfirmed.** If the research infrastructure is still staffed, a practice with a research coordinator has latent capacity for protocol-driven remote monitoring
Heart-failure clinic	**Not evidenced.** Heart-failure management is listed as a capability in third-party group descriptions, but no dedicated clinic, programme page or heart-failure nurse role appears in any public source	A 24–56% heart-failure panel with no named heart-failure pathway is the clearest structural gap in the practice, and the natural first cohort

1.2 The operating model: independent ownership, hospital-embedded leadership

This group occupies an unusual structural position, and it is the single most important thing to understand about it commercially. **It is independently owned and it simultaneously supplies the cardiovascular leadership of the county's principal cardiac hospital.** Published biographies on the practice's own site place its physicians in the medical directorship of cardiovascular services and of the chest pain centre at both Dignity Health St. John's Regional Medical Center in Oxnard and its Camarillo sister campus, the medical directorship of cardiac rehabilitation at both, and the chair of the department of medicine at St. John's Regional. The practice's own history describes the county's first dedicated coronary care unit and its first coronary stent implantations as its clinicians' work.

Two consequences follow. First, **adoption friction inside this practice is low** — the group controls its own profit and loss, its own electronic record and its own billing, so a decision to build a service line does not have to pass through a health system's capital committee. Second, **anything a hospital or network partner might read as competitive will be felt personally**. A programme positioned as revenue the practice keeps, complementary to what the network already supplies, is a very different conversation from one positioned as a replacement for it. This report is written for the first version.

The revenue mix is technical, not cognitive, and that shapes where the gap is. Services per beneficiary across the largest CY2024 panels run between roughly 31 and 44. A cardiologist billing office evaluation and management alone would run three to six. **Ratios in the thirties and forties mean the fee-for-service book is dominated by in-office imaging and hospital-based procedural work rather than by cognitive visits**.[10] The electrophysiology panel is the instructive exception — the lowest services-per-beneficiary ratio in the group at under eight, and one of the largest allowed amounts, which is the signature of high-value ablation and device work. A practice with this shape has very little recurring, non-procedural revenue, and a very large population it sees episodically. That is exactly the shape a monthly management service fills.

Ownership, and why it is worth protecting deliberately. No health-system, foundation, management-services or private-equity parent appears in the CMS enrollment record; all ten reassigned clinicians reassign to the group's own TIN rather than to a foundation or independent practice association TIN; and the group appears in the SCICN-VC and Dignity Health Care Network directories as an **affiliated location, not an owned entity**.[11] A twenty-four-month news sweep found no transaction, merger or affiliation change. Independence is the group's current position and it is a reasonable thing to want to keep. An infrastructure layer the practice can rent rather than build — one that leaves the TIN, the patient relationships, the clinical protocols and the data with the practice — is one of the few ways to add a capability of this size without giving anything up to acquire it.

1.3 Design principles for the 2026 service line

Principle	What it means at this practice
Longitudinal by default	Every heart-failure, uncontrolled-hypertension, post-ablation, post-implant and post-discharge patient leaves the encounter enrolled in monitoring or monthly management — not merely scheduled for a return visit a quarter later
Separate the two remote programmes cleanly, first	Rhythm and implanted-device monitoring 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 ever at risk (Section 9.3)
Complementary to the network, by design	The network's care coordination is scoped to an attributed, high-utilization sub-population. The service line covers the whole panel continuously. One attribution policy, written before the first enrollment, keeps them additive rather than overlapping (Section 5)
Bilingual from day one	The programme runs on monthly outbound telephone contact in a county where 30.2% of residents speak Spanish at home. Spanish-language enrollment scripting, device onboarding and care-management staffing are launch requirements, not phase-two enhancements
One front door	A single enrollment, consent and device-logistics workflow; referral to the service line is one order inside the practice's existing eClinicalWorks chart, with enrollment status visible in real time (Section 8)
The partner carries the load	One nurse practitioner and two physician assistants across nine physicians is a thin advanced-practice bench for a care-management build. The practice supplies clinical direction and supervision; the partner supplies enrollment, devices, monitoring, documentation and claims

[10] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026): services and beneficiary counts per rendering NPI, from which the services-per-beneficiary ratios are derived. Beneficiary counts are per-provider and contain duplication across providers; they are not unique-patient counts.

[11] CMS Revalidation Clinic Group Practice Reassignment file (dataset modified July 14, 2026): all ten clinicians reassign to the group's own TIN rather than to a foundation or independent practice association TIN, and no health-system, foundation, management-services or private-equity parent appears in the CMS enrollment record. The SCICN-VC and Dignity Health Care Network directories both list the practice as an affiliated location rather than an owned entity (retrieved August 3, 2026). The twenty-four-month news sweep was partial - a search quota was exhausted before news-specific queries completed - so absence of transaction news is weak evidence rather than proof.

Principle	What it means at this practice
Answer the coinsurance question up front	RPM and PCM carry the 20% Part B coinsurance, and dual-eligible share runs from 11% to 40% across the practice's own panels. The consent conversation and the collection workflow both need an explicit answer before enrollment starts, not after the first statement goes out
Single scorecard	Clinical, operational and financial metrics for the service line reviewed monthly by the physician lead and the administrative lead, with capture rate treated as the metric that quietly decides whether the modeled P&L is realised (Section 9.5)

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

2. The Remote Care Service Line — The Operating Spine

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

2.1 What it is: the cardiology clinical & billing stack

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

Programme	Core codes	What it does	Where it lands at this practice
TCM — Transitional Care Management *(identified, not modeled)*	99495 / 99496	The 30-day post-discharge transition: interactive contact within two business days, face-to-face visit within 14 or 7 days depending on complexity	The practice's clinicians round and operate inside the county's principal cardiac hospital, so it generates its own discharge flow. Deliberately excluded from every financial figure in this report — and the one service the practice's own network already tells member physicians to bill
RPM — Remote Physiologic Monitoring	99453; 99454 / 99445; 99457 / 99470; 99458	Cellular blood-pressure cuffs, weight scales and pulse oximeters; daily physiologic data; 24/7 review and alert triage; monthly clinical management time	The between-visit layer for heart failure (weight and blood pressure), for uncontrolled and resistant hypertension, and — via the short-window code 99445 — for the 2–15 day post-discharge, post-ablation, post-implant and post-structural-heart windows
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Heart failure as the qualifying condition. In a cardiology panel the single dominant condition genuinely is the cardiac one — the clinical situation PCM was written for, and the monthly chassis for guideline-directed therapy titration

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

Three coordination rules, all of which have to be written down before the first enrollment

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.

Rhythm monitoring and physiologic monitoring are different benefits. Implanted-device and rhythm monitoring (the 93xxx family) reads the device's own telemetry or a rhythm recorder; physiologic monitoring (99453 onward) reads patient-generated data from a separate connected device — blood pressure, weight, pulse oximetry. The rule to design around is that the same data stream is never billed twice, and the documentation has to make that distinction obvious on its face. *Confirm the specific pairings with the payer and with billing counsel before launch.*

The practice and the network cover different populations. The practice owns the transitional window at discharge and owns RPM plus PCM on the cardiac condition across the whole panel; the referring primary-care physician owns any longitudinal primary-care wrapper; the network's care coordinators serve their attributed, high-utilization cohort. **One shared care plan**, with explicit task ownership, so no patient is touched twice for the same purpose. Write that policy before the first enrollment — it prevents duplicate-billing denials and it protects both relationships (Section 5).

2.2 Standalone value: a margin-positive service line

On this account the standalone P&L is not the supporting argument — it is *the* argument. There is no mandatory-model deadline to lean on and no shared-savings reconciliation to wait for. The service line has to pay for itself on professional fees billed under the practice's own TIN, and it does. Four layers of value follow, in order of how load-bearing they are here:

1. **Direct professional-fee revenue — the lead layer.** Recurring monthly billing on a population the practice already manages clinically, delivered at top-of-license staffing under general-supervision rules. Modeled at $4,032,643 of net reimbursement over 24 months, $1,720,841 of it net to the practice. It depends on no reconciliation, no attribution list and no third party's agreement.
2. **Avoided cost and readmission exposure.** Modeled at approximately 179 avoided hospitalizations over 24 months — on the order of $2.7 million at an illustrative $15,000 per admission, accruing to the payer and to the admitting hospitals rather than to the practice, but visible to both. In a group whose physicians hold the cardiovascular leadership of the county's principal cardiac hospital, that visibility is worth something specific (Section 6).
3. **Device and procedural throughput.** A monitored discharge pathway is what converts a structural-heart, ablation or implant case from an overnight bed-day into a same-or-next-day discharge, and it is the prerequisite for a resistant-hypertension pathway (Section 7).
4. **Independence and optionality.** The practice keeps its own TIN, its own data and its own patient relationships while adding an infrastructure layer it would otherwise have to build, buy, or depend on a hospital or network partner to supply. For a group whose defining characteristic is that it is still its own company after fifty-five years, that is not a soft benefit.

The CY2026 billing stack

Service / code	Type	~CY2026 magnitude	Notes
TCM — 99495 / 99496 ***(not modeled)***	Per discharge	~$200 / ~$280	Moderate / high complexity. Interactive contact within two business days; face-to-face within 14 or 7 days — upside beyond every financial figure in this report
RPM — 99453	One-time setup	~$20	Device setup and patient education; requires qualifying data days

Service / code	Type	~CY2026 magnitude	Notes
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 one local factor cuts the other way

The figures above are illustrative national non-facility magnitudes for CY2026. Actual payment is locality-adjusted and set by the Medicare Administrative Contractor for California. The financial model in this report uses MAC-locality rates auto-resolved for ZIP 93030 in the CoachCare Value Analysis — California, locality 01182-17. Verify against the current CY2026 Physician Fee Schedule and the applicable California locality files before budgeting, and note that CMS rulemaking for CY2027 is in progress: remote-monitoring code values are subject to change inside the 24-month window modeled here.

