

## Brookhaven Heart

An independent, physician-owned cardiology group in Patchogue, Suffolk County, New York, with its own primary care network, MD365: two cardiology offices and ten primary care sites on one Medicare billing number and one eClinicalWorks system, with Medicare panels of about 3,150 cardiology and 2,950 primary care patients

# Cardiovascular & Primary Care Service Line Optimization Report

## 2026 Strategy Report

A scalable, profitable remote care service line for Brookhaven Heart: remote monitoring and principal care management for the cardiology panel, remote monitoring and chronic care management for MD365's primary care panel, billed under Brookhaven Heart's own NPIs at Long Island's CY2026 Medicare rates, staffed by CoachCare and run inside eClinicalWorks

### Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the leadership of Brookhaven Heart and MD365. It is the companion to the practice's remote care strategy page and makes the same case at report length: why this is the year, what the practice's own Medicare claims show, how one service line runs across both panels inside eClinicalWorks, what it returns over 24 months at Long Island's rates, and how it fits the ACO the practice joined in January and the hospitals' new accountability for the 30 days after discharge.

Brookhaven Heart already bills remote monitoring and care management. In CY2024 its clinicians billed device supply for about 666 traditional-Medicare patients and chronic care management for about 861, and MD365 offers both as Connected Care. This report is about scale and structure: taking an average of about 312 monitored patients a month to about 1,500 across both panels, with a cardiology protocol and the staffing to carry it.

**Prepared by CoachCare for discussion with Brookhaven Heart. © 2026 CoachCare.**

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## Executive Summary

**Brookhaven Heart** is an independent cardiology group founded in Patchogue in 2006. Six cardiologists and a nurse practitioner cover interventional coronary and peripheral work, non-invasive imaging and heart failure from offices in Patchogue and New Hyde Park. The practice also runs its own primary care network, **MD365**: eight physicians and nine nurse practitioners and physician assistants across ten Long Island sites, billing Medicare under the same number. Both brands run on one eClinicalWorks instance.<sup>1</sup>

The practice's CY2024 traditional-Medicare claims describe two different panels. The cardiologists' patients average 75 years old with a weighted risk score of 1.44, and heart failure runs at 18%; MD365's average 71 with a risk score of 1.12. And remote care is already part of the practice: **Brookhaven Heart clinicians billed remote-monitoring device supply for about 666 patients and chronic care management for about 861**, roughly \$916,000 of Medicare allowed charges.<sup>2</sup>

### The observation this report is built on

**Build it once in eClinicalWorks, and one service line covers both panels.**

The same care team, devices and claims pipeline serve the cardiology patients and the MD365 primary care patients. The same work counts for the Medicare Shared Savings Program ACO Brookhaven Heart joined in January 2026, on the Enhanced track, and for the 30 days after discharge that the four hospitals where its physicians hold privileges now answer for under TEAM. Today's program is the baseline it grows from. Fee-for-service reimbursement pays for the whole line; the Value Analysis does not model shared savings.

## What the Value Analysis returns

| Both arms               | Year 1      | Year 2      | 24 months   |
|-------------------------|-------------|-------------|-------------|
| Net reimbursement       | \$2,005,447 | \$3,743,310 | \$5,748,757 |
| CoachCare fees          | \$1,160,729 | \$2,143,227 | \$3,303,956 |
| Net to Brookhaven Heart | \$844,718   | \$1,600,083 | \$2,444,801 |
| Practice margin         | 42.1%       | 42.7%       | 42.5%       |

*CoachCare Value Analysis: cardiology arm, remote monitoring and principal care management for a Medicare panel of 3,150 with 7 referring clinicians; MD365 arm, remote monitoring and chronic care management for a Medicare panel of 2,950 with 17 referring clinicians; one CoachCare-funded on-site enrollment specialist per arm; CY2026 New York locality 02 amounts. CoachCare fees include \$97,951 of implementation, eClinicalWorks integration and telephonic outreach. Margin is net to the practice divided by net reimbursement.*

The two arms carry similar weight. Cardiology returns \$2,637,728 of net reimbursement and \$1,084,446 to the practice over 24 months; MD365 returns \$3,111,029 and \$1,360,355. **At month 24 the service line holds 1,913 unique patients**, with about 1,500 on remote monitoring against the 312 a month the practice averaged in CY2024.

- 1. Positive from month 2, with nobody hired.** Implementation and the eClinicalWorks setup post in month 1; every month after is positive, and the monthly net climbs with the census to \$140,726 by month 24. CoachCare delivers 42,493 care-team hours over 24 months, about 20.4 full-time-equivalent years, with 11 care managers at month 12 and 12 at month 24, at 165 patients each.

<sup>1</sup> brookhavenheart.com and md365.org, physician, provider and location pages, retrieved October 24, 2026; CMS Doctors and Clinicians, July 2026, and the PECOS reassignment file, September 2026, for the practice's group enrollment; both sites link the same eClinicalWorks patient portal and healow practice.

<sup>2</sup> CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, the six cardiologists and the ten MD365 clinicians who billed that year: 99454 patients and 99490 patients summed per clinician; allowed at CY2024 rates. Traditional Medicare only; Medicare Advantage claims are not in the file.

2. **The eligible panel sets three of the four ceilings.** MD365 remote monitoring fills in month 9 and chronic care management in month 10; cardiology remote monitoring fills in month 12. Cardiology principal care management is the exception: it is still climbing at month 24, 717 enrolled against a ceiling of 803. For MD365 the panel moves the answer almost one-for-one: at 2,300 patients the 24-month total is \$5,170,514, at 3,600 it is \$6,266,767. The chart count is the first thing to confirm.
3. **A second enrollment specialist on the cardiology side is the one staffing lever.** It cannot raise any ceiling, but reaches cardiology principal care management's by month 16: 24-month net reimbursement rises from \$5,748,757 to \$6,367,076 (+\$618,319), and net to the practice from \$2,444,801 to \$2,711,672. We recommend scoping it; the forecast of record keeps one specialist per arm.
4. **One eClinicalWorks instance covers both brands.** CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically, and a flagged patient reaches the first day of service in under five days (Section 4).
5. **The ACO year rewards the months between visits.** The service line avoids about 188 hospitalizations over 24 months and works every month on blood pressure control, diabetes control and depression follow-up, measures the ACO reports. The forecast itself is fee-for-service and counts no shared savings (Section 7).
6. **All four of the practice's hospitals now answer for the 30 days after discharge.** Each has been a mandatory TEAM participant since January 2026, and coronary bypass is TEAM's cardiac episode. A two-business-day call, a cuff and a scale at home, and a flag to the patient's cardiologist are the post-discharge layer those episodes depend on. With the follow-up visit the practice already schedules, the same call lets it bill transitional care, 99495 (\$254.35) or 99496 (\$344.57); the forecast carries none of it.
7. **The CY2027 proposed rule takes 6.0% off this line.** A 20.5% cut to device supply is 9.4% on remote monitoring across both arms and \$346,213 over 24 months on the whole line. Section 8 draws the cascade.

**The ask is a working session:** confirm both panels' Medicare chart counts, map today's remote care program, agree on the cardiology flag criteria, and scope the eClinicalWorks integration before the first patient enrolls.

