COACHCARE | SERVICE LINE STRATEGY

Atlanta Heart Associates

Atlanta Heart Associates PC · McDonough, Griffin, East Point, Riverdale, Jackson and Fayetteville, Georgia — an independent, physician-owned cardiology group serving the south-metro Atlanta corridor

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as the operating spine for heart failure population management, readiness for a mandatory CMS specialty model that begins January 1, 2027, and a margin-positive standalone P&L billed under the practice's own TIN

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the physician leadership of Atlanta Heart Associates PC. It assembles the practice's public footprint, its CY2023 and CY2024 Medicare service record, its verified position relative to the CMS Ambulatory Specialty Model, the corridor's cardiovascular outcome and enrollment data, the 2026–2027 payment environment, and a modeled financial forecast into a single argument: eleven of this group's cardiologists are named on a CMS preliminary list to be scored on heart failure quality and cost from January 2027, and the layer of care that determines those scores — what happens between visits and after discharge — 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 30253 — Georgia, locality 10212-01) — verify against practice data before budgeting.

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

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Executive Summary

Atlanta Heart Associates PC is an independent, physician-owned Georgia professional corporation founded in 1992, headquartered at 3333 Jodeco Road in McDonough with additional offices in Griffin, East Point, Riverdale, Jackson and Fayetteville — a south-metro corridor footprint across Henry, Spalding, Fulton, Clayton, Butts and Fayette counties that is distinct from the north-metro concentration of most large Atlanta cardiology groups. CMS records current to mid-2026 resolve **21 physicians enrolled under the group's own organization PAC ID — 13 in general cardiovascular disease, 4 in interventional cardiology, 2 in cardiac electrophysiology and 2 in vascular surgery**.[1] All of them reassign their Medicare billing rights directly to the practice's own PAC ID rather than to a health system, a management-services organization or a private-equity platform. It is, in the most literal sense, still its own company — and it is one of very few independent cardiology groups of this size left in metropolitan Atlanta.

Four facts define this report, and all four come from public CMS files.

1. **Eleven of the group's cardiologists are named on the CMS preliminary CY2027 participant list for the Ambulatory Specialty Model, Heart Failure cohort.** The listing sits under the organization's legal name and was verified bidirectionally by National Provider Identifier against the practice's live CMS roster: eleven of the twenty-one physicians enrolled under the group's PAC ID appear in the file, and the other ten appear nowhere in it under any organization name or state.[2] **This is a preliminary list. No final CY2027 list existed in the CMS catalog as of August 3, 2026, and the model's design is under active proposed revision.** Section 3.1 states the caveat in full.
2. **The billable care-management layer is completely empty.** Every one of the 21 enrolled physicians was queried individually against the full remote physiologic monitoring, remote therapeutic monitoring, chronic care management, principal care management and transitional care management code sets, in **both CY2023 and CY2024**. **Zero services on every code, for every provider, in both years.**[3] The practice's own website corroborates it: no monitoring, care-management or heart failure programme is advertised anywhere on it.
3. **They are not remote-monitoring-naïve, and that reframes the whole conversation.** In the same CY2024 file the group billed roughly **$294,000 of mobile cardiac telemetry technical support** across twelve physicians, followed approximately **905 cardiac implantable electronic device patients** remotely, and — the decisive number — carried **223 patients on implantable hemodynamic heart-failure monitors (93297), up 57% from 142 the year before**.[4] A practice doing that has device technicians, a triage inbox, an alert-review protocol and documented remote-

[1] CMS Doctors and Clinicians National Downloadable File (resource mj5m-pzi6), vintage June 26, 2026, filtered to the organization legal name and resolving to a single organization PAC ID, 6204737216, with an organization member count of 21. CMS primary specialty per clinician is taken from the same file. Roll-up on organization PAC ID, rather than name matching, is what makes this an identity test rather than a string match.

[2] CMS Ambulatory Specialty Model Participants, CY27_Prelim_ASMParticipants_Public.csv (CY2027 PRELIMINARY; dataset modified February 4, 2026; retrieved August 3, 2026). The file carries 6,637 rows across two cohorts. Matching was run in both directions and without any filter on the file's state column, which is known to be miscoded for some participants: every identifier on the practice's live CMS roster was tested against the entire file regardless of organization name or state, and every file row whose organization legal name normalizes to the practice's was tested against the live roster. Eleven matched in both directions; the other ten roster identifiers appear nowhere in the file. All eleven carry ASM_CY27_PARTICIPANT = Yes and ASM_CY27_SMALLPRACTICE = No. CY2028 through CY2031 flags are null for all eleven, i.e. CMS has published determinations for CY2027 only. No final CY2027 list existed in the CMS catalog as of the retrieval date.

[3] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024 (released May 21, 2026) and CY2023. All 21 enrolled physicians queried individually against 99453, 99454, 99457, 99458, 99091; 98975-98981; 99490, 99439, 99491, 99437, 99487, 99489; 99424-99427; G0511; and 99495, 99496. Zero services on every code, for every physician, in both data years. CMS suppresses any provider/HCPCS line with fewer than 11 beneficiaries, so this establishes the absence of a programme at meaningful scale rather than the absence of any patient.

[4] Same file and vintage: CPT 93228, 93229, 93294, 93295, 93296, 93297 and 93298, aggregated across the enrolled physicians. Counts are sums of per-physician beneficiary counts and contain duplication across physicians; they are not unique-patient counts and should be read as upper bounds. The 93297 year-over-year comparison is CY2023 142 beneficiaries against CY2024 223.

monitoring habits. **It already runs the hardest part of a remote care programme, and bills none of the care management around it.**

4. **The scale of the model exposure is unusual for an independent group.** Of the 2,610 Heart Failure cohort clinicians named nationally across 944 organizations, **the median organization has one**. Only 44 organizations — **4.7% of them** — have eleven or more. This practice is one of the 44, it ranks **third in Georgia** behind two health-system-employed groups, and it appears to be the largest independent, physician-owned Heart Failure cohort in the state.[5] Every larger cohort in Georgia has a health system's population-health department behind it.

The central argument

1. Standalone value. TCM + RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based upside — modeled at **$6,439,593** of net reimbursement and **$2,720,077** net to the practice over 24 months, a **42.24% 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 serves the CY2027 Ambulatory Specialty Model Heart Failure cohort, the unbilled post-discharge window, the group's shared-savings and quality position, device and procedural throughput, and the standalone P&L. Build once, use everywhere.

The clinical case is strong and it needs no exaggeration. The practice's CY2024 Medicare panel carries a beneficiary-weighted **HCC risk score of 1.81 against a national average of 1.00**, with **heart failure prevalence of 36.3%**, ischemic heart disease at 40.5%, chronic kidney disease around 44% and diabetes around 47%, at an average beneficiary age of 74 to 77.[6] The corridor around it matches: **four of the five counties the practice's offices sit in run above both the Georgia and the national heart-disease mortality rate** — Butts at 442.8 per 100,000, Spalding 426.1, Clayton 415.8 and Henry 386.9, against 346.4 for Georgia and 315.3 for the United States. Henry also carries the highest stroke mortality in the footprint at 118.3 per 100,000, roughly 56% above the national rate.[7] Georgia is a Stroke Belt state, and its own CDC figures corroborate the designation rather than merely inheriting it.

One market fact must be stated up front, because it constrains the sizing. Medicare Advantage penetration across this footprint runs **well above the state average** — 62.2% in Henry, 69.1% in Clayton, 65.3% in Butts, 63.4% in Spalding, against 56.2% for Georgia — with Fayette the outlier at 48.6%.[8] **Original Medicare is the minority payer in this market**, and the Ambulatory Specialty Model applies only to Original Medicare. That cuts two ways, and both matter. It narrows the model-scored population to roughly a third of the Medicare panel in the core counties — and it means the remote care service line has a large Medicare Advantage and commercial population sitting outside the model that the same infrastructure serves, on terms that have to be confirmed contract by contract rather than assumed.

[5] Computed directly from CY27_Prelim_ASMParticipants_Public.csv, Heart Failure cohort only, August 3, 2026: 2,610 clinicians across 944 distinct organizations, median one clinician per organization, 44 organizations (4.7%) with eleven or more, and 134 Georgia-coded clinicians across 37 organizations. Ownership classifications in the Georgia ranking are this report's characterization from CMS enrollment structure, not a CMS data field.

[6] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026): beneficiary-weighted average HCC risk score, condition prevalences, mean beneficiary age and dual-eligible share across the 21 enrolled physicians. The dual-eligible share is a share of the practice's Original Medicare beneficiaries in CY2024 Part B claims; it is not the same denominator as a state-level or Medicaid claim-line dual share and the two must not be conflated.

[7] CDC heart disease mortality (resource mri7-5jtw) and stroke mortality (resource y5ii-knwc), age-adjusted for adults 35+, spatially smoothed three-year average centred on 2023, from National Vital Statistics System and Census denominators; queried by county August 3, 2026. Georgia 346.4 and United States 315.3 heart-disease deaths per 100,000 from the same source.

[8] CMS Medicare Monthly Enrollment, April 2026 snapshot (dataset modified July 23, 2026), queried by county August 3, 2026.

The timing is specific, and it is unusually favourable. The practice went live on **Epic, running as hosted departments inside a health system partner's tenant under a Community Connect arrangement**, between April 18 and May 8, 2026 — roughly three months ago, after about six years on a legacy niche cardiology system.[9] The instinct is to read a fresh migration as change fatigue and a reason to wait. The opposite is closer to the truth: the workflows are already being rebuilt, the build decisions are still open, and adding a care-management layer is cheapest at exactly this moment. The CY2026 Physician Fee Schedule also expanded remote monitoring in ways that suit this practice specifically — **99445** pays the monthly device-supply amount for 2–15 days of data where 16 or more were previously required, and **99470** pays for the first 10 minutes of monthly management time where the floor had been 20. The model's first performance year opens January 1, 2027. A service line chartered in late 2026 is operating at census before that clock starts.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **16,252-patient in-scope Medicare base across 29 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 **$1,580,712** in Year 1 and **$4,858,881** in Year 2 (**$6,439,593** over 24 months — RPM $4,860,237, PCM $1,579,356); **$2,720,077** net to the practice after CoachCare fees; 512,295 physiologic readings; approximately **325 avoided hospitalizations**; and 52,701 care-team hours delivered, about **25.3 full-time equivalents** of clinical labour the practice does not have to hire. Month 1 is modeled at −$2,669 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, and post-device-implant and post-discharge windows. Name a physician lead from among the eleven named clinicians and pair them with the practice manager on operations. Target the first billable enrollment within 90 days.
2. **Re-verify the CY2027 participant list before anything is committed.** Everything in Section 5 rests on a **preliminary** file. CMS has said it intends to publish a final CY2027 list, and separately proposed changes to the model in the CY2027 Physician Fee Schedule notice of proposed rulemaking published July 14, 2026, with comments due September 14, 2026. Diarise a re-check and re-run the identifier match.
3. **Start with the heart-failure population the practice can already see.** The 223 beneficiaries on implantable hemodynamic monitors in CY2024 are an already-identified, already-remotely-managed heart failure cohort — and three of the five physicians billing that follow-up are among the eleven named clinicians. That is the shortest path from today's workflow to a monitored census (Sections 4.2 and 5).
4. **Bill the transitional-care window the group already generates.** Eighteen of the 21 physicians hold privileges at the dominant admitting hospital, and **no transitional care management was billed against any patient in either CY2023 or CY2024**. TCM is deliberately excluded from every financial figure in this report so the forecast stays conservative — which makes it a separate, additive decision the practice can take on its own merits (Sections 2.1 and 6).
5. **Use the Epic build while it is still being built.** The tenant belongs to the health system partner, not to the practice, so integration scope, interface approval and data-governance sign-off must be confirmed with the system in contracting rather than assumed. Establish who controls that approval before any scoping commitment (Section 8).