One local factor deserves an honest note rather than a footnote. **Dual-eligible share runs from 11% to 40% across this practice's own CY2024 panels**, clustering higher in the largest ones, against 17.3% of Ventura County Medicare beneficiaries overall. RPM and PCM carry the 20% Part B coinsurance; for dual-eligible patients Medicaid is the secondary payer, which changes both the collection workflow and the consent conversation. This is not an edge case at these shares — it needs an explicit answer in the proposal. *It also means the county's high median household income should not be used to describe this practice's patients*: county-level affluence is concentrated at the eastern end of the county, and the Oxnard panel this group actually serves does not look like the county average.

Modeled economics

The companion Value Analysis prices an RPM + PCM programme on the practice's base. The modeled population is an estimated **7,307-patient in-scope base across 12 referring clinicians**, all of it in scope in Year 1. *This is a discovery-stage estimate and should be validated against the practice's own chart counts before budgeting.* For reference, the CY2024 CMS file records 6,142 beneficiary relationships across the eight rendering NPIs — but that figure is a sum of per-provider counts, so a patient seen by two of the group's cardiologists is counted twice, and the true unique traditional-Medicare panel is materially smaller. The modeled base is wider than traditional Medicare alone: it is the practice's whole addressable panel, and commercial and Medicare Advantage volume is neither visible in any public dataset nor separable from it. **A unique-patient denominator cannot be derived from public files and has to come from the practice's own record.**

Enrollment builds bottom-up from **12 referring clinicians at eight referrals per clinician 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 (5,480 patients) and 85% for PCM (6,211), with acceptance of 35% and 30% respectively. Revenue is reported as **net** reimbursement — gross allowed amounts less a 7% realization discount for payer mix and collection, as configured in the model.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$1,011,459	$3,021,184	**$4,032,643**
CoachCare fees (incl. setup & integration)	—	—	$2,311,802
Net to the practice	**$425,620**	**$1,295,221**	**$1,720,841**
Practice margin	**42.08%**	—	**42.67%**
Net reimbursement by programme	RPM $752,743 · PCM $258,716	RPM $2,210,393 · PCM $810,791	RPM $2,963,136 · PCM $1,069,507
Claims / billed units	—	—	67,002
Physiologic readings collected	—	—	282,352
Hospitalizations avoided (modeled)	—	—	~179 (≈$2.7M at an illustrative $15,000 each)
Care-team hours delivered	—	—	30,479 (≈14.7 FTE)
Active programme enrollments at month 24	—	—	2,790 (RPM 1,918 · PCM 872)
Unique patients (de-duplicated)	1,263 at month 12	2,180 at month 24	—

CoachCare Value Analysis, MAC locality CA 01182-17 (ZIP 93030), RPM and PCM only. Chronic care management is carried at zero eligibility. Transitional care management is excluded entirely. Illustrative, modeled — verify against practice data.

The margin, and how it is defined

24-month practice margin: 42.67% — net to the practice ÷ net reimbursement. Year 1 is **42.08%**, on $4,032,643 of net reimbursement and $1,720,841 net to the practice over the full 24 months.

Month 1 is modeled at **−$4,037** because one-time implementation lands there, and **every month from month 2 onward is net-positive**. By month 24 the programme is modeled at $294,741 of monthly net reimbursement and $126,465 of monthly net to the practice. The more useful way to describe the timing is this: no practice capital is at risk while the census builds, because CoachCare funds the enrollment engine, the devices and the monitoring staff.

The two arms behave differently, and it matters for planning. **RPM is ceiling-pinned**: it reaches its modeled ceiling of 1,918 enrolled patients at month 21 and holds there, so Year 2 RPM growth is a function of how quickly the census fills rather than of how large the eligible pool is. **PCM is not** — it stands at 872 patients at month 24 against a modeled ceiling of 1,863, still climbing, limited by enrollment pace rather than by eligibility. **Year 2 is therefore a growth year rather than a steady state, and the census at month 24 is not the programme's terminal size**. Raising referral throughput or adding a second enrollment pathway moves the PCM arm materially; it does very little for RPM once the ceiling is reached.

Recurring-revenue mechanics

Each month's enrolled census re-bills, so revenue is a function of census and capture rate rather than of visit volume. Year 2 net reimbursement ($3,021,184) is 3.0× Year 1 ($1,011,459) on the same referral engine, purely from census accumulation. Unit economics are modeled at approximately $110.19 of net reimbursement per RPM patient-month and $99.21 per PCM patient-month.

This is the structural difference between the service line and everything else in the practice's revenue mix. Imaging and procedural revenue is transactional — it exists when a patient is in the building. **A monitored census bills every month whether or not anyone is scheduled**, which is why a practice with an unusually technical, episodic revenue base has more to gain from it than a practice with a large cognitive book. *All figures are illustrative, modeled — verify against practice data.*