## 1. Why Now: Two Panels, One ACO, Four TEAM Hospitals

Four changes reached Brookhaven Heart at the same time, and each points at the months between appointments: the heart-failure patient whose weight climbs in week three, the MD365 patient whose blood pressure stays above goal after a new agent, the patient sent home from the hospital on a Friday.

| The shift                               | What it means for Brookhaven Heart                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. The panel is the unit of care</b> | A cardiology patient seen two or three times a year spends most of the year with no data in the chart, and a primary care patient with diabetes and hypertension is similar. Between visits weight creeps up, a new agent leaves blood pressure above goal and an A1c drifts, and the office hears at the next visit or from the emergency department. Managing panels of about 3,150 cardiology and 2,950 primary care Medicare patients means knowing which of them are trending the wrong way this week. |
| <b>2. The ACO year</b>                  | Since January 2026 Brookhaven Heart has been a participant in a Medicare Shared Savings Program ACO on the Enhanced track, which carries two-sided risk. Its patients' admissions now count against the ACO's spending benchmark, and the ACO reports blood pressure, diabetes and depression measures on them <sup>3</sup> . MD365's primary care visits drive which patients are assigned.                                                                                                                |

<sup>3</sup> CMS Medicare Shared Savings Program ACO Participants, performance year 2026 (data.cms.gov dataset 9767cb68), and the CMS Quality Payment Program eligibility record for the practice's clinicians, 2026: Enhanced track, first agreement period, start January 1, 2026, retrospective assignment, not in ACO Primary Care Flex.

| The shift                                   | What it means for Brookhaven Heart                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3. TEAM at all four hospitals</b>        | All four hospitals where Brookhaven Heart physicians hold privileges became mandatory participants in TEAM, the Transforming Episode Accountability Model, on January 1, 2026 <sup>4</sup> . Each is accountable for Medicare spending through the 30 days after a coronary bypass discharge, and the cardiology follow-up is part of that window.                                                                                                                                                                                                                                                                                       |
| <b>4. Codes for the work between visits</b> | Remote monitoring pays when a patient takes readings on 16 or more days in a month, and two codes new in 2026, 99445 and 99470, pay for shorter months such as the first weeks after an enrollment or a discharge; in this forecast they carry 17.6% of remote-monitoring gross reimbursement across both arms. <sup>5</sup> At Long Island's CY2026 rates, one cardiology patient on remote monitoring and principal care management (99454, 99457, 99426) is worth <b>\$200.09 a month</b> in Medicare allowed charges, and one MD365 patient on remote monitoring and chronic care management (99454, 99457, 99490) <b>\$198.10</b> . |

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

## 2. Brookhaven Heart Today: Cardiology and MD365 on One Chart

### 2.1 Two cardiology offices, ten primary care sites

| Site                                                                     | What happens there                                                                                                                                                                                                                       | What it means for this program                                                                                                                                         |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Patchogue cardiology office</b><br>325 East Main Street, headquarters | The main cardiology office: consultations, echocardiography, stress testing, vascular studies, device checks and the heart failure clinic                                                                                                | A cardiology launch site. Patients flagged at the visit or after an echo go home with cellular devices, and home averages are in the chart before the next appointment |
| <b>New Hyde Park Nassau County</b>                                       | The second cardiology office, sharing the building with an MD365 primary care site                                                                                                                                                       | Both arms in one building: a cardiology referral and a primary care enrollment can happen on the same day                                                              |
| <b>Patchogue hospital campus</b>                                         | A practice suite on the campus of the Patchogue hospital                                                                                                                                                                                 | Close to the discharges the post-discharge cadence follows                                                                                                             |
| <b>MD365 primary care</b><br>Ten sites across Suffolk and Nassau         | East Moriches, Shirley (two sites), Centereach, Brentwood, Oakdale, Lake Ronkonkoma, Patchogue, Syosset and New Hyde Park: primary care, walk-in care and wellness visits, with Connected Care for remote monitoring and care management | The MD365 arm's enrollment points, with one specialist rotating across them and the same flags in every chart                                                          |

*brookhavenheart.com and md365.org, location and service pages, retrieved October 24, 2026.*

The cardiology bench is six cardiologists and a nurse practitioner, covering interventional coronary and peripheral work, non-invasive imaging and heart failure. MD365's referring bench is eight family and internal medicine physicians and nine nurse practitioners and physician assistants. The Value Analysis counts 7 referring clinicians on the cardiology side and 17 on MD365.<sup>6</sup>

<sup>4</sup> CMS TEAM participant list, hospitals as of August 18, 2026, matched to the four hospitals on the practice's affiliation page: all four mandatory in the New York-Newark-Jersey City metropolitan area, participation from January 1, 2026.

<sup>5</sup> CoachCare Value Analysis for Brookhaven Heart, 2026: 99445 and 99470 carry \$280,012 and \$45,228 of \$1,845,025 on the cardiology arm and \$247,030 and \$39,900 of \$1,626,191 on the MD365 arm, 17.6% of remote-monitoring gross reimbursement in total.

<sup>6</sup> CMS Doctors and Clinicians, July 2026, PECOS reassignment file, September 2026, and NPPES taxonomies, reconciled to the two websites' physician and provider pages. Clinicians in other specialties who bill under the same group are not counted.

## 2.2 What the CY2024 claims say, arm by arm

The CY2024 Medicare by-provider and by-provider-and-service files were queried for the six cardiologists and the ten MD365 clinicians who billed that year. The profile below is the traditional-Medicare panel each arm saw.<sup>7</sup>

| CY2024 traditional Medicare             | Cardiology              | MD365 primary care                        |
|-----------------------------------------|-------------------------|-------------------------------------------|
| Average age                             | 75                      | 71                                        |
| Weighted HCC risk score (national 1.00) | 1.44                    | 1.12                                      |
| Dual-eligible share                     | About 20%               | About 22%                                 |
| Hypertension                            | 75% (at the cap)        | 74% (at or near the cap)                  |
| High cholesterol                        | 75% (at the cap)        | 75% (at the cap)                          |
| Diabetes                                | 45%                     | 37%                                       |
| Ischemic heart disease                  | 44%                     | 33%                                       |
| Chronic kidney disease                  | 28%                     | 19%                                       |
| Atrial fibrillation                     | 24%                     | 16%                                       |
| COPD · depression                       | 22% · 21%               | 20% · 20%                                 |
| Heart failure                           | 18%                     | 13%                                       |
| Echocardiograms · stress tests          | About 1,000 · about 660 | Not billed by the primary care clinicians |
| Initial hospital visits                 | 89 services             | Not billed                                |

*CMS Medicare Physician & Other Practitioners, CY2024. CMS caps published prevalence at 75%, so hypertension and high cholesterol are floors, and suppresses lines under 11 beneficiaries. Echocardiograms, stress tests and hospital visits are services, not patients.*

These are the panels remote care is built for: hypertension in at least three charts of four on both sides, diabetes in 45% of cardiology patients and 37% of MD365's, and heart failure in nearly one cardiology patient in five. The forecast treats 85% of the cardiology panel as eligible for principal care management and 75% for remote monitoring; on MD365, 75% for chronic care management and 65% for remote monitoring.