[9] The health system partner's public provider directory exposes structured electronic medical record identifiers, and every one of the practice's locations resolves as a department inside the system's Epic instance flagged as external - the Community Connect signature for a non-owned practice hosted in a system tenant (retrieved August 3, 2026). The cutover date is reconstructed from Internet Archive captures of the practice's own site: the legacy portal link disappeared between November 9, 2025 and January 19, 2026, and the system MyChart link first appears in the May 8, 2026 capture, with the April 18, 2026 capture carrying neither. The legacy platform is evidenced by its own JavaScript namespace and script-bundle path in archived captures of the retired portal.

6. **Write the attribution policy before the first enrollment.** The practice owns transitional care at discharge and RPM plus PCM on the cardiac condition; the referring primary-care physician owns any longitudinal primary-care wrapper; one shared care plan, with explicit task ownership. This prevents duplicate-billing denials and referral friction, and it is also the substrate for the collaborative care arrangement the Ambulatory Specialty Model requires (Sections 2.1 and 5).
7. **Size the Medicare Advantage population separately.** Roughly 62% to 69% of the Medicare population in the core counties sits in Medicare Advantage and outside the model entirely. Any forecast that blends it with Original Medicare will misstate both. Confirm which value-based and Medicare Advantage contracts the practice holds directly, and which it holds only through its clinically integrated network (Section 3.4).

1. Footprint & Operating Model

1.1 The practice

The legal entity is **Atlanta Heart Associates PC** — a Georgia professional corporation the practice dates to 1992, with a Medicare group enrollment identifier issued in 2004. The organizational National Provider Identifier is 1851327241 and the CMS organization PAC ID is 6204737216; the primary taxonomy on file is internal medicine, cardiovascular disease.[10] Public and legal names are the same, which matters more than it sounds: many independent groups are findable in CMS model files only under a legal name that differs from the trade name, and an account like that can look unaffiliated on a first pass. This one does not have that problem.

Office	County	Status in CMS enrollment data
McDonough (headquarters)	Henry	Corroborated — 3333 Jodeco Road, Suite A; the great majority of clinician-location rows in the CMS file resolve here
Griffin	Spalding	Corroborated — 747 South 8th Street, Suite A
East Point	Fulton	Corroborated — 1136 Cleveland Avenue; CMS records a different suite number than the practice website, a minor discrepancy worth confirming
Riverdale	Clayton	Corroborated — 483 Upper Riverdale Road, Suite C
Jackson	Butts	Advertised but not visible as a Medicare-registered practice location in the CMS file
Fayetteville	Fayette	Advertised but not visible as a Medicare-registered practice location in the CMS file
Locust Grove	*Henry*	*Appears in CMS enrollment for one clinician but is absent from the practice's current locations page — possibly a closed or consolidated site, and an open discovery item*

CMS Medicare Fee-For-Service enrollment and Doctors & Clinicians National Downloadable File, vintage June 26, 2026, cross-read against the practice's own locations page (retrieved August 3, 2026). A commercial profile and an older regional magazine feature describe seven sites; the current public footprint is six.

Roster, counted from CMS rather than from the website. The practice's own pages describe 28 providers — 19 cardiologists, 1 vascular surgeon, 7 nurse practitioners and 1 physician assistant — while its provider page currently lists 25 individuals, and a widely used commercial firmographic file reports 21 physicians. The authoritative physician count is the set who reassign Medicare benefits to the group's organization PAC ID: **21 physicians** as of the June 26, 2026 file, with a twenty-second vascular surgeon appearing in the July 14, 2026 reassignment extract — most plausibly a recent hire whose enrollment has not yet propagated to the downstream public files, and an open item rather than a fact.[11] 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. Treat 21 as the best available count and confirm the live roster in discovery.

The advanced-practice layer is worth a sentence on its own, and it is good news. No advanced practice provider appears under the group's organization PAC ID in the CMS Doctors & Clinicians file — all 21 enrolled clinicians are physicians. The eight advanced practice providers the practice advertises are therefore either not separately Medicare-enrolled under this taxpayer identification number,

[10] CMS Medicare Fee-For-Service Public Provider Enrollment and the NPPES NPI Registry (retrieved August 3, 2026) for the organizational National Provider Identifier, PECOS organization PAC ID, group enrollment identifier and primary taxonomy. The 1992 founding date is the practice's own account on its website and is not independently verified.

[11] CMS Doctors and Clinicians National Downloadable File, vintage June 26, 2026 (21 physicians), against the CMS Revalidation Clinic Group Practice Reassignment file, vintage July 14, 2026 (22 reassignments). Reassignment records capture reassignment relationships, so they can lag a departure and will miss a hire made after the snapshot date. The additional clinician in the later file is absent from the practice's public provider page and is treated here as an unverified recent hire.

or they bill incident-to. **An incident-to advanced-practice model is precisely the staffing structure that makes a care-management service line straightforward to stand up**, because the supervision and billing relationships the programme needs already exist. It also means advanced-practice capacity is invisible in claims data, so the true clinical bandwidth of this group is larger than the physician count implies.

Sub-specialty mix, confirmed by procedure evidence rather than by claim. Diagnostic and interventional cardiology are confirmed by left-heart catheterisation with coronary angiography (93458) across nine physicians and coronary stent placement (92928); electrophysiology by dual-chamber pacemaker insertion (33208) and defibrillator implant (33249) across the two electrophysiologists; and the vascular and vein line by sclerosant injection (36465).[12] The practice names nuclear cardiology, echocardiography, interventional cardiology, electrophysiology, vascular surgery and vein ablation as its service lines, and the claims record corroborates all of them. **No structural heart programme appears in the CY2024 Medicare record** — no transcatheter valve or left atrial appendage occlusion volume — and this report does not assume one.

1.2 The operating model: independent, and embedded in a system's infrastructure

The most important structural fact about this account is that two things are true at once, and neither cancels the other. **The practice is corporately independent**: it holds its own organization PAC ID, all of its clinicians reassign directly to it, no private-equity sponsor or management-services organization appears in any public source, and its physicians hold privileges across **two competing health systems** — a pattern incompatible with system employment.[13] At the same time it is **deeply embedded in one system's infrastructure**: it carries that system's clinically integrated network seal on its physician pages, it appears in the system's patient-facing directory, it runs on the system's Epic tenant, it admits overwhelmingly to the system's hospitals, and it has been a participant in the system's Medicare Shared Savings Program accountable care organization since that organization's inception in 2017.

Hospital	CCN	Physicians affiliated (of 21)	Of the eleven named clinicians
Piedmont Henry Hospital (Stockbridge)	**110191**	**18**	**10**
Piedmont Hospital, Inc. (Atlanta)	110083	13	7
Piedmont Fayette Hospital (Fayetteville)	**110215**	**11**	**8**
Wellstar Spalding Medical Center (Griffin)	**110031**	**10**	**4**
Southern Regional Medical Center (Riverdale)	110165	5	3
Wellstar Kennestone Regional (Marietta)	110035	2	1
Wellstar Sylvan Grove Medical Center (Jackson)	111319	2	1
Piedmont Newnan Hospital	110229	1	1

CMS Doctors & Clinicians Facility Affiliation Data, vintage June 26, 2026, joined to CMS Hospital General Information (April 28, 2026) for names and CCNs. 64 affiliation rows across the 21 physicians. A commercial firmographic file materially undercounts this — it omits both Piedmont Fayette and Wellstar Spalding, each larger than the affiliation it does report, and reports a Grady Health System affiliation that appears nowhere in the CMS data.

[12] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024: CPT 93458, 92928, 33208, 33249 and 36465, with the count of distinct billing physicians per code. Subject to the same 11-beneficiary suppression floor, so these are floors rather than complete procedure volumes.

[13] CMS Doctors & Clinicians Facility Affiliation Data, vintage June 26, 2026, joined to CMS Hospital General Information, vintage April 28, 2026, for hospital names and CMS Certification Numbers; 64 affiliation rows across the 21 physicians. The admission-share figure quoted in the text is from a commercial firmographic profile, is undated, and is directional only.

Read the affiliation table as a strategic asset rather than as an org chart. A group whose physicians hold privileges across two competing systems is not captive, and it is the shared cardiology bench across several hospitals in a corridor where cardiovascular mortality runs above both state and national rates. A commercial profile reports that roughly 89% of the group's admissions flow to the dominant hospital — a vendor figure, undated, treat it as directional — and the CMS affiliation data independently supports the direction: 18 of 21 physicians, and 10 of the eleven named clinicians, are privileged there.

The administrative layer is lean, and it is the constraint. The practice's published staff page lists nine administrative people, all managers or supervisors reporting to a physician president and chief executive — a practice manager, an office billing manager, three office and front-office managers, a marketing manager and two clinical or technical supervisors. **There is no chief operating officer and no population-health or care-management function**. A job-board sweep in August 2026 found no active posting for a care coordinator, a chronic-care or remote-monitoring nurse, or a practice administrator — *but that evidence is weak and should be treated as untested rather than as searched-and-empty*, because two major boards blocked automated access during research.[14] Taken with the rest of the picture it points to a lean back office with no dedicated care-management staffing. That is a staffing objection to anticipate rather than to argue with, and it is precisely the gap a full-service model fills (Section 9.2).

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-implant and post-discharge patient leaves the encounter enrolled in monitoring or monthly management — not merely scheduled for a return visit a quarter later
Start where the data already flows	The group already receives, reviews and acts on remote data for roughly 905 device patients and 223 implantable hemodynamic monitor patients. The new programme should extend an existing habit, not introduce a foreign one
One front door	A single enrollment, consent and device-logistics workflow; referral to the service line is one order inside the Epic chart the practice already uses, with enrollment status visible in real time (Section 8)
The partner carries the load	A manager-level administrative layer with no care-management function means the practice supplies clinical direction and supervision while the partner supplies enrollment, devices, monitoring, documentation and claims
Separate the two remote programmes cleanly	Implanted-device interrogation and patient physiologic monitoring are different benefits over different data. Define the boundary, the data source and the documentation for each before launch, so neither service is at risk (Section 9.3)
Six offices, two economies, one programme	Fayette runs a median household income near $112,000 with 8.6% uninsured; Clayton runs $59,800 with 17.0% uninsured and 17.9% of people below poverty. Enrollment scripting, device logistics and coinsurance handling have to be designed for both ends of the corridor, not just for the headquarters
Single scorecard	Clinical, operational and financial KPIs for the service line reviewed monthly by the physician lead and the practice manager, and mapped explicitly to the measures eleven of the group's cardiologists may be scored on from 2027 (Sections 5 and 9.5)

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

[14] Job-board sweep, August 2026. The practice's own careers link points to a contact form rather than a job board; one major aggregator reported no open positions; two further boards blocked automated access during research and the session's search budget was exhausted. An absent posting is therefore weak evidence rather than proof of absence.

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 Medicare 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	Eighteen of 21 physicians privileged at the dominant admitting hospital, and zero TCM billed in either CY2023 or CY2024. The single largest identified gap — and deliberately excluded from every financial figure in this report
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 across a corridor with 37% to 43% county hypertension prevalence, and — via the new short-window code 99445 — for the 2–15 day post-discharge and post-implant 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 panel carrying 36.3% heart-failure prevalence. In a cardiology panel the single dominant condition genuinely is the cardiac one — the clinical situation PCM was written for, and the monthly chassis under a CY2027 Heart Failure cohort designation

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 quantified but excluded from every financial figure.

The one coordination rule

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

The practical rule here: the practice owns the transitional-care window at discharge and owns RPM plus PCM on the cardiac condition; the referring primary-care physician owns any longitudinal primary-care management wrapper; both work from **one shared care plan** with explicit task ownership. Write that policy before the first enrollment. It prevents duplicate-billing denials, it protects the referral relationship, and it is the same substrate the Ambulatory Specialty Model's collaborative care arrangement will require from 2027 (Section 5).