2.3 Connective tissue: one infrastructure, every lever

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

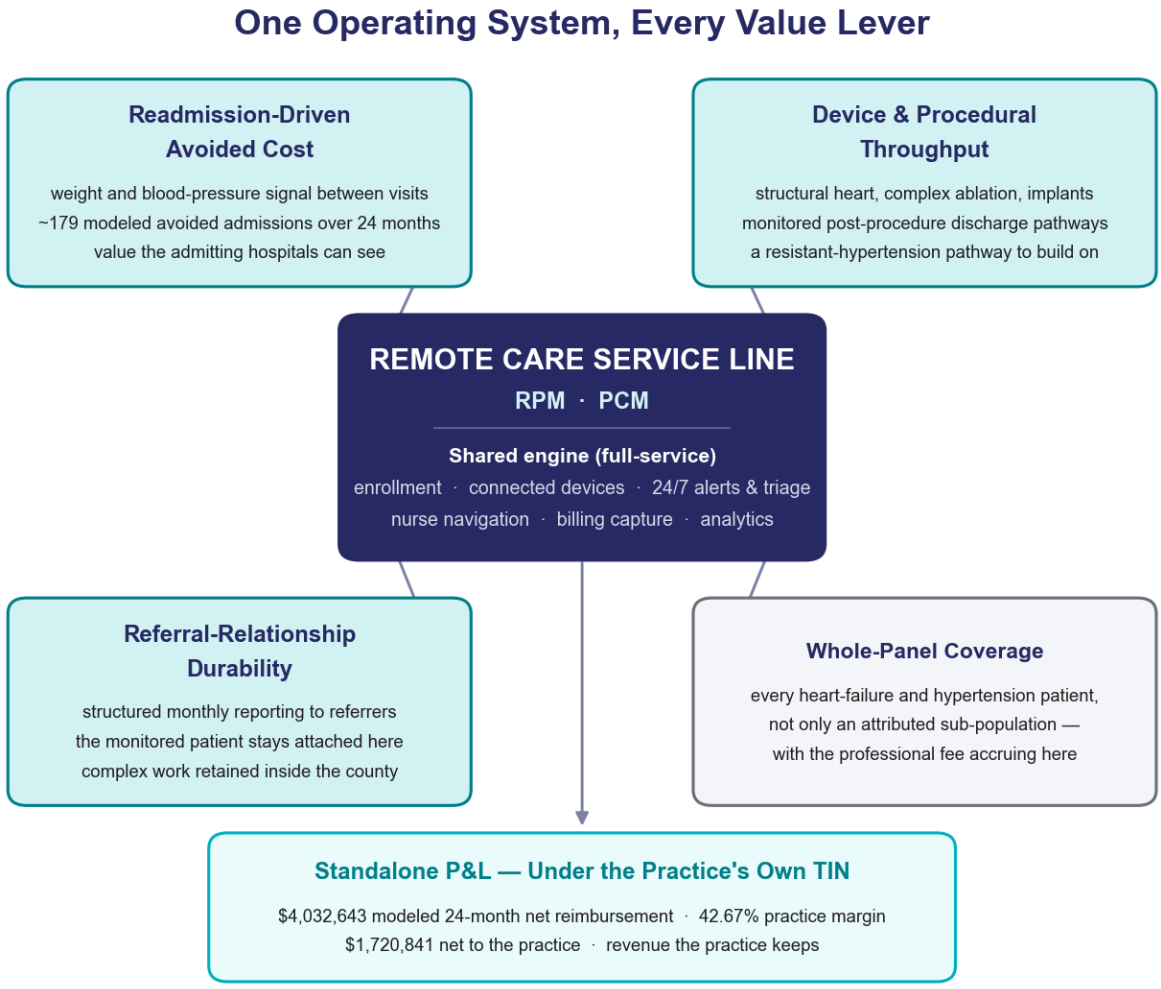

Figure 1. The Remote Care Service Line as connective tissue: one operating system producing the standalone P&L, readmission-driven avoided cost, referral-relationship durability, device and procedural throughput, and whole-panel coverage alongside the network's own care-coordination programme.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Standalone P&L — the lead layer	No mandatory model and no shared-savings reconciliation on the practice's own TIN, so the programme has to pay for itself on professional fees — and CY2026 code expansion (99445, 99470) widens what is billable	**$4,032,643 of modeled 24-month net reimbursement at a 42.67% practice margin** — billed under the practice's own TIN, dependent on no reconciliation and no third party's agreement
Readmission-driven avoided cost	A panel running 24–56% heart failure and 34–74% atrial fibrillation, with no named heart-failure pathway evidenced and no between-visit data layer	Daily weight and blood-pressure signal with 24/7 triage turns deterioration into a same-week outpatient intervention instead of an emergency-department visit. Modeled at ~179 avoided admissions over 24 months — illustrative, modeled
Referral-relationship durability	Complex structural and rhythm work is pulled toward quaternary centres 50–70 miles east, and the group has responded by recruiting operators affiliated with those centres	A monitored patient with a monthly touch stays attached to this practice. Structured monthly reporting back to the referring physician is both good practice and a referral-retention mechanism (Section 6)
Device and procedural throughput	Structural heart, complex ablation, implants and lead extraction — all performed inside hospitals the group does not own, where bed-days are the binding constraint	A monitored discharge pathway converts a post-procedure bed-day into a same-or-next-day discharge, and short-window RPM makes the recovery period billable (Section 7)
Whole-panel coverage	The network's RN care-coordination programme is scoped to an attributed, high-utilization sub-population, and the practice bills nothing for it	The service line covers the whole panel continuously, with the professional fee accruing to the practice's own TIN. Complementary rather than duplicative — and one attribution policy keeps it that way (Section 5)
Transitional care *(identified, not modeled)*	The group's physicians round and operate inside the county's principal cardiac hospital, so it generates its own discharge flow — and its own network already publishes guidance telling member practices to bill this service	The same enrollment and monitoring engine covers the 30-day window; short-window RPM is billable today via 99445, and TCM remains a separate decision the practice can take on its own merits

Read that table one way and it is six separate problems, each with its own project plan, its own budget line and its own reason to be deferred. Read it the other way and it is **one asset, built once and paid for once, that answers all six**. The practice already owns the hardest input to that asset — a working remote-data habit in cardiac rhythm, with clinicians who already act on data that arrives between visits. What it does not yet own is the physiologic data layer, the enrollment engine and the billing capture that turn a habit into a service line.

3. 2026 Policy, Payment and Contracting Environment

Three things shape what is buildable here in 2026: what CMS now pays for, what the county's payer structure supports, and what California law permits a services agreement with a professional medical corporation to look like.

3.1 The CY2026 fee schedule: remote care gets more billable

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

Why the short-window codes matter more here than at most cardiology groups. This practice's revenue is dominated by procedures and imaging rather than by office visits, and the population it sees is therefore episodic by construction: a patient arrives, is imaged or treated, and leaves. Before 2026 the days immediately after those episodes were clinically the most consequential and financially invisible. **A code that pays for two to fifteen days of data is a code written for exactly this practice's shape.**

3.2 The market: a majority fee-for-service county, and a growing one

Year	Total Medicare beneficiaries	Traditional fee-for-service	FFS share	Medicare Advantage	MA share
2019	149,920	97,537	65.1%	52,383	34.9%
2022	161,223	96,864	60.1%	64,359	39.9%
2023	165,508	98,379	59.4%	67,129	40.6%
2024	169,916	99,265	58.4%	70,651	41.6%
2025	**174,236**	**101,650**	**58.3%**	**72,586**	**41.7%**

CMS Medicare Monthly Enrollment, Ventura County (FIPS 06111), annual figures; April 2026 release, dataset modified July 23, 2026. Dual-eligible beneficiaries reached 30,118 in 2025, 17.3% of the county total.

Two readings follow, and the second is the one that matters. First, **Ventura County is not an Advantage-dominated market**. At 41.7% it sits below the national Medicare Advantage average and well below California's most penetrated counties — this is not an Orange County or a Los Angeles County payer structure. Second, and more usefully, **the traditional fee-for-service pool has grown in absolute terms across the whole period** — 97,537 beneficiaries in 2019 against 101,650 in 2025 — while the county's total Medicare population grew 16.2% and Medicare Advantage absorbed most of that growth. **The billable denominator is stable and growing, not shrinking**, which is exactly the condition under which a fee-for-service benefit is worth building a service line on.

The honest counterweight on payer mix

The Advantage share is rising roughly half a point a year, and a delegated independent practice association operating in precisely this service area contracts for Medicare Advantage and commercial HMO business across the county. **Whether this practice holds a contract with it could not be confirmed from any public directory** — a commercial firmographic file asserts the affiliation; no public source corroborates it.

Two things are genuinely unknown and neither can be resolved without asking. **Whether any of the practice's Advantage volume is capitated at all** — in California, specialists under a delegated association are far more often paid fee-for-service off a fee schedule out of the professional risk pool than sub-capitated, and sub-capitation of interventional cardiology is uncommon, so the working assumption is fee-for-service with the association rather than CMS as payer. And **whether Advantage and commercial plans in this market pay 99453, 99454, 99457, 99458 and 99424–99427 at all, and at what rate**.

This is the number-one discovery item on this account, and no public source can supply it. Everything in Section 2.2 is modeled on the traditional-Medicare channel; Advantage and commercial volume is a separate, additive conversation.

3.3 No mandatory model exposure, and no shared-savings offset

Two verification questions were run to conclusion, and both came back clean in the practice's favour.

First, on CMS model exposure: no mandatory model exposure — pure-upside timing, and prepared if selection maps change. Nothing in this report depends on a compliance deadline, and the practice is under no clock it did not choose. The verification was run against the current published participant files and should be re-run against each subsequent vintage as a matter of routine.

Second, on shared savings, the finding is more useful than it first looks. The practice's membership of a clinically integrated network and of the Dignity Health Care Network directory is confirmed by those networks' own directories. But the CMS Medicare Shared Savings Program participant files were searched in full for both PY2025 and PY2026 — 15,192 and 15,370 participant rows respectively — and **the practice appears in zero rows in either year**.[12] This report therefore makes **no claim of accountable care organisation participation**. The nuance is worth stating plainly rather than glossing: specialists commonly participate as ACO providers or suppliers under another entity's participant TIN, and only participant TINs appear in that file, so a negative there is not proof of non-participation in the network's programme. What it does establish is that **the practice almost certainly carries no direct shared-savings risk on its own TIN**.

Why that is a selling point rather than a footnote. The standard objection to adding billable services inside a value-based structure is that incremental Part B spending shows up against a total-cost-of-care benchmark and is clawed back at reconciliation. **On this practice's own TIN, that mechanism does not appear to exist** — which means every dollar of RPM and PCM reimbursement is incremental Part B revenue with no offset against it. *Confirm directly whether any of the group's clinicians are listed as ACO providers or suppliers under the network's participant TIN*, because that is the one arrangement that would change the analysis, and it is not discoverable from public files.

[12] CMS Medicare Shared Savings Program Accountable Care Organization Participants, PY2025 (15,192 rows) and PY2026 (15,370 rows), dataset modified February 4, 2026, and the corresponding Accountable Care Organizations files, modified April 16, 2026. Zero participant rows match this practice in either year, and no accountable care organisation is registered under the network's brand name in either year. Only participant TINs appear in that file; clinicians participating as ACO providers or suppliers under another entity's participant TIN would not appear, so this is not proof of non-participation in the network's programme.

3.4 California contracting: what the commercial structure has to look like

A design constraint, settled up front

California prohibits general business corporations from employing physicians or controlling medical decision-making, and this practice is structured as a professional medical corporation whose shares must be held by licensed physicians. The fee-splitting provisions of the California Business and Professions Code apply alongside it. **The consequence for this engagement is specific and unambiguous: a percentage-of-collections model is a non-starter**.[13]

The structure this report assumes is a services and technology agreement with the medical corporation at fair market value — a flat or per-enrolled-patient fee — with the group retaining clinical control, supervising the clinical work, and billing the codes itself under its own TIN. The CoachCare fee line in Section 2.2 is modeled on that basis.

Stating this first is not a caution; it is how a serious proposal to a California medical corporation opens. The group's counsel will raise both doctrines, and an engagement designed around them from the beginning does not have to be re-papered later. *This is a general description of California law, not legal advice on this account — the structure should be reviewed by the practice's own healthcare counsel.*

One more structural point that follows from the same doctrine, and it is in the practice's favour. Because the group must retain clinical control and must bill the codes itself, the service line necessarily accrues to the practice rather than to a vendor. The professional fee, the patient relationship, the clinical protocols and the data all stay inside the medical corporation. For an independent group fifty-five years into its own ownership, the legal constraint and the commercial preference point in the same direction.

[13] California's corporate practice of medicine doctrine prohibits general business corporations from employing physicians or controlling medical decision-making; California Business and Professions Code section 650 governs fee-splitting and rebates. This is a general description of California law and not legal advice on this account. The commercial structure should be reviewed by the practice's own healthcare counsel before it is proposed.