## 2.3 The remote care program already billed

Brookhaven Heart is not starting from zero. In CY2024 its clinicians billed remote monitoring and care management for several hundred traditional-Medicare patients, and MD365 offers both to its patients as Connected Care.

| CY2024 traditional Medicare                       | Cardiology | MD365                          | Practice                                                       |
|---------------------------------------------------|------------|--------------------------------|----------------------------------------------------------------|
| Remote-monitoring device supply (99454), patients | About 540  | 127                            | About 666                                                      |
| Chronic care management (99490), patients         | About 590  | 273                            | About 861                                                      |
| Principal care management (99426), patients       | About 74   | No program at meaningful scale | About 74                                                       |
| Average active a month                            |            |                                | About 312 on remote monitoring, 409 on chronic care management |
| Medicare allowed, these codes (CY2024 rates)      | \$761,112  | \$155,283                      | Roughly \$916,000                                              |

<sup>7</sup> CMS by Provider (8889d81e) and by Provider and Service (92396110), CY2024, queried by NPI: 3,153 cardiology and 2,308 MD365 established-visit beneficiary-clinician pairs; prevalence weighted by beneficiaries; hospital, echo and stress counts are services.

*CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024. Patients are counted under the billing clinician; average active patients are billed months divided by 12. Remote device checks of pacemakers and defibrillators are separate and not included.*

Today's program is the baseline the service line grows from. The forecast of record covers the full eligible panel on both arms, traditional Medicare and Medicare Advantage, and reaches about 1,500 remote-monitoring patients at month 24. Who runs Connected Care today, and how many patients are active now, is the second item on the confirmation list. What the service line adds, specifically:

1. **Enrollment capacity.** One CoachCare-funded on-site enrollment specialist per arm, telephonic outreach and chart flags take remote monitoring from about 312 patients a month to about 1,500.
2. **A cardiology protocol.** Heart-failure weight and blood-pressure flags, titration support and rate control, each routed to the patient's own cardiologist.
3. **Principal care management for cardiology patients** with one dominant cardiac condition, while chronic care management stays with MD365 primary care. The two cannot bill for the same patient in the same month, so which cardiology patients stay on chronic care management is a design choice to make together (Section 3.2).
4. **eClinicalWorks-integrated enrollment, documentation and claims** across both brands (Section 4).
5. **Staffing CoachCare carries.** Care managers, enrollment, devices and claims preparation on CoachCare's payroll, with no hiring at the practice.

The cardiology offices also run remote checks of pacemakers and defibrillators for about 100 patients, and they run a heart failure clinic. Device transmissions report rhythm and device function, not blood pressure or daily weight, so the service line sits beside the device clinic rather than replacing it.<sup>8</sup>

## 2.4 The market, and the rate basis

Suffolk County had 339,629 Medicare-eligible residents in October 2026, and 29.86% of them were in a Medicare Advantage plan, well below the New York State share; 235,351 were in Original Medicare in July 2026. Most of the practice's Medicare base is fee-for-service, and those patients are the ones who can be assigned to the ACO. In the county 17.9% of residents are 65 or older, and 27.8% of those report a disability; 24.8% of residents speak a language other than English at home, 16.1% of them Spanish. Among adults, 31.7% have high blood pressure, 10.0% diabetes and 5.7% coronary heart disease.<sup>9</sup>

Every Brookhaven Heart and MD365 site sits in New York locality 02, NYC Suburbs/Long Island, under National Government Services, the Medicare administrative contractor. Every dollar in this report is priced at those CY2026 amounts.<sup>10</sup>

# 3. The Service Line: Two Arms, One Platform

## 3.1 The clinical and billing stack

One discharge code and three monthly programs, split across two arms, with one enrollment conversation, one care team and one billing pipeline into the practice's own billing through eClinicalWorks. The forecast carries the monthly programs; transitional care stays on the stack and carries no dollars.

<sup>8</sup> CMS by Provider and Service, CY2024: remote interrogation of implanted devices (93294 to 93298), patients counted once across the cardiologists.

<sup>9</sup> CMS Medicare Advantage State/County Penetration, October 2026: Suffolk County 29.86% (101,430 of 339,629 eligibles). CMS Medicare Monthly Enrollment, July 2026: 235,351 in Original Medicare. American Community Survey 2020–2024 (DP02, DP05). CDC PLACES 2025 release, Suffolk County, crude prevalence.

<sup>10</sup> CY2026 Physician Fee Schedule, National Government Services carrier 13202, New York locality 02: geographic indices work 1.064, practice expense 1.189, malpractice 1.857; conversion factor \$33.4009.

| Program                                               | What it does clinically                                                                                                                                             | Who it fits                                                                                                                              | Net reimbursement per patient-month         |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| <b>Transitional care management (TCM), both arms</b>  | Contact within two business days of discharge, medication reconciliation, a visit within 14 days (99495) or 7 days at high complexity (99496)                       | Every patient discharged home from a hospital or observation stay                                                                        | <b>Named at \$0; not in the forecast</b>    |
| <b>Remote physiologic monitoring (RPM), both arms</b> | Cellular cuffs, scales and glucose meters send readings between visits against thresholds the practice's clinicians set; 99453, 99454 or 99445, 99457, 99458, 99470 | Heart failure and uncontrolled hypertension first, then atrial fibrillation, coronary disease after a stent, diabetes and kidney disease | <b>Cardiology \$113.85 · MD365 \$113.74</b> |
| <b>Principal care management (PCM), cardiology</b>    | A disease-specific care plan and at least 30 minutes of clinical staff time a month for a patient with one high-risk condition; 99426, 99427                        | Heart failure, resistant hypertension, atrial fibrillation on anticoagulation                                                            | <b>\$104.82</b>                             |
| <b>Chronic care management (CCM), MD365</b>           | A comprehensive care plan and at least 20 minutes of clinical staff time a month for a patient with two or more chronic conditions; 99490, 99439                    | MD365 patients with hypertension, diabetes, COPD, kidney disease or depression in combination                                            | <b>\$127.50</b>                             |

| Codes                | What they pay for                                                                | CY2026 New York locality 02 |
|----------------------|----------------------------------------------------------------------------------|-----------------------------|
| <b>99495 · 99496</b> | Transitional care, visit within 14 days · within 7 days                          | \$254.35 · \$344.57         |
| <b>99453</b>         | Remote monitoring setup and education, once                                      | \$26.26                     |
| <b>99454 · 99445</b> | <b>Device supply, 16+ days · 2 to 15 days in 30 (99445 new in CY2026)</b>        | <b>\$62.18 · \$62.18</b>    |
| <b>99457 · 99458</b> | Treatment management, first 20 minutes · each additional 20                      | \$59.90 · \$47.59           |
| <b>99470</b>         | <b>Treatment management, 10 to 19 minutes (new in CY2026)</b>                    | <b>\$30.13</b>              |
| <b>99426 · 99427</b> | Principal care management, clinical staff, first 30 minutes · each additional 30 | \$78.01 · \$62.49           |
| <b>99490 · 99439</b> | Chronic care management, clinical staff, first 20 minutes · each additional 20   | \$76.02 · \$58.16           |

### How the rates apply

CY2026 non-facility amounts, New York locality 02, NYC Suburbs/Long Island (National Government Services, carrier 13202), ZIP 11772. One device code (99454 or 99445), one first-tier management code (99457 or 99470) and one care-management program bill per patient per month; transitional care bills once per discharge alongside them. One cardiology patient on 99454, 99457 and 99426 is \$200.09 a month in Medicare allowed charges; one MD365 patient on 99454, 99457 and 99490 is \$198.10.