And a boundary this practice will care about more than most: implanted-device interrogation (93294–93298) and patient physiologic monitoring (99453 onward) are different benefits over different data — the device's own telemetry versus patient-generated physiologic readings from a separate connected device. The rule to design around is that the same data stream is not billed twice. This group already bills the device side at scale, so the boundary is not academic here. *Confirm the specific pairings with the payer and with billing counsel before launch.*

2.2 Standalone value: a margin-positive service line

Before any value-based upside, the service line stands on four layers of value:

1. **Direct professional-fee revenue.** Recurring monthly billing on a population the practice already manages clinically, delivered at top-of-license staffing under general-supervision rules. Modeled at $6,439,593 of net reimbursement over 24 months, $2,720,077 of it net to the practice.
2. **Avoided cost and readmission exposure.** Modeled at approximately 325 avoided hospitalizations over 24 months — on the order of $4.9 million at an illustrative $15,000 per admission. In a corridor where heart-disease mortality runs above both state and national rates, and in a model that names reducing avoidable hospitalizations as a stated goal, that value is visible to the group's hospital and network partners as well as to the group.
3. **Procedural and referral throughput.** A monitored pathway is what keeps a post-implant or post-discharge patient attached to this practice rather than transferring the relationship with the referral — in a corridor where the dominant system's own employed cardiology group operates in the same towns (Section 7).
4. **Strategic position and model readiness.** 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 partner to supply. Under a preliminary CY2027 Heart Failure designation, that infrastructure is also the group's negotiating position and the clearest expression of its independence.

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
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-implant windows now billable

Service / code	Type	~CY2026 magnitude	Notes
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

The figures above are illustrative national non-facility magnitudes for CY2026. Actual payment is locality-adjusted and set by the Medicare Administrative Contractor for Georgia. The financial model in this report uses MAC-locality rates auto-resolved for ZIP 30253 in the CoachCare Value Analysis — Georgia, locality 10212-01. Verify against the current CY2026 Physician Fee Schedule and the applicable Georgia 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 cuts against the practice at the point of enrollment, and the model should be read with it in mind. The corridor's coverage profile is uneven — Clayton County runs 17.0% uninsured and 17.9% below poverty, Spalding 13.3% and 18.9%, against 8.4% and 12.5% nationally — so patient-side collection on the 20% coinsurance that remote monitoring and care management generate will be materially harder in the southern offices than in Fayette. A single blended acceptance rate across six offices will overstate the southern sites. Plan the enrollment sequence accordingly (Section 9.1).

Modeled economics

The companion Value Analysis prices an RPM + PCM programme on the practice's Medicare base. The modeled population is an estimated **16,252-patient in-scope Medicare base across 29 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 sum of per-provider beneficiary counts published by CMS across the 21 physicians for CY2024 is 20,622 — a figure that contains substantial duplication, because a patient seen by two physicians is counted twice. A unique-patient denominator cannot be derived from the public file and has to come from the practice's own record. The 29 referring clinicians in the model are the 21 Medicare-enrolled physicians plus the eight advanced practice providers the practice advertises.

Enrollment builds bottom-up from **29 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 (12,189 patients) and 85% for PCM (13,814), with acceptance of 35% and 30% respectively, and 1.5% monthly attrition. Revenue is reported as **net** reimbursement — gross allowed amounts less a 15% realization discount for payer mix and collection, as configured in the model.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$1,580,712	$4,858,881	**$6,439,593**
CoachCare fees (incl. setup & integration)	$920,558	$2,798,958	$3,719,516
Net to the practice	**$660,154**	**$2,059,923**	**$2,720,077**

Modeled result	Year 1	Year 2	24-month
Practice margin	**41.76%**	—	**42.24%**
Net reimbursement by programme	RPM $1,198,392 · PCM $382,321	RPM $3,661,845 · PCM $1,197,036	RPM $4,860,237 · PCM $1,579,356
Claims / billed units	—	—	118,128
Physiologic readings collected	—	—	512,295
Hospitalizations avoided (modeled)	—	—	~325 (≈$4.9M at an illustrative $15,000 each)
Care-team hours delivered	—	—	52,701 (≈25.3 FTE)
Active programme enrollments at month 24	—	—	5,328 (RPM 3,946 · PCM 1,382)
Unique patients (de-duplicated)	2,205 at month 12	4,360 at month 24	—

CoachCare Value Analysis, MAC locality GA 10212-01 (ZIP 30253), 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: 42.24% — net to the practice ÷ net reimbursement. Year 1 is **41.76%**, on $6,439,593 of net reimbursement and $2,720,077 net to the practice over the full 24 months.

Month 1 is modeled at **−$2,669** because one-time implementation lands there, and **every month from month 2 onward is net-positive**. By month 24 the programme is modeled at $517,375 of monthly net reimbursement and $219,481 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.

Both arms are enrollment-limited rather than eligibility-limited, and that is the single most important planning fact in this table. RPM stands at 3,946 enrolled patients at month 24 against a modeled ceiling of 4,266, still climbing; PCM stands at 1,382 against a ceiling of 4,144, with the great majority of its eligible pool untouched. **Neither arm reaches its ceiling inside the modeled window**, which means Year 2 is a growth year rather than a steady state and the census at month 24 is nowhere near the programme's terminal size. The practical consequence is that referral throughput, not eligibility, is the lever: raising referrals per clinician, or opening a second enrollment pathway, moves both arms materially. This is a different situation from a practice whose RPM arm pins against its ceiling early, and it should change how the first twelve months are managed.

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 ($4,858,881) is 3.1× Year 1 ($1,580,712) on the same referral engine, purely from census accumulation. Unit economics are modeled at approximately $99.62 of net reimbursement per RPM patient-month and $92.45 per PCM patient-month, across 48,790 RPM and 17,084 PCM patient-months over the 24 months.

The two value streams compound rather than compete. The professional fee is the practice's revenue and depends on no reconciliation, no shared-savings determination and no hospital agreement — while the same monitored census is what moves the readmission, cost and quality results that the Ambulatory Specialty Model would score from 2027. *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.

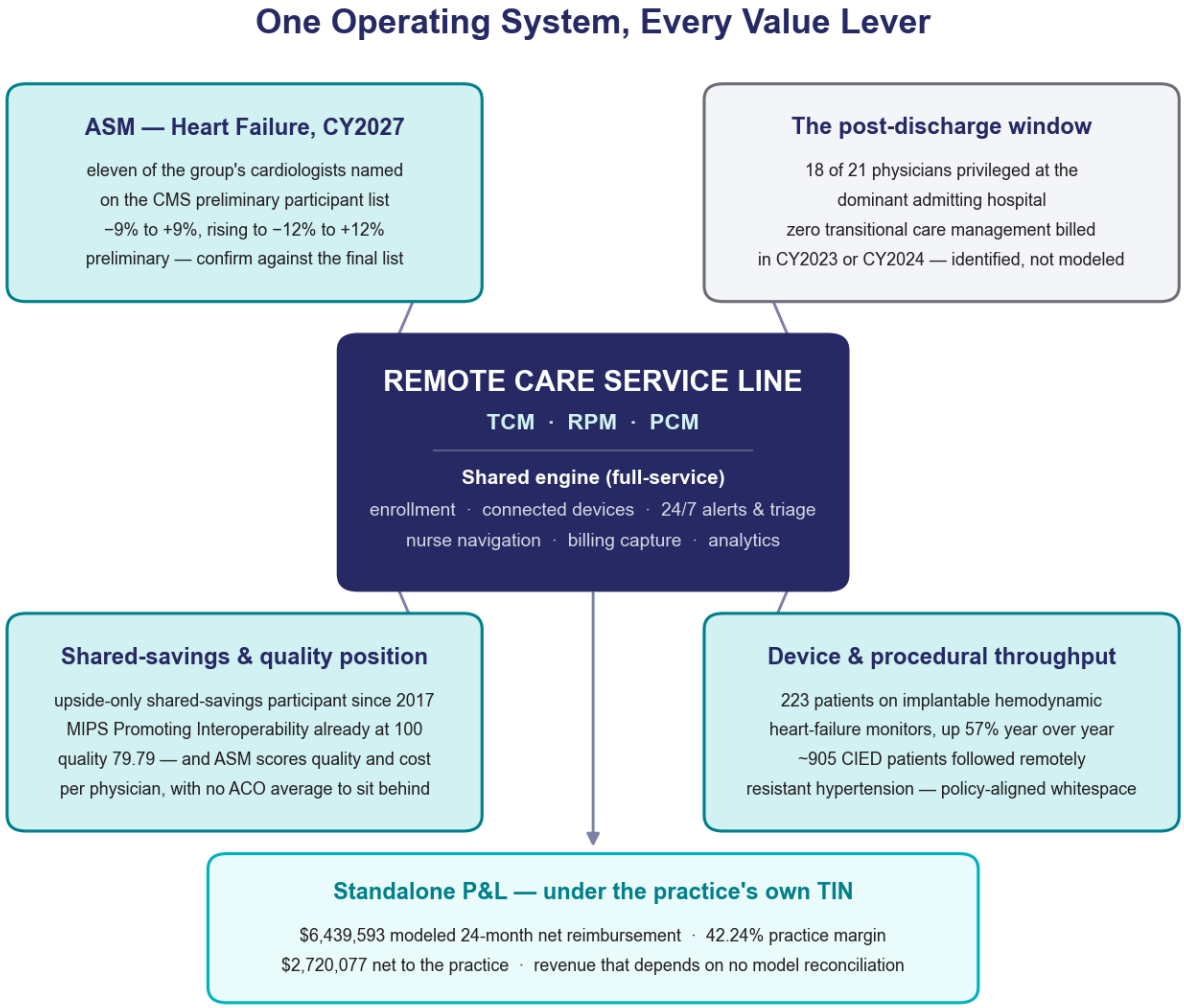

Figure 1. The Remote Care Service Line as connective tissue: one operating system powering the CY2027 Ambulatory Specialty Model Heart Failure cohort (preliminary participant list — confirm against the final file), the unbilled post-discharge window, the group's shared-savings and quality position, device and procedural throughput, and the standalone P&L.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
ASM — Heart Failure cohort, CY2027	Eleven of the group's cardiologists are named on the CMS preliminary CY2027 participant list; a −9% to +9% Part B adjustment applies in the first two performance years, rising toward −12% to +12%; clinician-level quality and cost, plus group-level care improvement and interoperability	A monitored heart failure census produces the between-visit intervention that moves cost and utilization, and produces the documentation the quality measures are scored from. The shared care plan is also the substrate for the required collaborative care arrangement with primary care

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
The post-discharge window *(identified, not modeled)*	Eighteen of 21 physicians privileged at the dominant admitting hospital, and zero transitional care management billed in either CY2023 or CY2024	The same enrollment and monitoring engine covers the 30 days after discharge; short-window RPM is billable today via 99445 and 99470, and TCM remains a separate decision the practice can take on its own merits
Shared-savings and quality position	An upside-only shared-savings participant since 2017, scored through the accountable care organization's pathway; Promoting Interoperability already at 100 and quality at 79.79 in the most recent published year	Monthly structured contact generates the documented blood-pressure readings, weight trends and medication-tolerance notes that quality measures are scored from — as a by-product of care rather than as a separate abstraction project
Device and procedural throughput	223 patients on implantable hemodynamic heart-failure monitors, up 57% year over year, and roughly 905 device patients followed remotely — with no implant volume of the group's own in the CY2024 record	The physiologic layer reaches the far larger heart-failure population that has no implanted device, and keeps referred patients attached to this practice rather than transferring the relationship with the referral
Independence	The dominant system's own employed cardiology group is a 479-clinician organization operating in at least one of the same towns; private-equity and management-services consolidation has reached Georgia cardiology but not yet this corridor	A built, billable, hospital-facing post-discharge and heart-failure capability is the clearest thing an independent group can own that a referral partner cannot simply supply — and it is owned under the practice's own TIN
Standalone P&L	CY2026 code expansion (99445, 99470); revenue durability regardless of how any model performance year reconciles	$6,439,593 of modeled 24-month net reimbursement at a 42.24% practice margin — billed under the practice's own TIN and dependent on no reconciliation

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-monitoring operation running at scale, with staff who already triage device alerts for a living. What it does not yet own is the non-invasive physiologic data layer, the enrollment engine and the billing capture that turn a habit into a service line.