4. Performance Snapshot: The Starting Position

4.1 The panel: hypertension at the cap, heart failure to 56%, atrial fibrillation to 74%

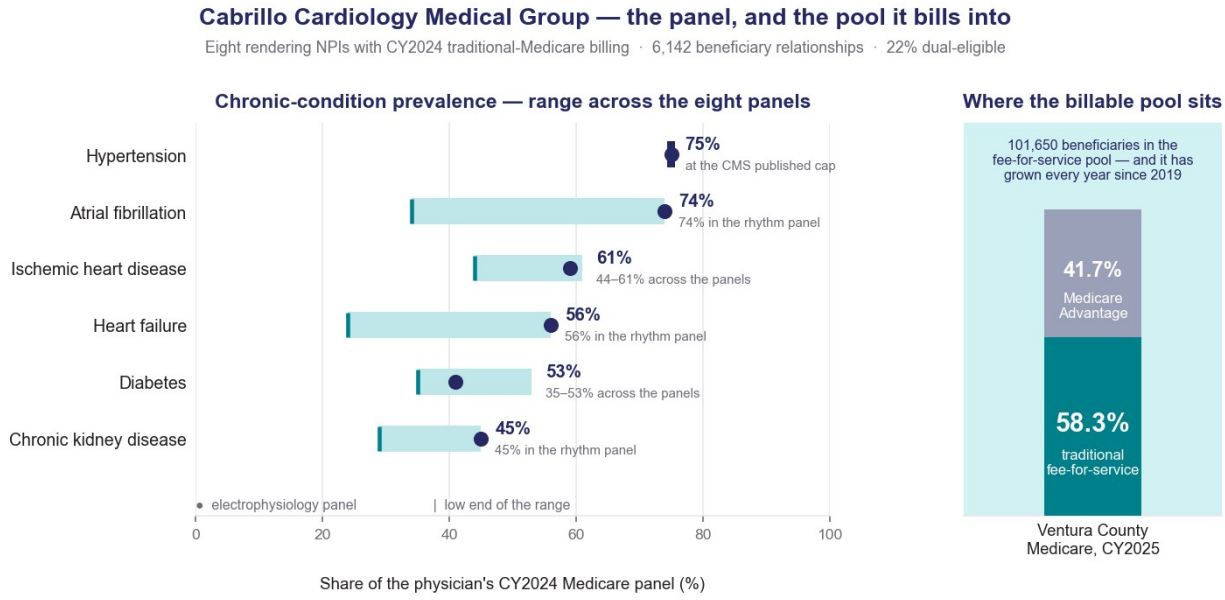

Figure 2. Chronic-condition prevalence across the eight CY2024 rendering panels, with the electrophysiology panel marked separately, against the county payer split. CMS Medicare Physician & Other Practitioners — by Provider, CY2024 (dataset modified May 21, 2026); CMS Medicare Monthly Enrollment, Ventura County, CY2025.

Condition	Range across the eight CY2024 panels	Rhythm panel	Read
Hypertension	**75% — uniformly, at the CMS published cap**	75%	The cap means 75% or more, not exactly 75%. Effectively the entire panel
Atrial fibrillation	34% – 74%	**74%**	The widest dispersion in the group, and the signature of a genuine rhythm practice
Ischemic heart disease	44% – 61%	59%	Consistent with a mature interventional and coronary programme
Heart failure	24% – 56%	**56%**	No named heart-failure clinic or pathway is evidenced anywhere. This is the clearest structural gap and the natural first cohort
Diabetes	35% – 53%	41%	Compounds the hypertension and kidney burden
Chronic kidney disease	29% – 45%	45%	Relevant to titration tolerance and to fluid-management risk
Dual-eligible share	11% – 40% of each panel	21%	Against 17.3% of county Medicare beneficiaries. Drives the coinsurance workflow (Section 2.2)

What this panel is, in one sentence: a hypertensive, heart-failure-heavy, atrial-fibrillation-heavy, kidney-compromised population in which essentially every patient carries two or more chronic conditions. **That is the eligibility bar for monthly care management and the textbook indication for remote physiologic monitoring, met by the practice's existing panel without recruiting a single new patient.** The electrophysiology panel is the sharpest version of it — 56% heart failure and 74% atrial

fibrillation on 972 beneficiary relationships — and it is also the panel whose patients already carry monitoring devices and are already accustomed to the practice looking at their data between visits.

Two honest qualifications on these figures

CMS publishes these chronic-condition percentages with **a cap at 75%**, so a panel reported at 75% hypertension may be considerably higher. The cap runs in the practice's favour here — it means the hypertension figure is a floor — but it should not be quoted as a precise prevalence.

These are **per-rendering-NPI** figures describing each physician's own Medicare panel, and the 6,142 beneficiary total is a sum of those panels, so a patient seen by two of the group's cardiologists is counted twice. The figures describe the *composition* of the practice's Medicare population accurately; they do not give a unique-patient count, and no public file can.

4.2 The service record: rhythm monitoring running, the physiologic layer empty

This is the finding the whole report turns on, and it needs stating precisely, because the careless version of it is both wrong and insulting. **This practice is not a remote-monitoring novice. It is a remote-monitoring operator that has not yet been paid for the physiologic half of the work.**

	Cardiac rhythm and device monitoring	Remote physiologic monitoring (99453 onward)
What is measured	The implanted device's own telemetry, or a rhythm recorder's — arrhythmia episodes, device diagnostics, lead integrity	Patient-generated physiologic data from a separate connected device — blood pressure, weight, pulse oximetry
Who it covers	Patients carrying a pacemaker, defibrillator, insertable cardiac monitor, ambulatory patch or telemetry unit	Any patient with a qualifying condition — the great majority of this practice's heart failure and hypertension panel carries no implanted device at all
What clinical question it answers	Has an arrhythmia occurred, and is the device working	Is this patient decompensating, is the blood pressure controlled, is the titration working
Status at this practice	**Published on the practice's own service pages** — insertable cardiac monitors, mobile cardiac telemetry described as transmitting arrhythmias wirelessly to clinicians, 14-day ambulatory patch, Holter and symptom-triggered event recorders, and implanted-device checks every three to six months	**No public evidence of any kind** — no programme page, no named device or monitoring vendor, no care-management job posting, no code-set evidence

The practice's own published electrophysiology and patient-resources pages, retrieved August 3, 2026, and a public-source sweep across CMS billing data, job boards and vendor material.

Two things follow, and they matter more than anything else in this report. First, **the objection that a practice this size could not run a remote programme is pre-answered by the practice itself**. Somebody here already receives transmissions that arrive between visits, decides which ones matter, escalates the ones that do, and documents the result. That is the operational core of a remote care programme, and it is already running. Second, **the layer CMS pays for separately — blood pressure, weight, pulse oximetry, and the monthly management time attached to them — appears nowhere**. A group with a 24–56% heart-failure panel and a 75%-plus hypertension panel is not collecting a single reimbursable home blood-pressure reading that this research could find.

What the absence of evidence does and does not establish

Stated at its true strength: **no physiologic remote-monitoring or care-management programme is visible in any public source** — the practice's own website carries no programme page and names no monitoring vendor; no care-coordinator, chronic-care nurse or remote-monitoring role appears on the job boards that were reachable; and no code-set evidence surfaced. Multiple independent sources point the same way.

Stated at its true limits: this is **absence of evidence, not proof of absence**. A programme launched recently would not yet be visible in published claims data; CMS suppresses low-volume lines; and Medicare Advantage or commercial activity would not appear in Medicare fee-for-service data at all. *Confirm current-state programmes directly in discovery — this is the single most important question to ask, and the answer changes the shape of the proposal either way.*

The equally important open question is the other half: **who reviews the rhythm transmissions today, on which platform, whether those transmissions are billed, and whether that team has spare capacity**. Nothing public answers it, and the answer determines whether the physiologic programme attaches to an existing workflow or stands up beside it.

4.3 The revenue picture, and why the commercial figure understates it

The CY2024 CMS Medicare Physician and Other Practitioners file was queried NPI by NPI across the ten reassigned clinicians. Eight have CY2024 records; two do not.[14] These figures are traditional Medicare Part B fee-for-service only — Medicare Advantage encounters are excluded by construction — so **every dollar below sits in the channel that RPM and PCM bill into**.

Measure	Value	What it means
CY2024 Medicare allowed, all eight rendering NPIs	**$12,207,641**	Sum across the eight NPIs with CY2024 billing
Conservative floor, excluding the one physician whose CMS practice address is a Los Angeles academic medical centre	**$10,873,144**	That physician carries two employer associations, so an unknown share of his volume belongs to the academic centre rather than to Cabrillo. Use this figure
Commercial firmographic file's reported figure	$7,534,472	62% below the full CMS sum, and 31% below the conservative floor. Almost certainly an older vintage, a subset of NPIs, or a TIN-level rather than rendering-NPI roll-up
Beneficiary relationships	6,142	A sum of per-provider counts containing duplication — not a unique-patient count
Services	148,943	Across the eight panels
Services per beneficiary, largest panels	~31 – 44	An office-visit-only cardiologist runs 3–6. This confirms a technical-component-heavy, imaging- and procedure-dominated revenue base
Services per beneficiary, electrophysiology panel	~7.8	The lowest ratio in the group against one of the largest allowed amounts — the signature of high-value ablation and device work
Dual-eligible beneficiary relationships	1,358 (22%)	Ranging from 11% to 40% by panel. Drives the coinsurance workflow

[14] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (file MUP_PHY_R26_P05_V10_D24_Prov.csv, dataset modified May 21, 2026), queried by each of the ten reassigned NPIs. Eight carry CY2024 records; two do not. Totals: $12,207,641 allowed, 6,142 beneficiary relationships, 148,943 services, 1,358 dual-eligible beneficiary relationships. These figures are traditional Medicare Part B fee-for-service only - Medicare Advantage encounters are excluded by construction. Beneficiary counts are per-provider and contain duplication.