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

## 3.2 Who owns which program

|                                  | Cardiology arm                                  | MD365 primary care arm                                                   |
|----------------------------------|-------------------------------------------------|--------------------------------------------------------------------------|
| <b>Programs</b>                  | Remote monitoring and principal care management | Remote monitoring and chronic care management                            |
| <b>Who governs the care plan</b> | The patient's cardiologist                      | The patient's MD365 physician, nurse practitioner or physician assistant |

|                                              | Cardiology arm                                                                                                              | MD365 primary care arm                                                                      |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <b>Where enrollment happens</b>              | Patchogue and New Hyde Park cardiology visits, echo and stress results, the heart failure clinic, post-procedure follow-ups | Visits and wellness visits at the ten MD365 sites, and telephonic outreach to MD365's panel |
| <b>Escalations go to</b>                     | The cardiologist or the nurse the office designates                                                                         | The MD365 clinician or nurse each site designates                                           |
| <b>Medicare panel · referring clinicians</b> | 3,150 · 7                                                                                                                   | 2,950 · 17                                                                                  |

**One rule shapes the split.** Chronic care management and principal care management cannot both bill for the same patient in the same month. In CY2024 the cardiologists billed chronic care management for about 590 patients, a reasonable choice for patients with several conditions. The service line moves cardiology patients with one dominant cardiac condition, such as heart failure, to principal care management under their cardiologist, and leaves chronic care management with MD365 primary care. Which patients move is a decision for the two sides to make together, patient by patient.

**The referral loop runs inside one chart.** An MD365 patient whose home weights or blood pressures point to heart failure or resistant hypertension is flagged for a cardiology referral in the same eClinicalWorks record. A cardiology patient whose care plan is mostly diabetes, kidney disease and depression is a candidate to move to MD365's chronic care management. Both arms share one care team, so the patient can keep the same care manager either way.

### 3.3 The care team, and the hours it keeps

CoachCare hires, trains and manages the care managers, at 165 patients each: 11 care managers for the 1,806 unique patients at month 12, and 12 for the 1,913 at month 24. One on-site enrollment specialist on CoachCare's payroll works the cardiology schedules in Patchogue and New Hyde Park, and a second rotates across the MD365 sites. Telephonic outreach reaches the rest, and clinicians order from the chart. Devices are cellular, with no Wi-Fi, smartphone or pairing needed. Monitoring runs on business hours: devices transmit daily, and care managers review readings, run outreach and send escalations Monday to Friday, 8 a.m. to 5 p.m. in the patient's time zone. Patients are told at consent to call 911 for an emergency and the practice for anything urgent.

Suffolk County is linguistically mixed, with nearly a quarter of residents speaking a language other than English at home. Planning outreach in Spanish as well as English, and which MD365 sites need it most, belongs in the launch plan (Section 9.5).

### 3.4 Transitional care after a discharge

The cardiologists billed 89 initial hospital visits for traditional-Medicare patients in CY2024, and claims show no cardiology transitional care management at meaningful scale; MD365 billed it for a handful of patients. The CoachCare care team can make the two-business-day contact and the medication reconciliation after each discharge the practice learns of, so the follow-up visit the practice already schedules can qualify as transitional care, furnished and billed by Brookhaven Heart at \$254.35 (99495, visit within 14 days) or \$344.57 (99496, high complexity, within 7 days). Remote monitoring and the care-management program then carry the patient past day 30. The forecast carries no transitional care dollars.<sup>11</sup>

Where discharge notices come from, for each of the four hospitals, is item five on the confirmation list in Section 9.5. The same post-discharge work is what each hospital's TEAM episode depends on (Section 7.3).

<sup>11</sup> CMS by Provider and Service, CY2024: 99221 to 99223, 89 services across the cardiologists; 99495 and 99496 below CMS's 11-beneficiary reporting floor for every cardiologist.

### 3.5 Around procedures

Patients scheduled for a catheterization, a coronary stent or a peripheral intervention can go on blood pressure, heart rate and weight before the procedure and stay on them through recovery, with the same care team and the same chart. After the procedure the patient goes home with a cuff, and the care team checks blood pressure, heart rate and symptoms until the follow-up visit. The short-month codes, 99445 and 99470, cover a partial first month. Device patients with heart failure can add a cuff and a scale, so both data streams sit in the same eClinicalWorks chart and the device team keeps reading the device.

### 3.6 Growing from today's program: build or partner

Brookhaven Heart has already answered part of the build-versus-partner question by building. It bills remote monitoring and chronic care management today, runs a heart failure clinic, and follows implanted devices remotely. What the claims do not show is scale: an average of about 312 monitored patients a month against a forecast that reaches about 1,500, principal care management for only about 74 cardiology patients, and no transitional care at meaningful scale.

| Question                            | What CoachCare brings                                                                                                                             | What stays with Brookhaven Heart                              |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <b>Who staffs the growth</b>        | Care managers at 165:1, on-site enrollment specialists and telephonic outreach, on CoachCare's payroll                                            | Clinical governance, the visits and the patients              |
| <b>How the cardiology side runs</b> | A cardiology protocol for weight, blood pressure and rate, with principal care management under the cardiologist                                  | Thresholds, routing and care plans, set by the cardiologists  |
| <b>How it fits today's program</b>  | Patients already enrolled can move across at a pace the practice sets; nothing about Connected Care has to change before the first new enrollment | The decision on how the two run side by side                  |
| <b>Who builds the claims</b>        | Automated claims in eClinicalWorks once each code's requirements are met                                                                          | Reconciliation and filing under its own NPIs, and the revenue |

## 4. eClinicalWorks: The Program Lives in the Chart

Brookhaven Heart and MD365 share one eClinicalWorks instance, the same patient portal and the same healow practice, so one integration covers both arms. CoachCare works inside eClinicalWorks' own workflows, and the practice's clinicians and staff do not learn a second system. Evidence of care, vitals and care plans are attached to each chart every month, enrollment status is visible at every site, and a flagged patient reaches the first day of service in under five days.<sup>12</sup> CoachCare is the only care-management application integrated with eClinicalWorks that creates claims automatically.

### 4.1 The six integration pillars

| Integration pillar                        | What happens in eClinicalWorks at Brookhaven Heart and MD365                                                                                                                                                                                                                                      |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Integrated enrollment</b>              | Flags in the chart prompt the order for patients who meet criteria the clinicians set: heart failure on a loop diuretic, two office readings at or above 140/90, atrial fibrillation with a rate above goal or a recent discharge on the cardiology side; two or more chronic conditions on MD365 |
| <b>Enrollment by services and devices</b> | The clinician orders by service and by device (cuff, scale, glucose meter), the way a test is ordered; the enrollment specialist can complete enrollment before checkout                                                                                                                          |
| <b>Exchange of health history</b>         | Diagnoses, ejection fraction, medications, vitals and labs pass to the care team at intake; the care plan comes back to the chart                                                                                                                                                                 |

<sup>12</sup> CoachCare eClinicalWorks integration overview, 2026: the six integration pillars; patients begin remote monitoring and care management in less than five days.

| Integration pillar                               | What happens in eClinicalWorks at Brookhaven Heart and MD365                                                                                              |
|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Integrated vital reports</b>                  | Home readings land in the chart, so the cardiologist or MD365 clinician sees home averages and weight trends at the next visit or in the inbox            |
| <b>Compliance documentation and care summary</b> | Evidence of care, vitals and the care plan attached monthly for every enrolled patient                                                                    |
| <b>Automated claim generation</b>                | Claims built for every patient, every month, once a code's requirements are met; the practice's billing team reconciles and files them under its own NPIs |

## 4.2 From a flag in the chart to a claim

1. **Flag.** A patient who meets the criteria is flagged in the chart and on a worklist: at a visit, after an echo, on an outreach list, or when a discharge notice arrives.
2. **Order.** The clinician orders remote care by service and device in eClinicalWorks, or the on-site enrollment specialist enrolls the patient during the visit.
3. **Device and welcome call, within five days.** Cellular devices ship ready to use. The assigned care manager calls to walk through the device and set a routine that fits the patient's day, and setup (99453) is earned.
4. **The monthly loop.** Readings land in the chart. The care manager works the care plan, logs time and routes escalations, and the device, management and care-management codes accrue as their requirements are met.
5. **The claim.** At month end the claim is built in eClinicalWorks: 16 reading days, 20 minutes of treatment management, 30 minutes of principal or 20 minutes of chronic care management. The practice's billing team reconciles the batch in its own work queue and submits it under its own billing entity and NPIs.