3. 2026–2027 Policy & Payment Environment

One mandatory CMS model bears directly on this practice, and it begins in five months. This section states what is verified about it, what is not, and what else in the 2026 payment environment changes the arithmetic.

3.1 ASM: a CY2027 Heart Failure designation, on a preliminary list

The **Ambulatory Specialty Model** begins **January 1, 2027** and runs five performance years through 2031, with payment years running 2029 through 2033 — so performance in calendar 2027 lands as a payment adjustment in 2029. It covers two conditions, with cardiology accountable for **heart failure**. It is a clinician-level model: participants are identified by taxpayer identification number and National Provider Identifier, are scored individually on quality and cost and at the group level on care improvement activities and Promoting Interoperability, and receive a Part B payment adjustment of **−9% to +9% in the first two performance years, rising toward −12% to +12% by the final performance year**. The design is **budget-neutral**: total positive adjustments cannot exceed total negative adjustments, which makes it a tournament scored against peers treating the same condition. Average performance is the break-even outcome, not a safe one. It also requires an electronic **collaborative care arrangement with primary care**. Most importantly for planning: **participation is mandatory for attributed clinicians** — there is no opting in and no opting out.[15]

[15] CMS Ambulatory Specialty Model overview fact sheet and participant readiness roadmap, and the CMS model landing page (retrieved August 3, 2026), for the start date, performance and payment years, the payment-adjustment range and its escalation, budget neutrality, participant identity by taxpayer identification number and National Provider Identifier, the at-least-20-episodes selection threshold, the four scored categories and their individual versus group-level assessment, the required collaborative care arrangement with primary care, and the notice of proposed updates in the CY2027 Physician Fee Schedule notice of proposed rulemaking published July 14, 2026 with comments due September 14, 2026.

What the verification actually says — and what it does not

Verified. Eleven clinicians appear in the CMS Ambulatory Specialty Model participants file, **Heart Failure cohort**, under the organization legal name ATLANTA HEART ASSOCIATES PC, with the CY2027 participant flag set to Yes and the CY2027 small-practice flag set to No. The match was tested in both directions: all eleven organization-name rows map to identifiers on the live CMS roster for organization PAC ID 6204737216, and none of the other ten roster identifiers appears anywhere in the file under any organization name or any state. There is no leakage in either direction.[16]

A second confirmation that this is not a name collision. The file also contains a similarly named but entirely separate Georgia cardiology organization in the northeast metro, with four Heart Failure clinicians of its own, and a third with one. **None of their identifiers appears under this practice's PAC ID, and these organizations must never be merged.**

The caveat, stated plainly. The file is the **CY2027 preliminary participant list** (dataset modified February 4, 2026, retrieved August 3, 2026). **No final CY2027 list existed in the CMS catalog as of that date**, and CMS separately proposed updates to the model in the CY2027 Physician Fee Schedule notice of proposed rulemaking published July 14, 2026, with comments due September 14, 2026. The phrasing this report holds to throughout — and the phrasing to hold to in any external material — is that these clinicians are **named on the CMS preliminary participant list**. *Preliminary lists can be revised, and a model under active rulemaking can change. Re-verify against the final CY2027 file before acting on anything in Section 5.*

One more thing to confirm rather than assert. Public evidence suggests at least one of the eleven may no longer practise at the group. Model attribution is built on a historical claims lookback, so a clinician who has since reduced hours or moved can still be named. **"Eleven named on the CMS preliminary list" is a fact about the file and is defensible either way; "eleven practising clinicians" is not. Ask, do not assert.**

A geography note, because the obvious check produces a false negative. The model's mandatory-area file lists 235 geographies — 220 core-based statistical areas and 15 metropolitan divisions. Atlanta appears exactly once, as **Metropolitan Division 12054, Atlanta–Sandy Springs–Roswell**, a subdivision of the larger core-based statistical area under the 2023 delineations. Anyone re-running this check by searching the geography file for the CBSA code will find nothing and conclude the practice is out of scope. It is not.[17]

Scale, for context, because it is the most commercially useful fact in this section. Of the 2,610 Heart Failure cohort clinicians named nationally, spread across 944 distinct organizations, **the median organization has one**. Only 44 organizations nationally — **4.7%** — carry eleven or more. Within Georgia, 134 Heart Failure clinicians are named across 37 organizations, and this practice ranks third:

Rank	Organization	Heart Failure clinicians named	Ownership
1	Piedmont Cardiology of Atlanta, LLC	21	Health-system employed
2	Georgia Heart Institute LLC	19	Health-system employed
3	**Atlanta Heart Associates PC**	**11**	**Independent, physician-owned**
4	St. Joseph's Cardiology Group LLC	8	Flagged small practice
5	Northside CV Professional Services LLC	7	Health-system employed

[16] CMS Ambulatory Specialty Model Participants, CY27_Prelim_ASMParticipants_Public.csv - CY2027 PRELIMINARY, dataset modified February 4, 2026, retrieved August 3, 2026. Bidirectional match on National Provider Identifier against the practice's live CMS roster under organization PAC ID 6204737216, with no filter applied to the file's state column. Eleven matched in both directions and no roster identifier appears in the file under any other organization name. The similarly named Georgia organizations referenced in the callout carry their own distinct organization PAC IDs.

[17] CMS Ambulatory Specialty Model mandatory geographic areas file, asm-mandatorygeographicareas_12_23_25.xlsx, dated December 23, 2025, downloaded August 3, 2026: 235 areas comprising 220 core-based statistical areas and 15 metropolitan divisions. Atlanta appears once, as Metropolitan Division 12054 under the OMB 2023 delineations - a subdivision of the larger core-based statistical area, whose code does not appear in the file.

Rank	Organization	Heart Failure clinicians named	Ownership
6=	Atlanta Heart Specialists LLC (Tucker) — a separate organization	4	Independent
6=	Wellstar Medical Group; The Emory Clinic; others	4 each	Health-system employed

Computed from CY27_Prelim_ASMParticipants_Public.csv, Heart Failure cohort only, queried August 3, 2026. Ownership labels are this report's characterization from CMS enrollment structure, not a CMS field. Preliminary list — confirm against the final CY2027 file.

The commercial reading is direct. Every larger Heart Failure cohort in Georgia sits inside a health system with a population-health department, a care-management staff and an analytics function behind it. This practice faces the same scorecard with none of that — and it appears to be the largest independent, physician-owned cohort in the state. That is not a weakness to be sold against; it is the reason an outsourced, full-service infrastructure is the rational answer rather than a hiring programme.

3.2 What the model scores — and where this practice already stands

The most recent published Merit-based Incentive Payment System scorecard is the best available proxy for readiness, and it says something specific. Seventeen of the group's physicians carry an identical PY2023 scorecard sourced through the accountable care organization's alternative-payment pathway rather than an individual or group submission: **Promoting Interoperability 100, Improvement Activities 40 at full credit, Quality 79.79, final score 89.89, and no cost score at all**.[18]

What the model scores	Where this practice stands today	What has to change
Promoting Interoperability — scored at the group level	**Already at 100**, attested on certified electronic health record technology and now consistent with a full Epic footprint	Effectively solved. This is a credibility-builder to lead with, not a gap to sell against
Care improvement activities — scored at the group level	Full credit in the most recent published year	Group-level scoring means the practice's infrastructure decisions, not individual physician effort, drive half the scorecard — which is an argument for building one shared engine rather than six office-level habits
Quality — scored per physician	**79.79 in the most recent published year** — respectable, but scored as an accountable-care-organization average rather than individually	Heart-failure quality measures include blood-pressure control. Monthly structured contact and home blood-pressure data are how that measure moves, and the service line generates both as a by-product of care
Cost — scored per physician	**Not scored at all today** under the alternative-payment pathway	**This is the genuinely new exposure.** The practice has no track record, no baseline and no muscle memory on a cost category, and it is about to be graded on one built from episode-based cost measures for heart failure — with zero reimbursed post-discharge or between-visit workflow to move it

[18] CMS Clinician Public Reporting - Overall MIPS Performance, PY2023 (ec_score_file.csv, published November 18, 2025), queried by National Provider Identifier August 3, 2026. Seventeen physicians under the group's organization PAC ID carry an identical scorecard with the source field indicating the alternative-payment pathway, which assigns the accountable care organization's score to every participating clinician - which is why individual performance is currently invisible.

The uncomfortable arithmetic, stated once

Under the accountable care organization's pathway every participating clinician receives the organization's score, so individual performance is currently invisible. **The model makes it visible**, and it does so per physician, on quality and cost, in a budget-neutral pool. The accountable care organization's own most recently published blood-pressure control result is 68.59%. That figure belongs to the organization, not to this practice — but it is the environment this practice's heart-failure quality performance currently sits inside, and under the model there is no average to sit behind.

The group's shared-savings arrangement is also **upside-only** at its current track level, carrying no downside risk. **The Ambulatory Specialty Model would therefore be the first genuine two-sided risk these physicians carry personally.** That is worth naming plainly, because it changes who needs to be in the room.

3.3 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 a device implant — from unfunded care into billable events. PCM (99424–99427) remains the monthly chassis for single-condition specialty management, and RPM and PCM stack in the same month with discrete documentation.

3.4 The market: Original Medicare is the minority payer here

County (office)	Total Medicare	Original Medicare	MA penetration	Dual share
Henry (McDonough)	43,397	16,421	**62.2%**	16.7%
Clayton (Riverdale)	39,666	12,239	**69.1%**	26.9%
Fulton (East Point)	163,659	75,028	54.2%	20.3%
Fayette (Fayetteville)	28,791	14,804	48.6%	7.0%
Spalding (Griffin)	16,572	6,072	63.4%	22.4%
Butts (Jackson)	5,779	2,004	65.3%	21.3%
Georgia	2,020,281	884,065	**56.2%**	18.9%

CMS Medicare Monthly Enrollment, April 2026 snapshot (dataset modified July 23, 2026). Across the five non-Fulton counties the practice serves, roughly 134,200 total Medicare beneficiaries, of whom about 51,500 are in Original Medicare.

Two consequences follow, and a forecast that ignores either will be wrong. First, **the model-scored population is a minority of the Medicare panel** — the Ambulatory Specialty Model applies to clinicians treating people with Original Medicare, and Original Medicare is roughly a third of the Medicare population in Henry and Clayton. The payment adjustment still applies to Part B claims, and the quality machinery built for it serves the whole panel, but the scored denominator is smaller than the practice may assume. Second, **the Medicare Advantage population is not lost volume — it is different volume**. Remote monitoring and care management are widely covered by Medicare Advantage plans, typically on plan-specific terms, so the same infrastructure serves it under contracts that have to be confirmed one by one. *Whether this practice holds Medicare Advantage or commercial value-based contracts directly, or only through its clinically integrated network, is not publicly discoverable and is a first-conversation question.*

The trend line is the part worth pausing on. In the headquarters county, total Medicare enrollment grew 48% in ten years — from 29,332 in April 2016 to 43,397 in April 2026 — while Original Medicare enrollment fell slightly, from 18,368 to 16,421. **Essentially all of the growth went to Medicare Advantage.** This is a fast-growing, fast-aging corridor in which the fee-for-service denominator is stable rather than expanding. That argues for building the capability now, on the fee-for-service base that exists, and for treating the Medicare Advantage population as the second phase rather than the first.

4. Performance Snapshot: The Starting Position

4.1 The panel: high-acuity, heart-failure-heavy, and split across two markets

A national-average Medicare beneficiary carries an HCC risk score of 1.00. Across the 21 physicians in this group, the beneficiary-weighted average is **1.81**, at an average beneficiary age of **74 to 77**.[19] The condition mix is the part that matters for a heart-failure model: **heart failure prevalence of 36.3%**, ischemic heart disease 40.5%, chronic kidney disease around 44% and diabetes around 47%, with a dual-eligible share of 16.4% of the practice's Original Medicare beneficiaries. That is a sick, old, chronic-heavy panel — the ideal denominator for remote monitoring and care management, and the population in which avoided admissions are both most achievable and most valuable.