The direction of the error is the point. It would be easy to look at a commercial file reporting $7.5 million across nine physicians and conclude the practice is smaller than it is. The CMS record says the opposite: **this is a larger fee-for-service book than the commercial data describes, by at least 44% on the conservative floor and 62% on the full sum**. A practice with an $10.9 million traditional-Medicare book is not a capitated group, and it is not a marginal one. It also means the in-scope base in the financial model is being measured against a bigger practice than the file suggests.

4.4 Position in the market

The hospital landscape in and around the practice's catchment, with CMS Certification Numbers resolved from the CMS Hospital Enrollments file:

Hospital	CCN	Relationship to this practice
Dignity Health St. John's Regional Medical Center, Oxnard	**050082**	**The practice's primary admitting site**. A STEMI receiving centre and the county's only comprehensive stroke centre, with a Camarillo sister campus. The group's physicians hold the cardiovascular service line, chest pain centre, cardiac rehabilitation and department-of-medicine leadership here — a decades-old relationship and the practice's single largest strategic asset
Community Memorial Hospital, Ventura	050394	Second listed affiliation. Independent nonprofit system; a new Ventura tower opened in 2018, and the system has been through a chief-executive transition and a service-line consolidation since 2022
Community Memorial Hospital – Ojai	051334	Critical access hospital, same system
Ventura County Medical Center	050159	County safety-net system. Not a direct cardiology competitor, but it shapes the county's payer landscape
Adventist Health Simi Valley	050236	East-county acute care, outside the Oxnard and Camarillo core

CMS Hospital Enrollments file (Hospital_Enrollments_2026.07.17.csv, dataset modified July 27, 2026), filtered to California ZIPs beginning 930. Note that the CMS record for CCN 050082 carries a Camarillo trade name at an Oxnard address, consistent with the two Dignity campuses operating under a single certification.

The competitive dynamic worth understanding is centrifugal, and this group has answered it unusually well. Complex structural and rhythm work in Ventura County is pulled east toward quaternary centres fifty to seventy miles away. Rather than lose those cases, **this practice has clinicians on both sides of that gradient** — one of its electrophysiologists also practises at a major Los Angeles academic medical centre, and one of its structural operators carries a CMS-registered practice address at another. Read plainly, the group appears to be **retaining complex work inside the county by recruiting operators affiliated with the centres that would otherwise take it**.

That strategy has a soft flank, and it is the one this report addresses. Retention works at the moment of referral, but a patient's attachment to a practice is renewed between visits, not during them. A heart-failure patient seen twice a year has two touchpoints with this group and, in a county with a well-resourced network care-coordination programme and two large systems, many more with everyone else. **A monitored patient with a monthly contact and a structured monthly report going back to their primary-care physician has twelve**. That is the retention argument, and it is at least as strong as the revenue one.

One item flagged for handling rather than for use. A May 2024 local-press headline raised concerns about a shift to remote and centralised cardiac telemetry monitoring at the practice's primary admitting hospital's system. **The article body could not be retrieved, so the specifics — who raised the concerns, what changed, and how the system responded — are entirely unverified**, and nothing in it concerns this practice. It is noted here only because it means the phrase “remote monitoring” may carry a

local valence in this market that it does not carry elsewhere. *Do not raise it. Read the full article before any meeting, and be ready if the customer raises it.*

5. The Network Care-Coordination Programme — and the Layer Beside It

Read this section before the first meeting. The practice already has access to a real, staffed care-coordination programme through its clinically integrated network. Any proposal that appears unaware of it will be answered in one sentence — *"our network already does that"* — and the conversation will be over. It is also, on the evidence, **a good programme**, and this section describes it as one.

5.1 What the network programme is

Cabrillo is a listed member location of SCICN-VC (Southern California Integrated Care Network – Ventura County), a physician-led clinically integrated network affiliated with Dignity Health, and is separately listed in the Dignity Health Care Network location directory.[15] SCICN-VC publishes two relevant resources for its physician members:

- **An Ambulatory Care Coordination Programme**, staffed by care coordinators described as registered nurses with access to other clinical and social support professionals. Its stated target population is patients with two or more chronic conditions, multiple chronic or high-risk medications, multiple emergency-department visits or hospitalizations, social barriers such as living alone without caregiving support, and other provider-identified needs. Its stated services include personalised goals and self-management strategies, keeping patients in regular office visits at the member practice, medication adherence and risk assessment, prevention of avoidable admissions, transition-of-care planning and behavioural health screening. Referral is physician-initiated and supplemented by the network's own analytics-driven case-finding, and governance is described as physician-directed, with face-to-face meetings and shared care plans and outreach reports returned to the practice.
- **A transitional care management resource** covering the 30-day post-discharge window across acute, psychiatric, long-term care, skilled-nursing and rehabilitation discharges — which explicitly advises member practices to work with their coding and billing staff before implementation **so that the practice bills for the service**.

> **Said plainly, because it is true**
>
> This is an incumbent capability, not a paper programme. It is registered-nurse staffed, it is analytics-driven, it is physician-governed, and it appears to be available to member practices at no direct cost. A practice that uses it well is getting real value. **Nothing in this report is improved by pretending otherwise**.

5.2 What it covers, and what sits beside it

The two things are scoped differently along three axes — population, economics and modality. None of these is a criticism of the network programme; they are descriptions of what each instrument is for.

	The network's care-coordination programme	A practice-owned remote care service line
Population	Patients with two or more chronic conditions plus repeat emergency-department or hospital use, plus cases surfaced by the network's analytics — a high-utilization sub-population inside the network's attributed panel	**The whole panel, continuously** — every heart-failure and hypertension patient the practice sees, whether or not they have been admitted recently and whether or not they are attributed to the network

[15] SCICN-VC care-coordination page for physicians and transitional care management page, and the SCICN-VC and Dignity Health Care Network location listings for this practice, all retrieved August 3, 2026. The programme's staffing, target population, service list, referral routes and governance are quoted from the network's own published wording. Whether this practice uses the programme, how many of its patients are touched, how the programme is funded and whether any exclusivity or preferred-vendor terms exist are not disclosed publicly and are carried to the discovery agenda.

	The network's care-coordination programme	A practice-owned remote care service line
Economics	**The practice bills nothing for it**. The coordinator's time is the network's cost, and the network's economics are shared-savings — value that accrues to the network's performance rather than to the practice's profit and loss	**The professional fee accrues to the practice**, billed under its own TIN, under the codes in Section 2.1. Modeled at $4,032,643 of net reimbursement and $1,720,841 net to the practice over 24 months — illustrative, modeled
Modality	Telephonic and in-person coordination, medication adherence, goal-setting, transition-of-care planning and behavioural health screening. Neither published page describes physiologic monitoring or the monthly care-management codes	Connected devices producing daily blood-pressure, weight and pulse-oximetry data with 24/7 alert triage, plus documented monthly clinical management time — a data layer, not only a contact layer
Direction of reporting	Shared care plans and outreach reports returned to the practice	Structured monthly reporting from the practice back to the referring primary-care physician — which is where the referral-retention value sits (Section 6)
Who owns the relationship	The network coordinator, working alongside the member practice	The practice's own clinical team, under the practice's own protocols, with the partner supplying the staffing and the infrastructure beneath it

The honest summary is that these are complementary instruments, and the network's own material says so implicitly. Its transitional-care guidance tells member practices to bill the service themselves. That is exactly the logic this report extends across the rest of the panel: the network handles what the network is scoped to handle, and the practice bills for the longitudinal management it delivers to everyone else. **The failure mode to avoid is not competition — it is duplication**, where a patient receives a call from a network coordinator and a call from the practice's care team in the same week for overlapping purposes. That is a workflow problem with a workflow answer, and it is solved by writing one attribution policy before the first enrollment rather than after the first complaint.

What is not known, and must be established in discovery

Whether the practice actually uses the network's coordinators today, and if so how many of its patients are touched, at what cadence, and with what satisfaction. Membership of a network is not the same as use of its programme.

Whether any Cabrillo staff time is reimbursed under the arrangement, and how the programme is funded at the network level. Pricing is not disclosed publicly.

Whether any exclusivity, preferred-vendor or data-sharing terms exist that would constrain a third-party service. This is the one finding that could change the shape of the engagement, and it is not discoverable from outside.

Whether the delegated independent practice association operating in this county supplies a second care-management capability for its Medicare Advantage members. Its public pages describe utilization management but not disease management — which is not the same as it not existing.

The position to take into the room, in one sentence: the network covers transitions and high utilizers inside an attributed panel and the practice bills nothing for it; the service line covers the whole panel continuously and the professional fee accrues to the practice. **Both can be true at once, and the practice is better off with both than with either.**

6. Readmission Defence and Referral Durability

The second value layer is the one the practice does not bill for directly and should still care about, because it is what makes the service line defensible to everyone around it — the admitting hospitals, the referring physicians, and the network.

6.1 The clinical mechanism, stated without exaggeration

A heart-failure patient decompensates over days, not minutes, and the earliest reliable signals are weight gain and blood-pressure change. In the current state those signals exist and nobody sees them: the patient is weighed at a visit a quarter away, and the intervening trajectory is invisible. **Daily weight and blood-pressure data with 24/7 triage converts that trajectory into an actionable alert, and converts what would have been an emergency-department presentation into a same-week outpatient intervention** — a medication change, a diuretic adjustment, a nurse call, a brought-forward visit.