No one builds a claim by hand, patient by patient, month by month. Over 24 months the program produces 92,123 claims and billable units in eClinicalWorks for the practice's billing team.

## 4.3 One instance, both brands: reports, cost and timing

| Report                                              | What it shows                                                                                                                                                | At month 12 in this forecast                                  |
|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <b>Operational outcomes for practice leadership</b> | Unique patients active; new enrollments; enrollments by program, arm, site and clinician; reading days per patient; escalations by route; discharges         | <b>1,806 unique patients across 2,525 program enrollments</b> |
| <b>Clinical outcomes for the clinicians</b>         | Share of hypertensive patients at goal on home averages; heart-failure weight trends, diuretic changes and admissions; alerts by type and time to resolution | Built from the same chart data every month, by arm            |
| <b>Claims batch for the billing team</b>            | Claims created in eClinicalWorks for every patient whose codes were met that month                                                                           | Reconciled in the practice's own work queue                   |

The integration costs \$4,000 for setup, \$150 a month and \$1.50 per enrolled patient-month, billed once for the practice because both brands share the instance. With implementation and telephonic outreach the ancillary items total \$97,951 over 24 months across both arms, inside the \$3,303,956 of CoachCare fees. The build runs alongside onboarding, so it does not hold up the first enrollments, and the eClinicalWorks version and modules are item seven on the confirmation list. Patients who already use healow can keep using it, and nothing in the program depends on it.

## 5. Clinical Governance & Escalation

Every reading routes through one escalation engine with defined thresholds, trend rules, routing and documentation, so the practice never carries surveillance liability it did not agree to. Thresholds and routing are set with the cardiologists and with MD365's clinical leads, for each arm, before the first patient enrolls.<sup>13</sup>

### 5.1 One shared escalation engine

| Branch                     | The rule                                                                                                                                                                                                                          | Why                                                                                                    |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Critical value             | Escalate to the practice, regardless of symptoms                                                                                                                                                                                  | No practice preference can suppress it. A critical reading on its own goes to the practice, not to 911 |
| Out of range, not critical | Retake, then a structured symptom check                                                                                                                                                                                           | Most out-of-range readings resolve here, which keeps inboxes usable                                    |
| Trend                      | Three consecutive blood-pressure readings an hour or more apart; three heart-rate readings out of range within seven days; weight gain past the threshold the cardiologists set for heart failure; glucose out of range on repeat | A confirmed trend escalates like a single threshold breach                                             |
| Patient unreachable        | Document, leave a callback message, and escalate anyway if the reading was critical or a confirmed trend                                                                                                                          | Silence never downgrades a clinical finding                                                            |
| Documentation              | Six fields: vital · findings · method · contact · outcome · follow-up                                                                                                                                                             | Any escalation can be reconstructed end to end                                                         |

### 5.2 The emergent pathway

#### Non-negotiable, and stated as such

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

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

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

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

### 5.3 Three-way routing, on business hours

| Route                         | What goes there                                                                                                                                  | Who sees it                                                                                                                       |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| Emergency                     | Active emergent symptoms reported on a call                                                                                                      | 911 with the patient on the line; the office notified                                                                             |
| The patient's cardiologist    | Heart-failure weight gain, a blood pressure or heart rate out of range for a cardiology patient, confirmed after a retake, or a critical reading | The cardiologist or the nurse each cardiology office designates, in eClinicalWorks, with the readings and a recommended next step |
| The patient's MD365 clinician | The same findings for an MD365 patient, plus glucose and care-plan issues                                                                        | The MD365 clinician or nurse each site designates, in the same chart                                                              |
| Stable or resolved            | Worked, retaken and resolved                                                                                                                     | Documented as an FYI in the chart, without paging anyone                                                                          |

<sup>13</sup> CoachCare Care Management Programs standard operating procedures, March 2026: escalation logic, trend definitions, emergent protocol, care-management hours (Monday to Friday, 8:00 a.m. to 5:00 p.m. local patient time), post-discharge sequence and discharge governance.

The matrix is agreed for each cardiology office and each MD365 site. Care managers work readings and escalations Monday to Friday, 8 a.m. to 5 p.m. local patient time, so escalations land while the practice's clinicians are working. A reading that arrives on a weekend or overnight is worked the next business day, and the patient's standing instruction for anything urgent is the practice's own line, or 911.

## 5.4 The post-discharge cadence

Any emergency visit or hospitalization in the previous 60 days triggers the cadence. After a hospital or observation stay it also meets the two-business-day contact that transitional care requires, and each readmission it prevents is one fewer at the hospital where the patient was treated.

| Touch         | Window    | What happens                                                                                                                                                                  |
|---------------|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 · Stabilize | Day 1–2   | What led to the stay; discharge medications reconciled against what is in the house; a follow-up visit with the cardiologist or MD365 clinician confirmed within 7 to 14 days |
| 2 · Detect    | Day 5–8   | Adherence verified, weight and blood pressure trends re-checked, appointment and ordered labs confirmed                                                                       |
| 3 · Secure    | Day 12–14 | Medication and risk review, visit outcome, cardiac rehab referral confirmed where it applies, and a handoff into monthly monitoring                                           |

For heart failure the cadence runs on daily weight and blood pressure from day two, with guideline-therapy steps scheduled while the patient is watched. After coronary bypass or a stent it tracks blood pressure and heart rate while new medications settle, which covers the 30 days a TEAM episode measures.

## 5.5 A phone-first panel, and discharge governance

The cardiology panel averages 75 years old and MD365's 71, and 27.8% of Suffolk County's residents 65 and older report a disability. Devices are cellular and arrive ready to use, with no home internet, smartphone or pairing. The welcome call, the monthly care-management call and every escalation call are made by phone, so no patient has to learn an app. The routine is set on the welcome call to fit the patient's day, and a missed run of readings prompts a call, not a portal message.

1. **Unreachable patients escalate on a fixed clock.** Monitoring patients unreachable 45 days from enrollment, or 90 days without readings, go to the office as an FYI; in care management the first notice comes at six months without a live conversation.
2. **There is a hard backstop.** A recommended discharge goes to the office and is re-sent every 30 days; without an instruction, discharge from monitoring proceeds at 180 days, with the office notified.
3. **The practice always decides.** Discharge criteria, thresholds and routing belong to the cardiologists and MD365's clinicians, with the single exception of the emergent floor in Section 5.2.