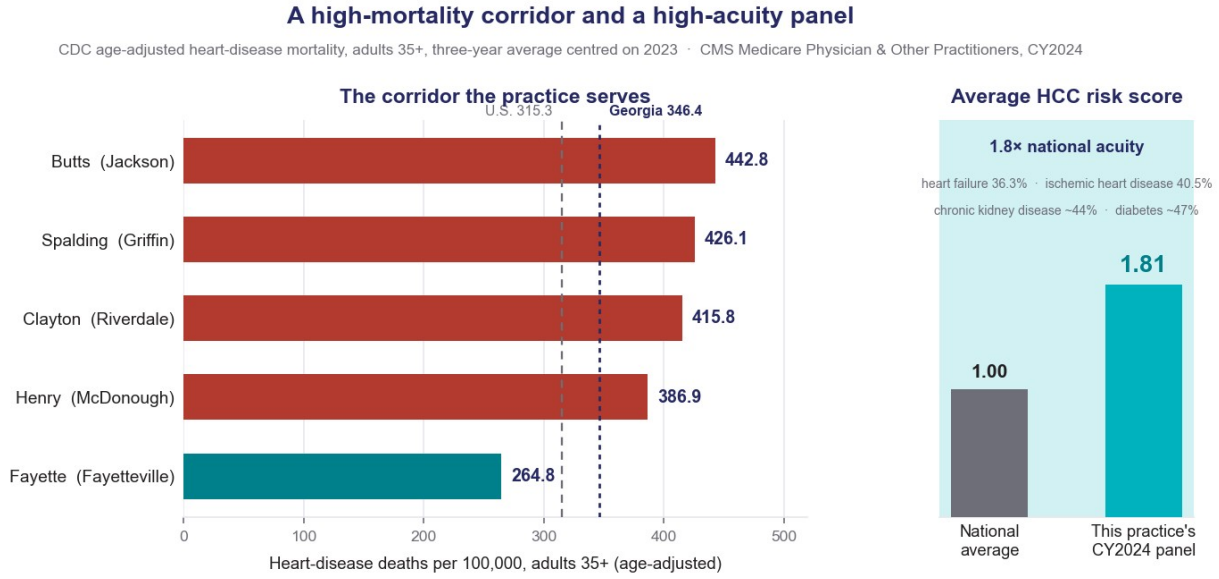

Figure 2. The corridor and the panel. Heart-disease mortality is CDC age-adjusted for adults 35+, a three-year average centred on 2023; panel acuity and prevalence are CMS Medicare Physician & Other Practitioners, CY2024, beneficiary-weighted across the 21 physicians. Directional snapshot — refresh against current data before use in any external material.

The socio-economic spread across the six offices is severe, and it is an operating constraint rather than a footnote. Fayette County runs a median household income of $111,978 with 3.9% of families below poverty and 8.6% uninsured; Clayton County runs $59,806 with 14.7% of families below poverty and **17.0% uninsured — roughly double the national rate**; Spalding runs 18.9% of people below poverty and 13.3% uninsured.[20] Clayton is also the most Medicare-Advantage-penetrated and most dual-heavy county in the footprint. **The fee-for-service coinsurance model is therefore weakest exactly where several of the offices sit**, and a single blended acceptance rate applied across all six will overstate the southern sites. This is not a reason to narrow the programme; it is a reason to sequence it, and to design coinsurance handling and onboarding support differently at the two ends of the corridor.

4.2 The service record: remote monitoring at scale, care management at zero

Every HCPCS line billed by all 21 physicians in **both CY2023 and CY2024** was screened against the full remote-monitoring and care-management code set — remote physiologic monitoring, remote therapeutic

[19] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026), beneficiary-weighted across the 21 enrolled physicians: average HCC risk score 1.814, heart-failure prevalence 36.3%, ischemic heart disease 40.5%, chronic kidney disease approximately 44%, diabetes approximately 47%, dual-eligible share 16.4% of the practice's Original Medicare beneficiaries, mean beneficiary age 74-77.

[20] U.S. Census Bureau American Community Survey, 2024 five-year estimates, profiles DP02/DP03/DP05 with income cross-checked against detail table B19013, retrieved directly from the Census data API and spot-checked against a regional-commission republication; all values matched. National comparison figures are from the same release.

monitoring, chronic care management, principal care management, and transitional care management. **Not one code from that set appears, for any physician, in either year.**[21] In the same file, the group's remote *device* monitoring is one of its larger lines:

CPT	What it is	Physicians	Beneficiaries	Services	Est. allowed
93229	**Mobile cardiac telemetry — technical support, up to 30 days**	**12**	**365**	**368**	**$293,886**
93228	Mobile cardiac telemetry — physician review	12	372	375	$9,151
93296	Device remote interrogation, technical, up to 90 days	2	905	1,515	$32,003
93297	**Implantable hemodynamic monitor, remote, 30 days**	**5**	**223**	**1,098**	**$31,990**
93294	Pacemaker remote interrogation, up to 90 days	2	628	1,065	$30,730
93295	Defibrillator remote interrogation, up to 90 days	2	283	459	$16,512
93298	Implantable loop recorder, remote, 30 days	2	47	145	$14,437

CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024 (released May 21, 2026), across the 21 enrolled physicians. Beneficiary counts are sums of per-physician counts and are NOT de-duplicated — a patient followed by two physicians is counted twice — so treat them as upper bounds. CMS suppresses any line with fewer than 11 beneficiaries.

Three things follow, and they matter more than anything else in this report. First, **this practice already runs a remote-monitoring nurse workflow**. A group interrogating roughly 900 implanted devices remotely and running mobile cardiac telemetry across twelve physicians has device technicians, a triage inbox, an alert-review protocol and documented remote-monitoring habits. The usual first objection to a remote care programme — that the nurses could not run one — is pre-answered by the group's own claims data. Second, **223 beneficiaries on implantable hemodynamic monitors is a heart failure population**. Those are pulmonary-artery pressure sensors placed in advanced heart failure patients, and the volume grew 57% in a year, from 142 in CY2023. Third — and this is the sharpest fact in the file — **three of the five physicians billing that heart-failure follow-up are among the eleven clinicians named on the preliminary CY2027 participant list**. The named cohort is already running an implantable heart-failure monitoring programme. It simply has no wrapper around it, no non-invasive layer beside it, and no care-management billing under it.

[21] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024 and CY2023, screened for all 21 enrolled physicians against the full remote physiologic monitoring, remote therapeutic monitoring, chronic care management, principal care management and transitional care management code sets. Zero services on every code, for every physician, in both years - subject to CMS's suppression of any provider/HCPCS line with fewer than 11 beneficiaries.

The programme exists in claims and is invisible everywhere else

The practice's public website advertises a device clinic and an onsite anticoagulation clinic, describes a loop recorder that "allows remote monitoring," and lists Holter and cardiac outpatient telemetry. **It says nothing at all about implantable hemodynamic heart-failure monitoring**, and it advertises no heart failure clinic, no remote patient monitoring programme, no chronic care management, no cardiac rehabilitation and no telehealth.

That convergence is what makes the whitespace finding safe to act on: **two fully independent methods — the CMS claims record and the practice's own website — agree on both the presence list and the absence list**. The one thing they disagree on is the implantable hemodynamic programme, which the claims prove and the website omits entirely. A practice billing 1,098 remote interrogations a year on a heart-failure device and never mentioning it has the clinical instinct and no programme wrapper around it.

An anticoagulation clinic, incidentally, *is* a care-management programme: scheduled non-visit touches, protocol-driven titration, nurse documentation, recurring billing. This group does not need persuading that nurse-run, protocol-driven, between-visit chronic care works. It runs one. The conversation is that CMS now pays substantially more for the physiologic version of it, and that a mandatory model has put a clock on it.

What the claims data proves, stated precisely

CMS suppresses any provider / HCPCS line with fewer than 11 beneficiaries, so a pilot-scale programme would not appear in these files. What the record therefore establishes is that **no remote physiologic monitoring or care-management programme at meaningful scale existed in either CY2023 or CY2024**. It does not establish that literally zero patients were ever monitored, and it cannot speak to a programme launched in 2025 or 2026 — the next CMS release covering data year 2025 is not expected until roughly mid-2027. It also covers Medicare fee-for-service only; commercial or Medicare Advantage remote monitoring would not appear at all, which matters more here than in most markets given the corridor's Medicare Advantage penetration. *Confirm current-state programmes directly in discovery.*

4.3 The corridor: mortality above both the state and the national rate

Four of the five counties in which the practice's offices sit run above both the Georgia and the national heart-disease mortality rate: **Butts 442.8 per 100,000, Spalding 426.1, Clayton 415.8 and Henry 386.9, against 346.4 for Georgia and 315.3 for the United States**. Fayette is the exception at 264.8. Stroke mortality tells the same story, and the headquarters county carries the highest figure in the footprint at **118.3 per 100,000 — roughly 56% above the national rate**.[22]

Measured prevalence is consistent rather than extreme. County coronary heart disease and angina prevalence runs 5.2% to 7.7%, hypertension 37.1% to 43.1%, diabetes 12.6% to 16.2%, and obesity reaches 45.2% in both Henry and Clayton. **The honest reading is that this is a genuinely high-burden corridor whose outcomes are worse than its measured prevalence alone would predict** — which is a care-coordination and follow-up problem as much as a disease-burden one, and precisely the gap that transitional care, remote physiologic monitoring and principal care management close. Note also what is missing: the CDC's county prevalence programme publishes no standalone heart-failure measure, so no county-level heart-failure prevalence figure exists to cite. The practice's own panel figure — 36.3% — is the better number, and it comes from the group's own claims.

Georgia is a Stroke Belt state, and its own data carries the signature rather than merely inheriting a historical label: statewide stroke mortality runs 10.8% above the national rate and heart-disease mortality 9.9% above. *The CDC's narrative pages blocked automated retrieval during research, so the designation itself is cited to a secondary source while the corroborating mortality figures come directly from CDC data.*

[22] CDC heart disease mortality (resource mri7-5jtw) and stroke mortality (resource y5ii-knwc), age-adjusted for adults 35+, spatially smoothed three-year average centred on 2023; queried by county August 3, 2026. CDC PLACES county estimates, 2025 release (BRFSS survey year 2023), supplied the county prevalence figures; PLACES publishes no standalone heart-failure measure. The Stroke Belt designation is cited to a secondary source because CDC's narrative pages blocked automated retrieval; the corroborating state-versus-national mortality figures are CDC data.

4.4 Position in the market

The competitive picture here is unusual and it should be handled carefully. The dominant competitor is also the practice's network partner. The health system whose Epic tenant the practice runs on, whose accountable care organization it belongs to, and whose hospitals it admits to, operates its own employed cardiology organization of **479 clinicians**, including roughly 34 in Fayetteville — the same town as one of this practice's six offices — plus a presence in Newnan and Sharpsburg on the same south-western arc, and a named heart failure centre in Newnan.[23] That organization carries 21 clinicians on the same preliminary Heart Failure participant list. **This is a reason for the practice to want independent capability, not a reason to attack a partner**, and every piece of external material for this account should read that way.

The rest of the competitive set is closer than it looks. A health system cardiology clinic sits roughly a mile from the practice's Riverdale office; another sits one block from its Griffin office. Neither is a new entrant. Two competitors frequently named in commercial profiles are not competitors here at all: the large north-metro hospital cardiology network has no south-metro presence, and the similarly named Tucker group is a different company operating entirely in the north-eastern metro. *Private-equity and management-services consolidation has reached Georgia cardiology — three platforms entered the state between December 2023 and June 2026 — but none of them has reached this corridor*. That is a medium-term threat to independence rather than a present competitor, and it is another argument for owning a capability that makes the practice harder to displace.

One more piece of market context belongs here because it changes the referral picture. The dominant admitting hospital opened a $215 million patient tower in May 2026, adding 96 patient rooms and three operating rooms, and was designated a Level III trauma centre; a second system hospital in the footprint broke ground on a $275 million expansion in February 2026. **Capacity in this corridor is being added, not removed**, and the group is the shared independent cardiology bench across it. A practice that arrives at those conversations with a working post-discharge programme and measured readmission data is negotiating from a different position than one arriving with a proposal.