The Value Analysis models that mechanism at **approximately 179 avoided hospitalizations across 24 months** on the modeled enrolled census — on the order of **$2.7 million at an illustrative $15,000 per admission**. **Two qualifications, both important.** That value accrues to the payer and to the admitting hospital, not to the practice's profit and loss — it is not double-counted anywhere in Section 2.2. And it is modeled rather than measured: *All figures are illustrative, modeled — verify against practice data.*

What this report deliberately does not claim

No county-level or hospital-level readmission benchmark for Ventura County was retrieved during this research, so **this report quotes no readmission rate for the county, the hospitals or the practice**. The avoided-admission figure above is a model output driven by the enrolled census and the modeled clinical effect, not a measured local gap.

That is a deliberate omission rather than an oversight. A physician audience will discount an entire document over one unsupported epidemiological claim, and the argument does not need one: the practice's own panel composition — 24% to 56% heart failure, 34% to 74% atrial fibrillation, 29% to 45% chronic kidney disease — is sufficient justification on its own. *Pull the local readmission and utilization benchmarks before any external use of this material.*

6.2 Why the hospital partners will see it

The group's physicians hold the medical directorship of cardiovascular services, the chest pain centre and cardiac rehabilitation at the county's principal cardiac hospital and its sister campus, and the chair of its department of medicine. **The clinicians who determine what happens after a cardiac discharge, and the institution that carries the consequence of it, are already in the same room** — which is a materially better starting position than most independent groups have.

A post-discharge capability that measurably reduces avoidable readmissions is worth something specific to a hospital partner, and a group that arrives with working data is negotiating from a different position than one arriving with a proposal. **The sequencing point is the one that matters, though: none of this requires a hospital's agreement to begin**. The transitional-care and short-window remote-monitoring revenue is the practice's own, billed under its own TIN, whether or not any hospital ever co-invests a dollar. Build it first; have the conversation second.

One condition on any hospital-supported arrangement

Any arrangement in which a hospital or health system supports, subsidises or co-invests in physician-practice services must be structured to comply with the physician self-referral and anti-kickback rules — and, in California, alongside the corporate-practice and fee-splitting constraints in Section 3.4. *Take that structure to healthcare counsel before it is proposed, not after.*

6.3 Referral durability, which is the quieter half

The practice's referral position rests on two things: the hospital leadership relationships, and the primary-care physicians who send patients. The first is secure. The second is renewed or eroded every quarter, and it is renewed by what the referring physician hears back.

- **A structured monthly report is a referral instrument.** Enrolled patients generate a monthly summary — readings, trend, interventions, medication changes, escalations — that goes back to the referring primary-care physician as a by-product of the programme rather than as a separate administrative effort. A referring physician who receives twelve structured updates a year from this practice, and two from another, is not making a close decision.
- **Attachment is renewed between visits, not during them.** A patient with a monthly contact, a device in the home that this practice supplied, and a care team they can reach is attached to this practice in a way a twice-yearly office visit does not achieve — particularly in a county with two large systems and a well-resourced network coordination programme both touching the same patients.
- **It protects the complex-case retention strategy.** The group's approach to quaternary leakage has been to recruit operators affiliated with the centres that would otherwise take the work. That secures the procedure. A monitored longitudinal relationship secures everything that happens before and after it, which is where the durable revenue and the durable relationship both sit.
- **It gives the practice its own data.** Enrollment counts, adherence, alert-to-contact times, blood-pressure control rates and readmission deltas against the unenrolled panel are the practice's own measurements, on its own patients, in its own system. Whatever conversation comes next — with a hospital, with a network, with a plan — is better with that data than without it.

7. Powering Device and Procedural Throughput

Remote care is usually sold as a chronic-disease programme. In a group with this procedural profile it is also a throughput instrument, 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**. Every one of this practice's procedures is performed inside a hospital it does not own, which means bed-days are somebody else's constraint on the group's own volume — and the CY2026 short-window codes now pay for exactly the days in question.

Procedural line	What the practice publishes	What the service line adds
Structural heart	Transcatheter aortic valve replacement, patent foramen ovale closure and left atrial appendage occlusion, delivered by operators with quaternary-centre affiliations	Post-procedure blood-pressure and weight monitoring in the 2–15 day window, now billable via 99445; earlier discharge; structured anticoagulation follow-up — the highest-risk and least-supervised fortnight in the whole pathway
Electrophysiology — ablation and device implant	Complex ablation across atrial fibrillation, flutter, ventricular tachycardia, supraventricular tachycardia and premature ventricular complexes; pacemaker and defibrillator implant and generator change; lead extraction; insertable cardiac monitors	Post-ablation and post-implant physiologic monitoring sits *alongside* — not inside — device and rhythm monitoring. 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)
Peripheral vascular	Doppler and carotid imaging, endovascular intervention, varicose vein ablation	Short-window post-procedure monitoring, and a natural feeder into the hypertension pathway below — peripheral disease and uncontrolled blood pressure travel together
Hypertension and renal denervation	**No evidence of renal denervation** on the practice's published procedure list or anywhere in the public record. What the practice does have is a panel running at or above 75% hypertension across every one of its eight CY2024 Medicare panels	**Policy-aligned whitespace, not a current capability.** CMS national coverage determination 20.40 covers renal denervation for uncontrolled hypertension effective October 28, 2025 under Coverage with Evidence Development. Blood-pressure remote monitoring is intrinsic to that pathway — for candidate identification, for titration, and for the evidence the coverage condition requires

Read the renal-denervation row as an option, not a plan. Nothing in the public record indicates this group performs the procedure today, and this report does not assume it will. The point is narrower and more useful: a practice with a hypertension panel this large, a mature interventional bench, and — once this service line is running — blood-pressure monitoring at scale, is in the natural position to build a resistant-hypertension pathway. That pathway is the prerequisite for the procedure whenever the group chooses to look at it, and it is worth building on its own merits regardless.

The research infrastructure is an unexplored asset

The practice publishes a named clinical-research page listing cardiovascular outcome trials, registries and heart-failure cell-therapy studies with two named principal investigators. **Most listed enrollment dates fall between 2012 and 2016, and current activity is entirely unconfirmed** — this is flagged as a question, not asserted as a capability.

If that infrastructure is still staffed, it matters more than it looks. A practice with an active research coordinator has already demonstrated it can run protocol-driven, consent-based, documentation-heavy longitudinal follow-up on a defined cohort — which is a precise description of a remote monitoring programme. *Ask whether the research function is still running. It is a good question and a good opener.*

8. eClinicalWorks Integration & Technology Architecture

8.1 What is verified about the platform — and what follows from it

Confirmed, from direct evidence

The practice runs eClinicalWorks, on eClinicalWorks' cloud-hosted infrastructure. The patient portal linked from the practice's own patient-resources page resolves to a per-practice tenant on eClinicalWorks' hosted multi-tenant portal cluster, with a practice-specific portal identifier and the vendor's own portal stack, and one-time-passcode login enabled. The contact page references the same host independently.[16] This corroborates the commercial firmographic file's ambulatory EMR field, which is correct.

Why cloud-hosted matters commercially: eClinicalWorks is among the more integration-friendly ambulatory records — it exposes FHIR R4 interfaces and supports an established third-party application ecosystem — and a cloud-hosted tenant avoids the virtual-private-network and on-premises interface work a self-hosted deployment requires. **This is a favourable integration profile, and it removes the single most common source of delay in standing up a programme of this kind.**

What is not verified: the specific product version and edition, whether the practice licenses the vendor's patient application, whether any interface budget exists, and who owns the information-technology relationship. *Confirm all four before any integration scoping, timeline or contractual commitment.*

8.2 What the integration does

The integration pattern on a cloud-hosted eClinicalWorks tenant is well-trodden. What it delivers:

- **Enrollment inside the chart.** Referral to the service line is one order in the existing record, not a separate system, a separate login or a paper form.
- **Enrollment status visible in real time.** Whether a patient is enrolled, which programmes they are on, and which device they hold — visible to the clinician at the point of the next decision rather than in a monthly report.
- **Structured clinical exchange.** Health history out; vitals, evidence of care and care plans back into the chart on a monthly cadence, so the record the practice is audited on is the record it already keeps.
- **Automated claim generation.** The monthly per-patient claim is generated by the billing engine rather than assembled by hand.
- **A clean separation from the rhythm-monitoring workflow.** Physiologic data lands in its own defined place in the chart, distinct from device and rhythm transmissions, so the documentation boundary in Section 2.1 is enforced by the architecture rather than by anyone's memory.

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

8.3 Why automated claim generation matters here specifically

This is not a general benefit; it is the specific difference between a programme that runs at this practice and one that does not. At a modeled census of **2,790 active programme enrollments at month 24**, across two offices and twelve referring clinicians, 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 67,002 billed units over 24 months.** A practice whose administrative layer is small enough that no administrative leader is named on its own

[16] The practice's patient portal, linked from its own patient-resources page and referenced independently from its contact page, resolves to a per-practice tenant on eClinicalWorks' hosted multi-tenant portal cluster, with a practice-specific portal identifier, the vendor's own portal stack and one-time-passcode login enabled (verified live, August 2026). This is direct evidence of a cloud-hosted rather than self-hosted deployment. No job posting, vendor case study or press mention naming the platform was found; the confirmation rests on the portal evidence, which is strong.

website cannot assemble that by hand, and the failure mode is not a rejected claim; it is a programme that quietly stops billing what it delivers. Automated generation from the monitoring record is what makes the capture rate in Section 9.5 a real operating metric rather than an aspiration.