# 6. Value Analysis: The 24-Month Forecast

## 6.1 The headline economics

The forecast covers two arms at the CY2026 New York locality 02 amounts: remote monitoring and principal care management across a cardiology Medicare panel of 3,150 with 7 referring clinicians, and remote monitoring and chronic care management across an MD365 Medicare panel of 2,950 with 17. Each arm has one CoachCare-funded on-site enrollment specialist at 80 enrollments a month. No transitional care, TEAM or shared-savings payment is in these numbers.<sup>14</sup>

<sup>14</sup> CoachCare Value Analysis for Brookhaven Heart, 2026, two workbooks (cardiology and MD365 primary care) rolled up to the practice, the source of all Section 6 figures; sensitivity runs change one input at a time and recalculate both.

| Both arms                                                               | Year 1      | Year 2      | 24 months   |
|-------------------------------------------------------------------------|-------------|-------------|-------------|
| Net reimbursement                                                       | \$2,005,447 | \$3,743,310 | \$5,748,757 |
| CoachCare fees, including eClinicalWorks integration and implementation | \$1,160,729 | \$2,143,227 | \$3,303,956 |
| Net to Brookhaven Heart                                                 | \$844,718   | \$1,600,083 | \$2,444,801 |
| Practice margin                                                         | 42.1%       | 42.7%       | 42.5%       |

The margin rises from 42.1% to 42.7% as the one-time setup falls away, and year two returns **\$3,743,310 of net reimbursement, \$1,600,083 of it kept by Brookhaven Heart.**

## 6.2 The two arms, side by side

|                                    | Year 1      | Year 2      | 24 months   | Margin |
|------------------------------------|-------------|-------------|-------------|--------|
| Cardiology: net reimbursement      | \$816,644   | \$1,821,084 | \$2,637,728 |        |
| Cardiology: CoachCare fees         | \$487,785   | \$1,065,497 | \$1,553,281 |        |
| Cardiology: net to the practice    | \$328,859   | \$755,587   | \$1,084,446 | 41.1%  |
| MD365: net reimbursement           | \$1,188,803 | \$1,922,226 | \$3,111,029 |        |
| MD365: CoachCare fees              | \$672,945   | \$1,077,730 | \$1,750,675 |        |
| MD365: net to the practice         | \$515,859   | \$844,496   | \$1,360,355 | 43.7%  |
| Both arms: net to Brookhaven Heart | \$844,718   | \$1,600,083 | \$2,444,801 | 42.5%  |

*The one-time implementation and eClinicalWorks setup sit on the cardiology arm, which is why its first-year margin is lower; per-patient integration and outreach fees sit with each arm.*

MD365 carries slightly more of the line because chronic care management pays more per patient-month than principal care management and its panel fills sooner. Cardiology carries the higher-acuity patients and most of the post-discharge work. Of the 1,913 unique patients at month 24, about 1,040 are cardiology patients and about 870 are MD365's.

## 6.3 Where the revenue comes from

| 24 months                                                                            | Net reimbursement | CoachCare fees | Net to the practice |
|--------------------------------------------------------------------------------------|-------------------|----------------|---------------------|
| Cardiology remote monitoring                                                         | \$1,708,954       | \$988,840      | \$720,115           |
| Cardiology principal care management                                                 | \$928,773         | \$509,045      | \$419,728           |
| MD365 remote monitoring                                                              | \$1,506,259       | \$872,364      | \$633,895           |
| MD365 chronic care management                                                        | \$1,604,770       | \$835,756      | \$769,014           |
| Implementation, eClinicalWorks integration, per-patient EMR fee, telephonic outreach |                   | \$97,951       | -\$97,951           |
| Total                                                                                | \$5,748,757       | \$3,303,956    | \$2,444,801         |

Remote monitoring is 55.9% of the line across both arms, about \$113.85 a patient-month on either side, and it produces the readings, alerts and avoided admissions. Chronic care management pays about \$127.50 a patient-month on MD365 and principal care management about \$104.82 on cardiology. The **2,880 active program enrollments at month 24 belong to 1,913 unique patients**, because most care-

management patients are also monitored. The two codes new in 2026 carry 17.6% of remote-monitoring gross reimbursement on this mix.<sup>15</sup>

## 6.4 The ramp, month by month

Month 1 nets  $-\$1,416$  across the practice: the cardiology arm carries the one-time implementation fee and the eClinicalWorks setup at  $-\$4,615$ , while MD365 is already  $\$3,199$ . The program is positive from month 2, with  $\$13,224$  on 255 enrollments, and cumulative net to the practice is above zero by the end of month 2. New enrollments peak at about 318 a month during launch, so the monthly net climbs quickly: MD365's programs fill in months 9 and 10, cardiology remote monitoring in month 12, and principal care management keeps adding patients through month 24, when the practice nets  $\$140,726$  a month. At month 12 the program holds 2,525 active program enrollments across 1,806 unique patients, and cumulative net to the practice passes  $\$194,793$  at month 6,  $\$844,718$  at month 12 and  $\$2,444,801$  at month 24.

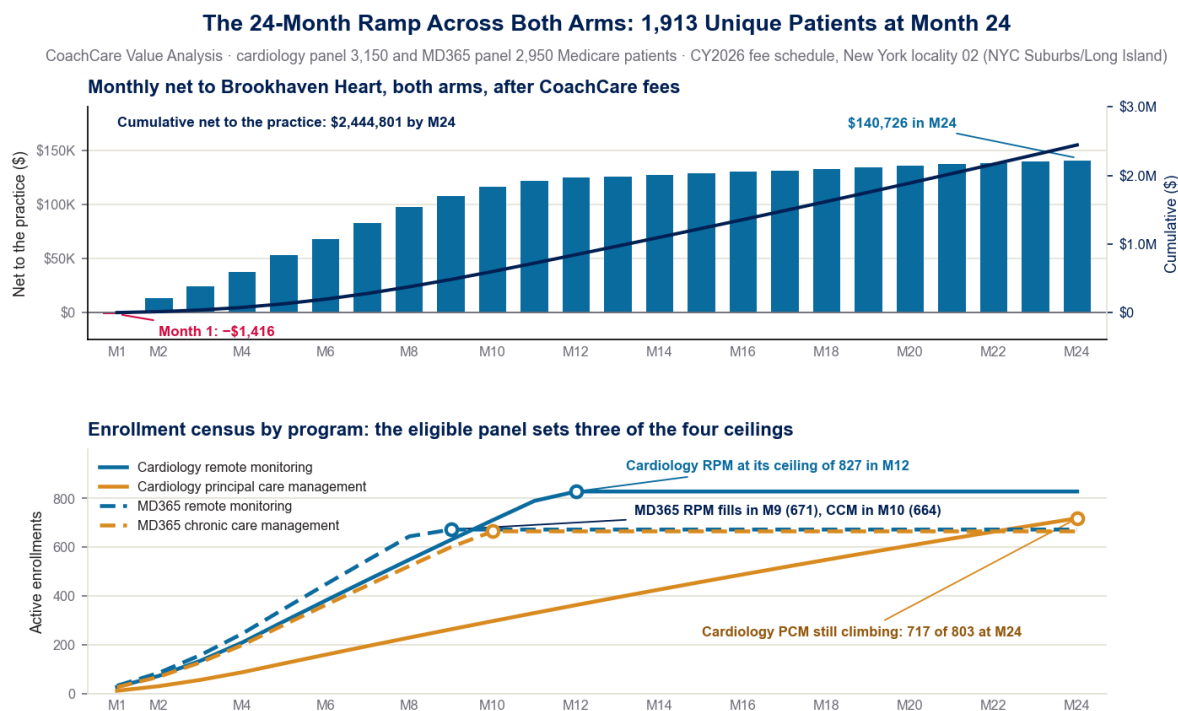


Figure 1. Monthly net to Brookhaven Heart after CoachCare fees, with cumulative net, and the enrollment census by program: MD365 remote monitoring and chronic care management fill in months 9 and 10, cardiology remote monitoring in month 12, and cardiology principal care management is still climbing at month 24. CoachCare Value Analysis, both arms.