[23] CMS Doctors and Clinicians National Downloadable File, vintage June 26, 2026, rolled up on organization PAC ID for competitor clinician counts and footprints, cross-read against the CY2027 preliminary participant file for each competitor's Heart Failure cohort count. Competitor office locations and the capital-project figures cited in this section are from those organizations' own published pages and from regional press coverage dated between October 2023 and July 2026.

5. Powering ASM: The Heart Failure Cohort

Reminder of the constraint on everything in this section. Eleven of the group's cardiologists are **named on the CMS preliminary CY2027 participant list for the Ambulatory Specialty Model**, Heart Failure cohort. That is a preliminary list; no final CY2027 list had been published as of August 3, 2026, and the model's design is under active proposed revision with a comment deadline of September 14, 2026. **Re-verify against the final file before acting on this section.** Everything below is written as readiness planning, not as a compliance instruction.

If the designation holds, the model is a good fit for what this practice already has and a poor fit for how it is currently staffed. It scores clinician-level quality and cost on a heart failure population across a performance year and converts that into a Part B payment adjustment. **A heart failure population is not managed in the exam room** — it is managed in the weeks between visits, on weight trend, blood pressure, symptom change and medication tolerance, and that is exactly the layer the group does not currently staff or bill.

The wedge, stated as precisely as the evidence allows

What is verified, and what is inference

Verified. The CMS Doctors & Clinicians file classifies the group's 21 physicians as 13 in general cardiovascular disease, 4 in interventional cardiology, 2 in cardiac electrophysiology and 2 in vascular surgery. **No advanced heart-failure or transplant subspecialist appears on the roster at all**, and all eleven named clinicians fall within the general cardiovascular disease classification.[24]

A nuance worth getting right, because two CMS sources differ. By self-reported NPPES taxonomy, four of the eleven register as interventional cardiologists even though CMS's own specialty file classifies them as cardiovascular disease. **The correct statement is therefore that CMS selected eleven of the practice's 21 physicians on attributed heart-failure episode volume** — the model's stated threshold is at least 20 attributed heart-failure episodes a year — not that it selected “the general cardiologists.” The distinction matters in front of a physician audience.

Inference, labelled as such. No heart failure clinic, disease-management pathway or named heart failure programme appears on the practice's website, and none is visible in the CY2023 or CY2024 claims record. A regional magazine profile from 2021 described one of the group's physicians as medical director of a congestive heart failure programme; that source is five years old, consumer-facing, and the role does not appear on the current site. *Whether a heart failure programme exists today in any form is an open discovery question, not a settled finding.*

The wedge is therefore this. CMS is about to score eleven of this group's cardiologists on heart-failure quality and cost, individually, in a budget-neutral pool — and on the public record there is no dedicated heart-failure programme, no reimbursed between-visit workflow and no post-discharge management layer for them to be scored on. **What the practice does have is better than most groups entering the model have**: an identified, already-monitored heart-failure population, a working remote-data operation, a full Epic footprint, and a Promoting Interoperability score already at 100. The gap is labour and workflow, not clinical capability or technology.

The cohort is already partly identified

Most cardiology groups entering a heart-failure model have to build the denominator first. This one has a head start on it. **223 beneficiaries carried implantable hemodynamic monitors in CY2024** — pulmonary-artery pressure sensors placed in advanced heart failure patients, already under remote surveillance, already attached to a nurse workflow, and growing 57% year over year. Three of the five

[24] CMS Doctors and Clinicians National Downloadable File, vintage June 26, 2026, rolled up on organization PAC ID 6204737216: CMS primary specialty for each of the 21 enrolled physicians. Self-reported NPPES taxonomies were retrieved separately (August 3, 2026) and differ for four of the eleven named clinicians, which is why this report describes selection as tracking attributed heart-failure episode volume rather than self-reported subspecialty.

physicians billing that follow-up are among the eleven named clinicians. Add the heart-failure share of a panel carrying 36.3% heart-failure prevalence, and the practice can populate a cohort from its own records in weeks rather than quarters. **The 223 is the seed, not the cohort** — the model-attributed population is far larger and reachable non-invasively, which is exactly what the physiologic layer adds.

The service line is the model's operating model

What the model scores	What the service line supplies
Cost of care across the heart failure year	A monitored census with 24/7 alert triage converts deterioration into a same-week outpatient intervention rather than an admission. Modeled at ~325 avoided hospitalizations over 24 months — illustrative, modeled, verify against practice data
Clinician-level quality measures	Monthly structured contact generates the documented blood-pressure readings, weight trends, symptom assessments and medication-tolerance notes the measures are scored from — as a by-product of care rather than as a separate abstraction project
Guideline-directed medical therapy titration	Titration is a production process, not an event. Home blood pressure and weight between visits give the clinical team the data to move doses on a schedule instead of waiting for the next quarterly visit — and PCM (99424–99427) is the monthly billing chassis for exactly that work
Group-level care improvement and interoperability	One enrollment workflow, one shared care plan and one analytics view across six offices is the group-level artifact this component asks for — and the group is already at 100 on the interoperability half of it
The electronic collaborative care arrangement with primary care	This group has no primary-care panel of its own, so the arrangement is a collaboration with **external referring primary-care physicians**: a shared care plan, structured monthly reporting back to the referring physician, and explicit task ownership. The attribution policy in Section 2.1 is the substrate — write it once and it serves both purposes
Health information exchange data sharing	Largely satisfied already by the Epic footprint (Section 8). The service line's contribution is to put structured monitoring data, care plans and evidence of care back into that record on a monthly cadence rather than leaving it in a vendor portal

Design decisions to take before the first performance year, not during it

Attribution. Which heart failure patients are the practice's to manage, and which belong to a referring physician's longitudinal wrapper. Settle it in writing.

Targeting. Start with the identified hemodynamic-monitor cohort and the post-discharge heart failure population — highest acuity, highest avoidable-utilization yield, and both already visible in the practice's own data.

One shared care plan. The collaborative care arrangement is an electronic artifact, not a handshake. Build it as the same care plan the service line already maintains, inside the Epic record.

Cost-category baseline. The group has never been scored on cost. Establish a baseline on heart-failure utilization now, while there is still a year of runway, so performance can be managed rather than discovered.

Roster truth. Confirm which of the eleven named clinicians are actively practising before any internal plan is built around the number.

Re-verification. Diarise a check against the final CY2027 participant list the week CMS publishes it, and a second check on what the CY2027 fee schedule rulemaking actually changes. Preliminary lists get revised, and models under rulemaking move.

The honest summary of this section is that the practice is **closer to readiness than most independent cardiology groups its size** — it has part of the cohort already identified, a remote-monitoring operation already running, a full Epic footprint, perfect interoperability attestation, and referral relationships already in place. It is further away on precisely one dimension: **nobody currently owns the month between visits, and nobody is paid for it**. That is a staffing and workflow gap rather than a clinical one, and

Section 9 is how it closes. Every commitment described above remains conditional on the final CY2027 participant list.

6. The Post-Discharge Window: The Largest Unbilled Asset

The correct statement first, because it is easy to overstate. This practice holds no CMS Certification Number and is not a hospital; its exposure to what happens inside a hospital is indirect. **Its exposure to what happens in the 30 days after a patient leaves one is entirely direct**, because those 30 days are outpatient cardiology, they belong to this group, and they are currently neither managed as a workflow nor billed as a service.

The evidence is unusually clean. **Eighteen of the group's 21 physicians hold privileges at the dominant admitting hospital**, and ten of the eleven clinicians named on the preliminary participant list are among them; thirteen are privileged at a second system hospital, eleven at a third and ten at a fourth.[25] A commercial profile puts roughly 89% of the group's admissions at the dominant hospital — a vendor figure, undated, directional only. And against all of that: **zero transitional care management billed by any of the 21 physicians in CY2023 or in CY2024**.[26]

Why this is the sharpest gap in the file

The model this practice's clinicians are named to names **reducing avoidable hospitalizations** as a stated goal and scores a cost category built from episode-based cost measures for heart failure. The single most reliable lever on that measure is what happens in the days immediately after a discharge — and the practice currently has **no reimbursed post-discharge workflow at all**. That is not a small operational gap; it is the specific mechanism the scorecard runs on.

The scheduling half of the workflow already exists. The practice's Epic build carries a **"Hospital Follow Up" visit type** with online scheduling live against it. The appointment pathway is built. What is missing is the two-business-day interactive contact, the discharge notification process, the monitoring in the first 14 days, and the documentation and billing that turn all of it into a service.

The post-discharge window, in billing terms

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

Why this is the same build as Section 5. Nothing in the table above is a separate asset. It is the same enrollment engine, the same devices, the same triage protocol, the same documentation and the same

[25] CMS Doctors & Clinicians Facility Affiliation Data, vintage June 26, 2026, joined to CMS Hospital General Information, vintage April 28, 2026: 64 affiliation rows across the 21 physicians, with 18 privileged at the dominant admitting hospital and 10 of the eleven named clinicians among them. The admission-share percentage quoted in the text is a commercial firmographic figure, undated, and directional only.

[26] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024 and CY2023: transitional care management codes 99495 and 99496 queried for all 21 enrolled physicians. Zero services in both data years, subject to CMS's 11-beneficiary suppression floor.

billing capture that the heart failure cohort needs from 2027 and that the standalone P&L runs on from month one. **Build once, reuse everywhere** is not a slogan here; it is the reason a 21-physician group with no population-health department can credibly answer a mandatory model.

Post-discharge readiness checklist

- A daily feed or process that tells the practice which of its patients were discharged yesterday, from which hospital — the single most common point of failure in a transitional care programme, and the one most likely to be solvable inside a shared Epic tenant.
- A standing two-business-day interactive contact protocol with named ownership and an escalation path, documented to survive audit.
- Device logistics that work at discharge rather than at the next office visit — the first 14 days are the window that matters, and 99445 now pays for them.
- A readmission view the practice can show its hospital and network partners, so the group's contribution is measured rather than asserted.
- An agreed definition of which post-discharge activity is the practice's and which belongs to a referring primary-care physician, written before the first enrollment.

One last point on sequencing, because it determines who has to say yes. 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 or network ever co-invests a dollar. **The partner conversation is what the capability makes possible — not what it depends on**. And where a hospital or network does support, subsidise or co-invest in physician-practice services, the arrangement must be structured to comply with the physician self-referral and anti-kickback rules. *Take that structure to healthcare counsel before it is proposed, not after.*

7. Powering Device, Vascular and Hypertension Throughput

Remote care is usually sold as a chronic-disease programme. In a group with this procedural profile it is also a retention and throughput instrument, and the mechanism is specific: **a monitored pathway is what keeps a post-procedure or referred patient attached to the practice rather than transferring the relationship along with the referral**. In a corridor where the dominant system's own employed cardiology group operates in the same towns, that is not an abstract benefit.