There is a second reason specific to this account. This practice's billing operation is currently optimised for high-value, low-frequency events — procedures and imaging studies, at roughly 31 to 44 services per beneficiary in its largest panels but concentrated in a small number of code families. **A recurring, low-value, high-frequency monthly claim stream is a different operational problem**, and it is the one most likely to be under-captured if it is bolted onto an existing workflow rather than generated automatically.

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 base	7,307	Discovery-stage estimate — validate against chart counts. Wider than traditional Medicare alone
Referring clinicians	12	Ten reassigned to the group's own PAC ID plus the two physician assistants on the practice's site
Referrals per clinician 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% (5,480) / 35%	Modeled ceiling 1,918 patients; reached at month 21
PCM eligibility / acceptance	85% (6,211) / 30%	Modeled ceiling 1,863; at 872 at month 24 and still climbing
Monthly attrition	1.5%	Discharge from programme
Revenue basis	Net of a 7% realization discount	Payer mix and collection, as configured in the model
MAC locality	California, 01182-17	Auto-resolved for ZIP 93030

Target populations and clinical pathways

Population	Why it is first	Pathway
Heart failure — the electrophysiology cohort first	The rhythm panel runs 56% heart failure and 74% atrial fibrillation, and those patients already carry monitoring devices and are already used to this practice watching their data between visits. Lowest-friction enrollment in the practice	Weight and blood-pressure RPM with 24/7 triage; PCM as the monthly chassis; titration against measured response
Heart failure — the rest of the panel	Heart failure runs 24% to 56% across the eight panels, and no named heart-failure clinic or pathway is evidenced anywhere	Same pathway, seeded from the practice's own problem lists rather than from a device registry
Uncontrolled and resistant hypertension	Hypertension sits at or above 75% in every one of the eight panels — the CMS published cap, so a floor rather than a ceiling	Blood-pressure RPM; protocolised titration; the candidate pool for any future resistant-hypertension pathway (Section 7)
Post-discharge cardiac	The group's clinicians round and operate inside the county's principal cardiac hospital, so it generates its own discharge flow — and its network already tells member practices to bill this window	TCM 99495 / 99496 (not modeled) plus short-window RPM via 99445 / 99470
Post-ablation, post-implant and post-structural-heart	A mature structural and rhythm bench, every case performed facility-side and every case opening a short window that is now billable	Short-window RPM (99445), kept explicitly distinct from device and rhythm monitoring

9.2 Staffing: nobody has to be hired

The model delivers **30,479 care-team hours over 24 months — approximately 14.7 full-time equivalents** — supplied by the partner under the practice's protocols and clinical supervision, alongside 134,004 care-management tasks, 33,501 chart updates, 20,101 patient conversations and 1,117 hours of call time. For a group with one nurse practitioner and two physician assistants across nine physicians, and no care-coordinator or chronic-care nurse role visible on any reachable job board, this is the layer that makes the programme possible at all rather than a nice-to-have. **The on-site enrollment specialist is funded by CoachCare — embedded value that is never deducted from the practice's margin, and never a practice cost line.**

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

Bilingual staffing is a design requirement on this account, not an enhancement

This programme runs on monthly outbound telephone contact. In Ventura County, **30.2% of residents speak Spanish at home and 14.9% speak English less than "very well"**; 24.9% of the county's Medicare beneficiaries are Hispanic or Latino, and Oxnard is the county's agricultural centre.[17] At that language profile, Spanish-language enrollment scripting, Spanish device onboarding and Spanish-speaking care-management staff are gating requirements for enrollment and adherence — not phase-two enhancements.

Raise it proactively rather than waiting to be asked. **Where it can be staffed it is a genuine differentiator on this account; where it cannot, it is a genuine disqualifier**, and finding that out in month one is far better than finding it out in month six. County language figures are U.S. Census Bureau American Community Survey 2024 five-year estimates; the practice's own patient mix was not separately measured and should be confirmed.

9.3 "We already monitor remotely, and our network already coordinates" — the answer

Both objections are going to come up in the first meeting, and both are legitimate. Neither is answered by arguing. Both are answered by being precise about what is and is not already covered.

On remote monitoring

The comparison table in Section 4.2 is the answer, and it should be walked through rather than asserted. Rhythm and device monitoring reads the device's telemetry and answers whether an arrhythmia occurred; physiologic monitoring reads patient-generated blood pressure, weight and oxygen saturation and answers whether the patient is decompensating. Different data, different question, different benefit — and the great majority of this practice's heart-failure and hypertension patients carry no implanted device at all. The design rule is that the same data stream is never billed twice, and the documentation has to make that 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. It simply has not monetised the physiologic side of it.**

On network care coordination

Section 5 is the answer, and the tone matters as much as the content. The network programme is real, it is registered-nurse staffed, and it is valuable — say so first. Then be precise: it is scoped to an attributed, high-utilization sub-population; the practice bills nothing for it; and neither published page describes physiologic monitoring or the monthly care-management codes. **The practice-owned service line covers the whole panel continuously, with the professional fee accruing to the practice's own TIN**. The network's own transitional-care guidance already tells member practices to bill the service

[17] U.S. Census Bureau, American Community Survey 2024 five-year estimates, profile DP02 for Ventura County, California (language spoken at home, population 5 years and over), retrieved August 4, 2026; and CMS Medicare Monthly Enrollment (April 2026 release) for the Hispanic or Latino share of county Medicare beneficiaries, CY2025 - 43,333 of 174,236. County-level figures only; the practice's own patient language mix was not measured and should be confirmed in discovery.

themselves — this simply extends that logic to the rest of the panel. And write one attribution policy so no patient is contacted twice for the same purpose.

9.4 Clinical workflow

1. **Identify.** Heart failure, uncontrolled hypertension, post-discharge, post-procedure. Built from the practice's own record, seeded by the electrophysiology cohort and the discharge list.
2. **Enroll.** One order in the eClinicalWorks chart. Consent, device selection and logistics handled by the partner; the on-site enrollment specialist covers both offices in rotation, with a telephonic pathway behind it — and both pathways scripted in English and Spanish.
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 179 modeled avoided admissions actually come from.
5. **Titrate.** Guideline-directed therapy adjusted against measured response on a schedule rather than at the next quarterly visit, with PCM as the monthly billing chassis for the work.
6. **Document and bill.** Time, readings and interventions captured as a by-product of care; claims generated automatically from the monitoring record (Section 8.3).
7. **Report back.** Structured monthly reporting to the referring primary-care physician, and a defined hand-off convention with the network's care coordinators for any patient both programmes touch.

9.5 KPI dashboard and expected impact

Domain	Metric	Why it is on the dashboard
Clinical	Blood-pressure control rate; weight-alert response time; heart-failure admissions and 30-day readmissions among the enrolled census	These are the measures that make the avoided-cost argument in Section 6 measurable rather than modeled, and they are the practice's own data on its own patients
Operational	Enrolled census by programme; enrollment conversion rate; device compliance (days with data); alert-to-contact time; share of enrollments completed in Spanish	Census is revenue. Days-with-data is what makes 99454 and 99445 billable in the first place. The language split is the leading indicator of whether the programme is reaching the whole panel
Financial	Time to first billable enrollment; capture rate (billed ÷ eligible); net reimbursement per patient per month; net to practice; coinsurance collection rate	Modeled at ~$110.19 per RPM patient-month and ~$99.21 per PCM patient-month. Capture rate is the metric that quietly decides whether the modeled P&L is realised; coinsurance collection is the one that decides whether patients stay enrolled
Strategic	Readmission delta versus the unenrolled panel; referral retention by referring physician; overlap rate with the network's coordination programme	The numbers that make the group's contribution measurable rather than asserted — in a hospital conversation, in a network conversation, and in a plan conversation

Expected impact over 24 months, as modeled: $4,032,643 of net reimbursement and $1,720,841 net to the practice at a 42.67% margin; 2,180 unique patients and 2,790 active programme enrollments at month 24; 282,352 physiologic readings; 67,002 billed units; approximately 179 avoided hospitalizations; and 30,479 care-team hours delivered. *All figures are illustrative, modeled — verify against practice data.*

9.6 Twelve-month roadmap

Phase	Months	What happens
Charter	0–1	Physician lead named; service line chartered with its own P&L; target populations agreed; payer mix and code coverage confirmed (Section 3.2); the services and technology agreement papered at fair market value under the constraints in Section 3.4; attribution and coordination policy written before the first enrollment
Stand up	1–3	eClinicalWorks integration built and the physiologic data boundary defined against the existing rhythm workflow; alert thresholds and escalation protocol set by the physician lead; on-site enrollment specialist placed; bilingual enrollment scripting and device onboarding materials in place before the first patient is approached
First census	2–6	The electrophysiology heart-failure and atrial-fibrillation cohort enrolled first, then the wider heart-failure panel; first billable enrollment inside 90 days; month 2 is the first net-positive month in the model
Extend	6–9	Hypertension, post-discharge, post-ablation, post-implant and post-structural-heart pathways added; second enrollment pathway opened to move the PCM arm, which is enrollment-limited rather than eligibility-limited
Institutionalise	9–12	Monthly scorecard running; capture rate, coinsurance collection and readmission delta reported; the TCM decision taken on its own merits; the hospital and network conversations opened from a position of measured data rather than proposal