| Month | Active enrollments | Net reimbursement | CoachCare fees | Net to the practice           |
|-------|--------------------|-------------------|----------------|-------------------------------|
| M1    | 97                 | \$12,581          | \$13,997       | <b><math>-\\$1,416</math></b> |
| M2    | 255                | \$31,855          | \$18,631       | \$13,224                      |
| M3    | 475                | \$58,174          | \$33,801       | \$24,373                      |
| M6    | 1,350              | \$160,518         | \$92,567       | \$67,951                      |
| M12   | 2,525              | \$292,142         | \$167,535      | \$124,607                     |
| M18   | 2,710              | \$310,677         | \$177,903      | \$132,774                     |
| M24   | 2,880              | <b>\$328,442</b>  | \$187,716      | <b>\$140,726</b>              |

<sup>15</sup> CoachCare Value Analysis: 99445 and 99470 carry  $\$612,170$  of  $\$3,471,216$  remote-monitoring gross reimbursement over 24 months across both arms.

## 6.5 What sets each ceiling

| Program                              | Eligible share and patients | Acceptance | Ceiling | Reached                 |
|--------------------------------------|-----------------------------|------------|---------|-------------------------|
| Cardiology remote monitoring         | 75% of 3,150, 2,362         | 35%        | 827     | M12                     |
| Cardiology principal care management | 85% of 3,150, 2,678         | 30%        | 803     | Past M24 (717 enrolled) |
| MD365 remote monitoring              | 65% of 2,950, 1,918         | 35%        | 671     | M9                      |
| MD365 chronic care management        | 75% of 2,950, 2,212         | 30%        | 664     | M10                     |

### Say the constraint out loud

For three of the four programs the eligible panel, not enrollment capacity, sets the ceiling. MD365's remote monitoring fills at 671 in month 9 and its chronic care management at 664 in month 10; cardiology remote monitoring fills at 827 in month 12. Past those months more enrollment effort cannot add patients, so for MD365 the size of the eligible panel is the binding constraint, and the chart count is confirmation item one.

Cardiology principal care management is the one program still limited by pace: 717 enrolled at month 24 against a ceiling of 803. A second on-site enrollment specialist on the cardiology side cannot raise any ceiling, but reaches this one by month 16 and fills cardiology remote monitoring in month 8 instead of 12. 24-month net reimbursement rises from \$5,748,757 to \$6,367,076 (+\$618,319), and net to the practice from \$2,444,801 to \$2,711,672.

**The second specialist is an option to scope.** The forecast of record keeps one per arm.

MD365's panel moves the forecast almost one-for-one because its programs are panel-limited. At 2,300 Medicare patients, the CY2024 claims count for the ten MD365 clinicians who billed that year, the MD365 arm returns \$2,532,786 over 24 months; at 3,600, which allows for the full current roster, \$3,629,039, against \$3,111,029 at the forecast's 2,950. The cardiology panel matters less: from 3,000 to 3,450 patients the practice total moves only from \$5,688,673 to \$5,864,142. Staffing works the other way. With a single specialist working only the cardiology offices the forecast falls to \$5,259,876, and with none to \$3,878,515.<sup>16</sup>

| Scenario                                                 | 24-month net reimbursement | Net to the practice | Unique patients at M24 | Cardiology RPM · PCM ceiling | MD365 RPM · CCM ceiling |
|----------------------------------------------------------|----------------------------|---------------------|------------------------|------------------------------|-------------------------|
| Forecast: one specialist per arm, panels 3,150 and 2,950 | \$5,748,757                | \$2,444,801         | 1,913                  | M12 · past M24               | M9 · M10                |
| No on-site enrollment specialist                         | \$3,878,515                | \$1,646,448         | 1,630                  | past M24 · past M24          | M13 · M18               |
| One specialist, cardiology offices only                  | \$5,259,876                | \$2,224,957         | 1,913                  | M12 · past M24               | M13 · M18               |
| A second specialist on the cardiology side               | \$6,367,076                | \$2,711,672         | 1,939                  | M8 · M16                     | M9 · M10                |
| Two specialists on each arm                              | \$6,493,064                | \$2,768,586         | 1,939                  | M8 · M16                     | M7 · M8                 |
| MD365 panel 2,300                                        | \$5,170,514                | \$2,192,581         | 1,721                  | M12 · past M24               | M7 · M8                 |
| MD365 panel 3,600                                        | \$6,266,767                | \$2,670,300         | 2,104                  | M12 · past M24               | M10 · M12               |
| Cardiology panel 3,000                                   | \$5,688,673                | \$2,420,567         | 1,873                  | M11 · past M24               | M9 · M10                |
| Cardiology panel 3,450                                   | \$5,864,142                | \$2,491,355         | 1,992                  | M13 · past M24               | M9 · M10                |

<sup>16</sup> Cardiology panel: 3,153 established-visit beneficiary-clinician pairs for the six cardiologists in CY2024, de-duplicated at 70% and grossed up for Suffolk County's Medicare Advantage share, about 3,150. MD365: the same method on the ten clinicians who billed in CY2024 gives about 2,300.

| Scenario                                                    | 24-month net reimbursement | Net to the practice | Unique patients at M24 | Cardiology RPM · PCM ceiling | MD365 RPM · CCM ceiling |
|-------------------------------------------------------------|----------------------------|---------------------|------------------------|------------------------------|-------------------------|
| MD365 referrals from the 10 clinicians who billed in CY2024 | \$5,559,903                | \$2,361,779         | 1,913                  | M12 · past M24               | M11 · M13               |
| An eighth referring clinician on the cardiology side        | \$5,810,925                | \$2,471,075         | 1,921                  | M11 · past M24               | M9 · M10                |
| Cardiology referrals from the six cardiologists only        | \$5,685,161                | \$2,417,956         | 1,904                  | M12 · past M24               | M9 · M10                |

### What Moves the Forecast: Enrollment Staffing and the MD365 Panel

CoachCare Value Analysis sensitivity runs, both arms recalculated, one input changed at a time; on-site specialists enroll 80 patients a month each

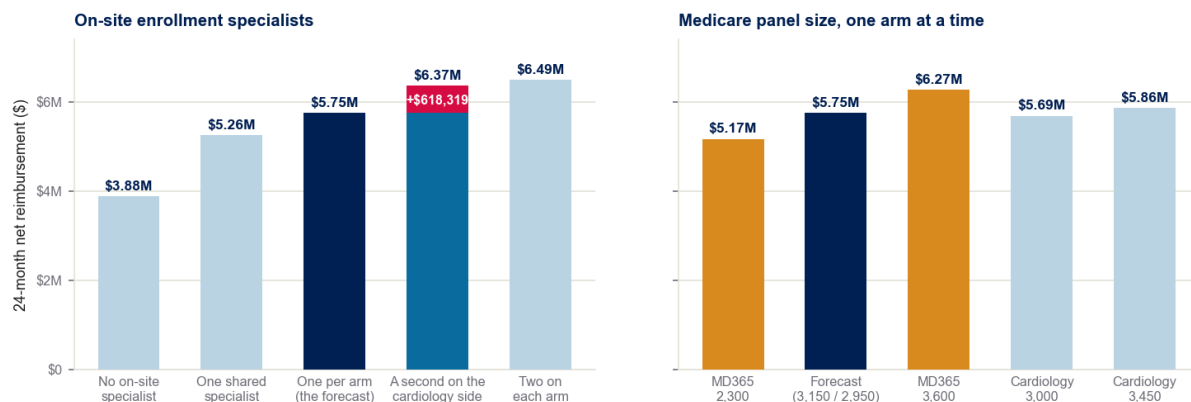


Figure 2. 24-month net reimbursement across on-site enrollment staffing (left) and panel size (right), with the second cardiology-side specialist's addition in red. CoachCare Value Analysis sensitivity runs, both arms recalculated.