Line	What the CY2024 Medicare data shows	What the service line adds
Diagnostic and interventional cardiology	Left-heart catheterisation with coronary angiography (93458) across nine physicians, 285 beneficiaries; coronary stent placement (92928) across two, 29 beneficiaries	Post-procedure blood-pressure and symptom monitoring in the 2–15 day window, now billable via 99445; structured follow-up that keeps the patient in this practice's orbit
Electrophysiology — device implant	Dual-chamber pacemaker insertion (33208), 58 beneficiaries, and defibrillator implant (33249), 18 beneficiaries, across the two electrophysiologists — alongside roughly 905 device patients followed remotely	Post-implant physiologic monitoring sits alongside — not inside — device interrogation. Blood pressure, weight and symptom data are patient-generated and distinct from the device's own telemetry (see the boundary rule in Section 2.1)
Implantable hemodynamic heart-failure monitoring	**The most interesting asymmetry in the file.** 223 beneficiaries on remote interrogation (93297) and 1,098 interrogations, but **no implant volume of the group's own** in the CY2024 record — most plausibly because the implants happen elsewhere, or because volume falls below the 11-beneficiary suppression floor. Both are consistent with the data; neither is asserted	**Either way the operational conclusion is favourable: this practice already owns the longitudinal remote-management relationship for a heart-failure population it did not implant.** That is exactly the muscle a heart-failure cohort needs. The gap is that it reaches ~223 patients through an invasive device while the attributed population is far larger and reachable non-invasively
Vascular and vein	Sclerosant injection (36465) across two clinicians, 42 beneficiaries; two vascular surgeons on the roster, with a possible third appearing in the July 2026 enrollment extract	Not a remote-monitoring line in itself, but evidence of continued investment in a service line the practice owns outright — and a reminder that the enrollment engine should be scoped to the whole practice, not only to cardiology
Hypertension and renal denervation	**No evidence of renal denervation** in the group's CY2024 Medicare billing or on its published procedure list. County hypertension prevalence runs 37.1% to 43.1% across the footprint, with obesity at 45.2% in the two largest counties — a very large treated-hypertension base	**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 RPM is intrinsic to that pathway — for candidate identification, for titration, and for the evidence the coverage condition requires

Two honest exclusions belong in this section. First, **no structural heart programme appears in this group's CY2024 Medicare record** — no transcatheter valve therapy, no left atrial appendage occlusion — and this report assumes none. Where such procedures are delivered for these patients, they are delivered elsewhere, and the group's role is diagnostic, referral and post-discharge. Second, **read the renal-denervation row as an option, not a plan**. Nothing in the public record indicates this group performs the procedure today. The point is narrower and more useful: a practice with a corridor-wide treated-hypertension population and above-benchmark cardiac mortality is in the natural position to build a resistant-hypertension pathway — and that pathway is the prerequisite for the procedure whenever the group chooses to look at it.

8. EMR Integration & Technology Architecture

8.1 Epic Community Connect, three months old — and why that is the opportunity

What is verified here, and what has to be confirmed in contracting

Verified: the platform is Epic, and it is not the practice's own tenant. Every one of the practice's locations resolves in the health system partner's provider directory as a department inside that system's Epic instance, flagged as external — the signature of a **Community Connect** arrangement, in which a non-owned practice runs as hosted departments in a system's Epic tenant. The practice operates no patient portal of its own; every portal link on its website routes to the system's MyChart. Epic online scheduling is live, with encoded visit types including new patient, follow-up, surgical clearance and **hospital follow-up**.[27]

Verified: the cutover is about three months old. Archived captures of the practice's own site date the public MyChart cutover to between **April 18 and May 8, 2026**, after roughly six years on a legacy niche cardiology system whose JavaScript namespace is still visible in archived captures of the old portal. The legacy portal was decommissioned first, between November 2025 and January 2026.

A live defect worth mentioning in the first conversation. The practice's patient-resources page still routes patients to the now-dead legacy portal while the site header routes them to MyChart. **Both links are live on the site today and one of them is broken.** It is a small thing, it is checkable in thirty seconds, and it is the kind of detail a practice manager will want to fix.

To be confirmed: who controls integration approval. The tenant belongs to the health system, not to the practice, so integration scope, interface approval and data-governance sign-off are likely to involve the system's information-technology function rather than practice leadership alone. *This is the single most important technical discovery question for this account, and it belongs in contracting rather than in implementation.*

Why a three-month-old cutover is the cheapest possible moment to add this layer. The instinct is to read a fresh migration as change fatigue and a reason to wait a year. The opposite is closer to the truth. The workflows are already being rebuilt, the build decisions are still open, the staff are already in a change posture, and the practice has just proved it will make and execute a major technology decision. There is also a substantive benefit already banked: a full Epic footprint largely satisfies the interoperability and health information exchange requirements the Ambulatory Specialty Model imposes, and the group's Promoting Interoperability score is already 100. **Epic gives them the record. It does not give them the programme.** Enrolling patients, capturing readings, staffing between-visit management and documenting time is labour, and that is what the service line supplies.

8.2 What the integration does

The integration pattern is well established for Epic; only the connector, the approval path and the timeline vary. 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 — and the record its network partner can see.

[27] The health system partner's public provider directory, retrieved August 3, 2026: every one of the practice's locations resolves as a department inside the system's Epic instance, flagged as external, with live Epic online scheduling and encoded visit types including a hospital follow-up pathway. The cutover window is reconstructed from Internet Archive captures of the practice's own site between November 2025 and June 2026.

- **Automated claim generation.** The monthly per-patient claim is generated by the billing engine rather than assembled by hand.

Scope note: integration capabilities are CoachCare-provided; confirm the connector, the product version, the approval path through the tenant owner 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 **5,328 active programme enrollments at month 24**, across six offices and 29 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 118,128 billed units over 24 months.** A manager-level administrative layer with one office billing manager 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.

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 drawn from the eleven named clinicians, a defined target population, and a first billable enrollment inside 90 days. The modeled funnel is deliberately conservative and bottom-up:

Model input	Value	Note
In-scope Medicare base	16,252	Discovery-stage estimate — validate against chart counts
Referring clinicians	29	21 Medicare-enrolled physicians plus the 8 advertised advanced practice providers
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% (12,189) / 35%	Modeled ceiling 4,266 patients; at 3,946 at month 24 and still climbing
PCM eligibility / acceptance	85% (13,814) / 30%	Modeled ceiling 4,144; at 1,382 at month 24 — the arm with the most headroom
Monthly attrition	1.5%	Discharge from programme
Revenue basis	Net of a 15% realization discount	Payer mix and collection, as configured in the model
MAC locality	GA 10212-01 (ZIP 30253)	Auto-resolved in the Value Analysis; verify against the current Georgia locality files

Target populations and clinical pathways

Population	Why it is first	Pathway
Heart failure — the identified cohort	223 beneficiaries already on implantable hemodynamic monitors in CY2024, followed in part by physicians named on the preliminary CY2027 participant list, growing 57% year over year	Weight + blood-pressure RPM with 24/7 triage; PCM as the monthly chassis; titration against measured response
Heart failure — the far larger non-device population	36.3% heart-failure prevalence across a panel carrying an HCC risk score of 1.81; the attributed population is far larger than the 223 and needs no implanted device	Non-invasive weight and blood-pressure RPM plus PCM — the layer that does not exist today
Post-discharge cardiac	Eighteen of 21 physicians privileged at the dominant admitting hospital, zero transitional care management billed in either year, and a hospital-follow-up pathway already built in Epic	TCM 99495 / 99496 (not modeled) + short-window RPM via 99445 / 99470
Uncontrolled and resistant hypertension	County hypertension prevalence 37.1% to 43.1%, obesity 45.2% in the two largest counties, and heart-disease mortality above both state and national rates	Blood-pressure RPM; protocolised titration; the candidate pool for any future resistant-hypertension pathway (Section 7)
Post-device-implant	Pacemaker and defibrillator implant volume across two electrophysiologists, and roughly 905 device patients already followed remotely	Short-window RPM (99445), kept explicitly distinct from device interrogation

A sequencing recommendation the socio-economic data supports. Consider phasing enrollment to bank early wins where coinsurance friction is lowest — the Fayetteville and McDonough ends of the corridor, where uninsured rates run 8.6% and 9.8% — before scaling into Riverdale and Griffin, where they run 17.0% and 13.3% and where a larger share of the Medicare population sits in Medicare Advantage. **This is a sequencing recommendation, not an exclusion**: the southern offices carry the corridor's highest mortality and its highest clinical need, and the programme is worth more there. It simply needs a different onboarding and coinsurance-handling design, and it should not be the first site the programme is judged on.

9.2 Staffing: nobody has to be hired

The model delivers **52,701 care-team hours over 24 months — approximately 25.3 full-time equivalents** — supplied by the partner under the practice's protocols and clinical supervision, alongside 236,255 care-management tasks, 59,064 chart updates, 35,438 patient conversations and 1,969 hours of call time. For a group whose administrative layer is nine managers and supervisors under a physician chief executive, with no population-health or care-management function at all, this is the layer that makes the programme possible rather than a nice-to-have. **The on-site enrollment specialist is funded by CoachCare: embedded value, 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. The incident-to advanced-practice structure already in place (Section 1.1) is the supervision chassis this fits into.

9.3 “We already do remote monitoring” — the answer

This objection is going to come up in the first meeting, and it should — the practice does already do remote monitoring, at a scale most cardiology groups never reach, and it has been doing it for at least a decade. The answer is not to argue with it. It is to be precise about what is and is not already covered.

	Remote cardiac device monitoring (93294–93298)	Remote physiologic monitoring (99453 onward)
What is measured	The implanted device's own telemetry — lead integrity, arrhythmia episodes, device diagnostics, pulmonary-artery pressure from an implanted sensor	Patient-generated physiologic data from a separate connected device — blood pressure, weight, pulse oximetry
Who it covers	Patients with an implanted pacemaker, defibrillator, loop recorder or hemodynamic sensor — roughly 905 device patients and 223 on hemodynamic monitors here	Any patient with a qualifying condition — the great majority of a panel carrying 36.3% heart-failure prevalence has no implanted device at all
What clinical question it answers	Is the device working, and has an arrhythmia occurred	Is this patient decompensating, is the blood pressure controlled, is the titration working
Status at this practice	Running at scale — and growing	**Zero in CY2023 and CY2024**

The two are different benefits over different data, and they answer different questions. The design rule is that the same data stream is not billed twice: a distinct device generating distinct physiologic data supports a distinct service, and the documentation has to make that distinction obvious on its face. *Confirm the specific code pairings with the payer and with billing counsel before launch.* Two further notes specific to this group. Which vendor platform runs the existing device clinic and the mobile-telemetry and hemodynamic monitoring is not discoverable from any public source, and the new programme has to

complement that installed workflow rather than collide with it — so identifying it is a high-value discovery question. And this practice has a long operating history with remote alert triage, which means alert-review protocol, documentation and escalation workflow are topics its clinicians will hold strong and well-informed opinions about. **Treat remote-monitoring governance as a conversation with experts, not an education.**

9.4 Clinical workflow

1. **Identify.** Heart failure, uncontrolled hypertension, post-discharge, post-implant. Built from the practice's own record, seeded by the identified hemodynamic-monitor cohort and the daily discharge list.
2. **Enroll.** One order in the Epic chart. Consent, device selection and logistics handled by the partner; the on-site enrollment specialist covers the offices in rotation, with a telephonic pathway behind it for patients who cannot come in — which matters disproportionately across a corridor this geographically spread.
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 325 modeled avoided admissions actually come from.
5. **Titrate.** Guideline-directed therapy adjusted against measured response on a schedule, 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 — which is good practice, a referral-retention mechanism, and the substrate for the collaborative care arrangement the Ambulatory Specialty Model requires.