References & Data Sources

- **CMS Revalidation Clinic Group Practice Reassignment** (dataset modified July 14, 2026): the ten-clinician reassigned roster, group PAC ID 5890693279, group enrollment identifier O20031222000943, PECOS specialty designations, employer-association counts and the California revalidation date. Queried on group legal business name; a similarly named but unrelated San Diego rheumatology entity under a different PAC ID was identified and excluded.
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024** (file MUP_PHY_R26_P05_V10_D24_Prov.csv, dataset modified May 21, 2026), queried by each of the ten reassigned NPIs: allowed amounts, beneficiary and service counts, registered practice city, dual-eligible counts and the chronic-condition prevalence figures for heart failure, atrial fibrillation, hypertension, chronic kidney disease, diabetes and ischemic heart disease. Eight NPIs carry CY2024 records; two do not. Chronic-condition percentages are published with a cap at 75%.
- **CMS Medicare Monthly Enrollment** (April 2026 release, dataset modified July 23, 2026), queried on county FIPS 06111: total, traditional fee-for-service, Medicare Advantage, aged and dual-eligible beneficiary counts for Ventura County by year, 2019 through 2025, and the Hispanic or Latino beneficiary share.
- **CMS Medicare Shared Savings Program participants and organizations, PY2025 and PY2026** (participants file modified February 4, 2026; organizations file modified April 16, 2026): both participant files searched in full — 15,192 and 15,370 rows — returning zero rows for this practice in either year, and no accountable care organisation registered under the network's brand name in either year's organisation file.
- **CMS Hospital Enrollments** (Hospital_Enrollments_2026.07.17.csv, dataset modified July 27, 2026), filtered to California ZIPs beginning 930: CCN-to-entity resolution, ownership and addresses for the acute hospitals in the practice's catchment — CCN 050082, 050394, 051334, 050159 and 050236.
- **CMS Innovation Center model participant files** were retrieved and searched to conclusion for the verification described in Section 3.3 — by clinician NPI across the full reassigned roster, by organisation legal name, by state, by market and by CMS Certification Number, with no filter applied that could mask a match. The verification is vintage-specific and should be re-run against each subsequent published file.
- **The practice's own website** (cabrillocardiology.com — home, about, our-physicians, contact, patient-resources, research, cardiovascular-services, peripheral-services, electrophysiology-services and the two location pages; retrieved August 3, 2026): the two evidenced offices and their hours, the published procedure range, the electrophysiology monitoring modalities, the implanted-device check cadence, the research programme and principal-investigator roles, the hospital leadership appointments, and the practice's own account of its history. The site's copyright line reads 2024, indicating it has not been refreshed in roughly two years.
- **The practice's patient portal** (verified live, August 2026): a per-practice tenant on eClinicalWorks' hosted multi-tenant portal cluster, with a practice-specific portal identifier, the vendor's own portal stack and one-time-passcode login enabled, linked from the patient-resources page and referenced independently from the contact page.
- **SCICN-VC** (scicn-vc.org — the network's care-coordination page for physicians, its transitional care management page, and its location listing for this practice; retrieved August 3, 2026) and the **Dignity Health Care Network** location directory: the description of the Ambulatory Care Coordination Programme, its staffing, target population, services, referral routes and governance; the transitional-care guidance to member practices; and the confirmation that this practice is listed as an affiliated location rather than an owned entity.

- **U.S. Census Bureau, American Community Survey 2024 five-year estimates** (profiles DP02, DP03 and DP05, retrieved August 4, 2026, cross-checked against detail tables B19013, B19113 and B01003): Ventura County population, age structure, income, poverty, insurance coverage, educational attainment, Hispanic or Latino share, foreign-born share and the language-spoken-at-home figures used in Sections 1.3 and 9.2. County-level only; Oxnard-city figures were not separately retrieved.
- **California Medical Network and payer structure sources:** the delegated independent practice association's own published plan list and services pages, and the California Office of the Patient Advocate report card entry for that association (measurement year not stated on the page).
- **CMS — CY2026 Medicare Physician Fee Schedule:** TCM 99495 and 99496; RPM 99453, 99454, 99445, 99457, 99470 and 99458; PCM 99424–99427; and the concurrency rules under which RPM and PCM stack. Locality-adjusted payment for this practice is set by the California Medicare Administrative Contractor; the model resolves ZIP 93030 to locality 01182-17. CY2027 rulemaking is in progress.
- **CMS national coverage determination 20.40,** renal denervation for uncontrolled hypertension, effective October 28, 2025 under Coverage with Evidence Development (Section 7).
- **California corporate practice of medicine and fee-splitting:** the general prohibition on general business corporations employing physicians or controlling medical decision-making, and California Business and Professions Code section 650. *Described here as general California law, not as legal advice on this account.*
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 6 and 9, including the 7,307-patient in-scope base, 75% / 85% RPM / PCM eligibility, 35% / 30% acceptance, the 12-clinician referral engine at eight referrals per clinician per month with 80% acceptance, one on-site enrollment specialist at CoachCare's expense, 1.5% monthly attrition, a 7% realization discount, and MAC-locality rates auto-resolved for ZIP 93030 (California, locality 01182-17).

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.

- **Payer mix, and whether any Medicare Advantage volume is capitated.** Traditional Medicare against Medicare Advantage against commercial against Medi-Cal, as a share of patients and of revenue; and whether the practice holds a contract with the delegated independent practice association operating in this county at all — a commercial file asserts the affiliation and no public directory corroborates it. *This is the number-one discovery item and it blocks the value model.*
- **Which plans pay the codes.** Whether Medicare Advantage and commercial plans in this market reimburse 99453, 99454, 99457, 99458 and 99424–99427 at all, and at what rate. Nothing public answers this, and it is where the delegated-risk question actually bites — not on traditional Medicare.
- **Whether any physiologic remote monitoring or care-management programme exists today.** No public evidence of one was found from any direction, but a programme launched recently would not yet be visible, CMS suppresses low-volume lines, and Medicare Advantage or commercial activity would not appear in fee-for-service data at all. *Ask directly.*
- **Who owns the rhythm-monitoring workflow, on which platform, and with what capacity.** The practice implants pacemakers, defibrillators, left atrial appendage devices and insertable cardiac monitors and references mobile cardiac telemetry and patch monitoring. Who reviews those transmissions, on which manufacturer or independent diagnostic testing facility platform, whether

the practice bills for them, and whether that team has spare capacity are all unknown. *This is the highest-value single question on the account.*

- **The depth of the network relationship.** Whether the practice actually uses the network's registered-nurse care coordinators, how many patients they touch, whether any Cabrillo staff time is reimbursed, and whether any exclusivity, preferred-vendor or data-sharing terms exist. Not discoverable from outside (Section 5).
- **Whether any of the group's clinicians participate as accountable care organisation providers or suppliers** under another entity's participant TIN. The practice appears in zero participant-TIN rows for either performance year, but only participant TINs appear in that file, so this cannot be resolved publicly. It is the one arrangement that would change the analysis in Section 3.3.
- **Whether a heart-failure clinic or disease-management pathway exists.** A 24–56% heart-failure panel implies one, but no named clinic, programme page or heart-failure nurse role appears in any public source. Likewise no anticoagulation clinic.
- **The third location.** Only Oxnard and Camarillo are evidenced against a commercial file reporting three. Whether the third is a hospital site of service, a legacy office, or a data artefact of a claims-derived address is unresolved.
- **True unique-patient panel size.** The 6,142 figure is a sum of per-provider beneficiary relationships and double-counts shared patients; the modeled 7,307 in-scope base is a discovery-stage estimate covering a wider population than traditional Medicare alone. The practice's own panel count is required before budgeting.
- **The administrative buying centre.** The practice's website names no administrative staff at all. A commercial file reports a chief operating officer; that record could not be corroborated from any public source. Confirm who owns operations and who signs before any assumption is made about the buying process.
- **eClinicalWorks specifics.** Version and edition, patient-application licensing, existing third-party integrations, interface budget and who owns the information-technology relationship. The platform itself is confirmed; none of these are.
- **Current clinical research activity.** The listed trials are mostly of 2012–2016 enrollment vintage. Whether the research infrastructure is still staffed is unconfirmed — and if it is, it is a material latent capability (Section 7).
- **Corporate filing details.** The California Secretary of State business-search endpoint blocks automated retrieval, so the 1971 filing date and entity number are aggregator-derived rather than page-verified. A manual lookup is needed before any contractual use, along with confirmation of the shareholder structure and whether any management-services agreement already exists.
- **Local press coverage of remote cardiac telemetry at the admitting hospital's system.** A May 2024 headline exists; the article body was not retrievable and its specifics are entirely unverified. Read it before any meeting (Section 4.4).
- **County-level readmission and utilization benchmarks.** Not retrieved during this research, which is why this report quotes none. Pull them before any external use of the avoided-cost argument in Section 6.

Global verification caveat

Facts in this report reflect public sources current to August 2026 and are cited above. Items flagged “CoachCare-provided,” “stated assumption,” “estimate,” “probable” or “confirm” were not independently verifiable from public sources. Reimbursement figures are illustrative national or modeled locality magnitudes — verify against the current CY2026 Physician Fee Schedule and the applicable California locality files, and note that CY2027 rulemaking is in progress. CMS model verification is vintage-specific and should be re-run against each subsequent published participant file. This report makes no claim of accountable care organisation participation. The electronic health record is confirmed; its version, licensing and integration surface are not. All Value Analysis outputs are illustrative, modeled — verify against practice data.

Prepared by CoachCare · August 2026.