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 the Ambulatory Specialty Model would score from 2027, and blood-pressure control is explicitly among the heart-failure quality measures
Operational	Enrolled census by programme; enrollment conversion rate by office; device compliance (days with data); alert-to-contact time	Census is revenue. Days-with-data is what makes 99454 and 99445 billable in the first place. Conversion by office is how the corridor's two economies get managed rather than averaged
Financial	Time to first billable enrollment; capture rate (billed ÷ eligible); net reimbursement per patient per month; net to practice	Modeled at ~$99.62 per RPM patient-month and ~$92.45 per PCM patient-month. Capture rate is the metric that quietly decides whether the modeled P&L is realised
Strategic	Post-discharge reach rate within two business days; readmission delta versus the unenrolled panel; referral retention by referring practice	The numbers to take into a hospital or network conversation, and the ones that make the group's contribution measurable rather than asserted

Expected impact over 24 months, as modeled: $6,439,593 of net reimbursement and $2,720,077 net to the practice at a 42.24% margin; 4,360 unique patients and 5,328 active programme enrollments at

month 24; 512,295 physiologic readings; 118,128 billed units; approximately 325 avoided hospitalizations; and 52,701 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 from among the eleven named clinicians; service line chartered with its own P&L; target populations agreed; integration approval path through the Epic tenant owner established (Section 8.1); attribution and coordination policy written before the first enrollment
Stand up	1–3	Integration built against the Epic build; alert thresholds and escalation protocol set by the physician lead, alongside the existing device-clinic protocols; on-site enrollment specialist placed; discharge-notification process agreed with the dominant admitting hospital
First census	2–6	Heart failure and post-discharge cohorts enrolled first, starting with the identified hemodynamic-monitor patients; first billable enrollment inside 90 days; month 2 is the first net-positive month in the model
Extend	6–9	Hypertension, post-implant and non-device heart-failure pathways added; the southern offices brought on with a coinsurance and onboarding design of their own; a second enrollment pathway opened, because both arms are enrollment-limited rather than eligibility-limited
Institutionalise	9–12	Monthly scorecard running; capture rate and readmission delta reported; TCM decision taken on its own merits; a cost-category baseline established before the first performance year; the final CY2027 Ambulatory Specialty Model participant list re-verified and the readiness plan in Section 5 confirmed against it

References & Data Sources

- **CMS Doctors and Clinicians National Downloadable File** (resource `mj5m-pzi6`, vintage June 26, 2026), rolled up on organization PAC ID 6204737216: the 21-physician roster, CMS primary specialty per clinician, the organization member count, and the absence of any separately enrolled advanced practice provider. Roll-up on organization PAC ID — rather than name matching — is what makes this an identity test rather than a string match.
- **CMS Revalidation Clinic Group Practice Reassignment** (`revalidation_clinic_group_practice_reassignment_pa_xref.csv`, vintage July 14, 2026): 22 direct reassignments to the group's own PAC ID and group enrollment identifier O20040114000144 — the strongest available evidence of corporate independence — and the twenty-second clinician absent from the earlier clinician file.
- **CMS Medicare Fee-For-Service Public Provider Enrollment** and the NPPES NPI Registry (retrieved August 3, 2026): organizational National Provider Identifier 1851327241, taxonomy, registered address, and per-clinician self-reported taxonomies. NPPES practice-location data for this group is materially stale — three records untouched since 2020 — and was used for taxonomy and change signals only, never for attribution.
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024** (released May 21, 2026): total Medicare Part B allowed of $7,106,430 across the 21 physicians, 74,535 services, beneficiary-weighted HCC risk score 1.814, heart-failure prevalence 36.3%, ischemic heart disease 40.5%, chronic kidney disease ~44%, diabetes ~47%, dual-eligible share 16.4%, mean beneficiary age 74–77.
- **CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024 and CY2023** (released May 21, 2026 and April 2025): the published HCPCS mix, the remote cardiac device and telemetry lines (93228, 93229, 93294, 93295, 93296, 93297, 93298), the procedural footprint (93458, 92928, 33208, 33249, 36465), and the negative screen across the full remote physiologic monitoring, remote therapeutic monitoring, chronic care management, principal care management and transitional care management code sets for all 21 physicians in both years. CMS suppresses lines with fewer than 11 beneficiaries.
- **CMS Ambulatory Specialty Model Participants** (`CY27_Prelim_ASMParticipants_Public.csv` — **CY2027 preliminary**; dataset modified February 4, 2026; retrieved August 3, 2026): 11 Heart Failure cohort clinicians under the organization legal name, CY2027 participant flag Yes and small-practice flag No; the national cohort of 2,610 clinicians across 944 organizations; and the Georgia ranking. **No final CY2027 list existed in the CMS catalog as of the retrieval date.**
- **CMS Ambulatory Specialty Model mandatory geographic areas** (`asm-mandatorygeographicareas_12_23_25.xlsx`, dated December 23, 2025): 235 mandatory geographies — 220 core-based statistical areas and 15 metropolitan divisions — with Atlanta appearing once, as Metropolitan Division 12054.
- **CMS Ambulatory Specialty Model programme documents:** the model overview fact sheet and the participant readiness roadmap (cms.gov, retrieved August 3, 2026), for the January 1, 2027 start, the five performance years and 2029–2033 payment years, the −9% to +9% adjustment rising toward −12% to +12%, budget neutrality, taxpayer-identification-number plus National-Provider-Identifier participant identity, the 20-episode selection threshold, the four scored categories, and the required collaborative care arrangement with primary care. The model page also carries CMS's notice that updates were proposed in the CY2027 Physician Fee Schedule notice of proposed rulemaking published July 14, 2026, with comments due September 14, 2026.
- **CMS Medicare Shared Savings Program, Accountable Care Organization Participants PY2026** (dataset modified February 4, 2026): the practice's participant row, initial start date January 1, 2017, BASIC track Level B — an upside-only arrangement carrying no downside risk —

low-revenue and retrospective assignment. The accountable care organization's own public reporting page supplied its PY2024 shared-savings and blood-pressure-control figures.

- **CMS Clinician Public Reporting — Overall MIPS Performance, PY2023** (`ec_score_file.csv`, published November 18, 2025): 17 physicians under the group's organization PAC ID carrying an identical scorecard sourced through the alternative-payment pathway — quality 79.79, Promoting Interoperability 100, improvement activities 40 at full credit, no cost score, final score 89.89.
- **CMS Doctors & Clinicians Facility Affiliation Data** (vintage June 26, 2026) joined to CMS Hospital General Information (April 28, 2026): 64 affiliation rows across the 21 physicians, resolving hospital names and CCNs and the distribution of privileges across two competing health systems.
- **CMS Medicare Monthly Enrollment** (April 2026 snapshot, dataset modified July 23, 2026), queried by county: total Medicare, Original Medicare, Medicare Advantage penetration and dual share for Henry, Clayton, Fayette, Spalding, Butts and Fulton counties, plus the ten-year enrollment trend for the headquarters county.
- **CDC heart disease and stroke mortality** (resources `mri7-5jtw` and `y5ii-knwc`, age-adjusted, adults 35+, spatially smoothed three-year average centred on 2023) and **CDC PLACES county estimates** (2025 release, BRFSS survey year 2023): county mortality and county prevalence, with the Georgia and national benchmarks used in Figure 2. PLACES publishes no standalone heart-failure measure.
- **U.S. Census Bureau American Community Survey, 2024 five-year estimates** (profiles DP02/DP03/DP05 and detail table B19013, retrieved directly and spot-checked against a regional-commission republication): county population, age 65+, median household income, poverty, uninsured rate and educational attainment across the six-county footprint.
- **The practice's own website and its archived captures** (atlantaheartassociates.com — home, who-we-are, locations, our-team, treatments, diagnostic-tests, patient-resources and vein-clinic pages, enumerated through the site's own search interface rather than by URL guessing, retrieved August 3, 2026; Internet Archive captures from 2015 through 2026): the six advertised offices, the described service lines, the device and anticoagulation clinics, the absence of any advertised monitoring, care-management or heart-failure programme, and the portal timeline in Section 8.1. The site is materially stale in places — its accepted-insurance list still names carriers that have not existed as independent brands for roughly a decade — and should be treated as weak evidence for anything time-sensitive.
- **The health system partner's public provider directory and Community Connect programme pages** (retrieved August 3, 2026): the practice's locations resolving as external departments inside the system's Epic instance, live Epic online scheduling including a hospital-followup visit type, and the system's published programme extending Epic to independent physicians.
- **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 Georgia Medicare Administrative Contractor; the model resolves locality 10212-01 for ZIP 30253.
- **CMS national coverage determination 20.40,** renal denervation for uncontrolled hypertension, effective October 28, 2025 under Coverage with Evidence Development.
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 5, 6 and 9, including the 16,252-patient in-scope base, 75% / 85% RPM / PCM eligibility, 35% / 30% acceptance, 1.5% monthly attrition, a 15% realization discount, the 29-clinician referral engine at eight referrals per clinician per month with 80% acceptance, one on-site enrollment specialist at CoachCare's expense, and MAC-locality rates auto-resolved for ZIP 30253 (Georgia, locality 10212-01).

Items not independently verified

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

- **The final CY2027 Ambulatory Specialty Model participant list, and what the CY2027 rulemaking changes.** The verification in this report rests on the **preliminary** CY2027 file, and CMS proposed updates to the model on July 14, 2026 with comments due September 14, 2026. *Re-query the participant dataset and re-run the identifier match before any asset ships, and retrieve the proposed-rule text before relying on any model detail.*
- **Whether all eleven named clinicians are still practising at the group.** Public evidence suggests at least one may not be, and two further roster physicians are absent from the current provider page. “Eleven named on the CMS preliminary list” is a fact about the file and holds either way; “eleven practising clinicians” is not established.
- **Whether any remote monitoring, chronic care or principal care management programme exists today.** CY2023 and CY2024 Medicare show zero across all 21 physicians, and the practice's own website corroborates it, but a programme launched in 2025 or 2026 would be invisible in current data, and Medicare Advantage or commercial activity would not appear at all — which matters more here than in most markets. *This is the single most important thing to ask directly.*
- **Who controls integration and interface approval on the Epic tenant.** The tenant belongs to the health system partner, not to the practice. Whether the practice can commission an integration on its own authority, or whether the system's information-technology function must approve it, determines the implementation path, the timeline and whose signature is needed. *This is the top technical discovery question.*
- **Which vendor platforms run the existing device clinic, the mobile cardiac telemetry and the implantable hemodynamic monitoring.** No vendor name appears anywhere on the practice's site or in any public source. The new programme must complement that installed workflow rather than collide with it, and the staff who run it are the natural operators of a physiologic programme.
- **Who staffs remote monitoring today, and at what capacity.** Eight advanced practice providers are advertised but none is separately Medicare-enrolled under the group's organization PAC ID, so advanced-practice capacity is invisible in claims. Determining whether a physiologic programme can be run with existing staff, or needs the partner's, requires asking.
- **Whether a heart failure clinic or named disease-management pathway exists in any form.** The implantable hemodynamic monitoring volume implies clinical ownership of a heart-failure population, but no named programme appears on the website or in the claims record, and the one public reference to a congestive heart failure medical directorship is a 2021 consumer magazine profile that the practice's current site does not repeat.
- **Who implants the hemodynamic monitors the practice follows.** No implant volume appears in the group's CY2024 record. Either the implants are performed elsewhere or the volume falls below CMS's 11-beneficiary suppression floor. Both are consistent with the data and neither is asserted here.
- **Whether the practice holds Medicare Advantage or commercial value-based contracts directly.** Not publicly discoverable, and unusually important here: roughly 62% to 69% of the Medicare population in the core counties is in Medicare Advantage and outside the specialty model entirely. Network membership terms are not public.
- **True unique-patient panel size and payer mix.** A unique-patient denominator cannot be derived from the public CMS files, which report beneficiary instances per code per provider and contain duplication; the per-provider sum is 20,622 against a modeled in-scope base of 16,252. The

modeled figure is a discovery-stage estimate. Commercial and Medicare Advantage volume is additive to every figure in this report.

- **The live roster and the office count.** Twenty-one physicians as of June 26, 2026 with a twenty-second in the July 14 reassignment extract; two advertised offices do not appear as Medicare-registered locations, and one CMS enrollment address does not appear on the practice's locations page. Confirm both before any outreach or model input depends on them.
- **Job-posting coverage.** Treat it as untested rather than searched-and-empty: two major boards blocked automated access during research. No care-coordinator, chronic-care nurse, device-technician or practice-administrator posting was found, but that is a floor and not a ceiling.
- **The specific quality and interoperability measures the cohort will be scored on.** These live in the CY2026 Physician Fee Schedule final rule's model tables, which were not retrieved for this report. Retrieving them would materially sharpen the readiness plan in Section 5.

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 Georgia locality files, and note that CY2027 rulemaking is in progress. The Ambulatory Specialty Model verification rests on the **preliminary** CY2027 participant list and must be re-checked against the final file, and the model's design is itself under active proposed revision with comments due September 14, 2026. Medicare claims figures cover fee-for-service only and are subject to CMS's suppression of lines with fewer than 11 beneficiaries; beneficiary counts drawn from per-provider files are not de-duplicated. All Value Analysis outputs are illustrative, modeled — verify against practice data.

Prepared by CoachCare · August 2026.