## 6.6 What the program produces clinically and operationally

| Output over 24 months         | Volume    | What it represents                                                                                                                                                              |
|-------------------------------|-----------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physiologic readings received | 296,662   | Blood pressure, heart rate, weight and glucose values arriving between visits                                                                                                   |
| Claims and billable units     | 92,123    | Created in eClinicalWorks for the practice's billing team                                                                                                                       |
| Care-team hours               | 42,493    | <b>About 20.4 full-time-equivalent years of work the practice does not employ:</b> 184,245 care-management tasks and 27,637 patient conversations over 1,535 hours of call time |
| Hospitalizations avoided      | About 188 | Admissions that never post against the ACO's spending benchmark (Section 7.1)                                                                                                   |

24-month totals, both arms. The avoided-admission count uses the workbook's baseline admission rate of 20% a year.

## 6.7 Published results from CoachCare cardiology programs

- **Blood pressure, in West Phoenix.** Cardiac Solutions, a physician-owned cardiology practice with three West Phoenix offices, put 2,738 patients on CoachCare remote monitoring. Stage 2 hypertension patients saw a 29.1 mmHg average systolic drop, and 94.8% improved. Patients who took readings consistently dropped 8.53 mmHg against 3.54 mmHg for those who did not.<sup>17</sup>
- **Readmissions, at the same practice.** Across 26,689 patients, the 30-day readmission rate was 7% for CoachCare patients against 15% for the rest.

<sup>17</sup> Cardiac Solutions case studies, April 2026: 2,738 remote-monitoring patients enrolled 12 months or more; 30-day readmissions of 7% against 15% across 26,689 patients.

- **Heart failure, at Iowa Heart.** Iowa Heart enrolled 450 advanced heart-failure patients and recorded zero readmissions over six months.<sup>18</sup>

The blood-pressure result followed the patients who kept taking readings, so the care team's monthly work is outreach and engagement, and clinician time goes to the escalations that need it.

## 7. The ACO and TEAM: Where the Months Between Visits Count

### 7.1 The ACO year: avoided admissions first

Brookhaven Heart joined a Medicare Shared Savings Program ACO on January 1, 2026, on the Enhanced track, which carries two-sided risk, in the ACO's first agreement period. Assignment is retrospective, so the patients who count are the ones whose primary care the practice's clinicians actually delivered during the year, and MD365's visits drive most of that. The ACO is not in ACO Primary Care Flex, so remote monitoring, principal care management and chronic care management bill fee-for-service as usual.

For an ACO the first number is admissions. The service line avoids **about 188 hospitalizations over 24 months** at the workbook's 20% annual admission rate; at a 40% rate, typical of a heart-failure cohort, it is about 376. Each one is spending that never posts against the ACO's benchmark. Documented monthly care management also keeps assigned patients in regular contact with the practice between visits.<sup>19</sup>

#### Two ledgers, kept separate

**Fee margin pays for the program.** \$2,444,801 to Brookhaven Heart over 24 months, paid claim by claim. The Value Analysis is fee-for-service and does not model shared savings.

**Avoided admissions and quality speak to the ACO.** Under two-sided risk the new Part B care-management spend also sits on the ACO's ledger, which is why the avoided admissions and the quality measures carry the argument there.

### 7.2 The quality measures the ACO reports

The Shared Savings Program scores every ACO each year on a set of quality measures, and the score decides whether the ACO meets the program's quality standard. Three of the measures the ACO reports move with this program's monthly work, and patients on both arms count in them.<sup>20</sup>

| Measure                                                     | What it counts                                                       | What the program does each month                                                                        |
|-------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Q236</b><br><b>Controlling high blood pressure</b>       | Hypertensive patients whose latest blood pressure is under 140/90    | Home averages give an accurate reading of control and a monthly chance to act on it, on both arms       |
| <b>Q001</b><br><b>Diabetes: A1c poor control (above 9%)</b> | Patients with diabetes whose latest A1c is above 9%; lower is better | Care management keeps A1c testing and medication changes on schedule; home glucose shows slippage early |
| <b>Q134</b><br><b>Depression screening and follow-up</b>    | Patients screened, with a follow-up plan when the screen is positive | PHQ-2 and PHQ-9 in monthly care management; positives routed to the patient's MD365 clinician           |

<sup>18</sup> Iowa Heart case study, 2026: 450 NYHA class III to IV patients over six months.

<sup>19</sup> CoachCare Value Analysis: 188.4 hospitalizations avoided over 24 months at the workbook's 20% baseline admission rate, 100.1 on the cardiology arm and 88.3 on MD365.

<sup>20</sup> Shared Savings Program quality reporting through the APM Performance Pathway: measures 001, 134 and 236 reported by the ACO.

With hypertension in at least three Medicare charts of four on both arms, Q236 covers most of the panel. Diabetes runs at 45% of the cardiology panel and 37% of MD365's, and depression at about one patient in five on each side.

### 7.3 TEAM: the 30 days after a CABG discharge

TEAM, the Transforming Episode Accountability Model, began on January 1, 2026, and is mandatory for hospitals in the regions CMS selected, Long Island's among them. All four hospitals where Brookhaven Heart physicians hold privileges are participants. TEAM holds the hospital accountable for an episode's total Medicare Part A and Part B spending, from the admission through 30 days after discharge, against a target price. The cardiology follow-up visit and any readmission inside those 30 days count in it.<sup>21</sup>

TEAM has five episode types, and one is cardiac: coronary artery bypass graft (CABG). The other four (lower-extremity joint replacement, hip fracture, spinal fusion and major bowel procedures) are not cardiology's. Brookhaven Heart follows the cardiac patients those hospitals discharge. A service line that calls within two business days, puts a cuff and a scale in the home and routes a flag to the patient's cardiologist is the post-discharge layer each hospital's CABG episode depends on.

TEAM lets each hospital name collaborators for its episodes, and a documented post-discharge program, with its cadence, escalations and monthly reports, is what that conversation needs. Hospitals also feel the 30 days through Medicare's Hospital Readmissions Reduction Program: in FY2026 it penalized heart-failure readmissions at 2 of the 4 hospitals on the practice's affiliation list, though not at the Patchogue hospital. TEAM does not change what Medicare pays Brookhaven Heart, and the Value Analysis carries no TEAM dollars.<sup>22</sup>

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

CMS published its proposed CY2027 physician fee schedule in July 2026. The comment period closed September 14, 2026, the final rule is expected in early November 2026, and the changes take effect January 1, 2027. The proposal cuts the remote-monitoring device-supply codes. Every code in this forecast was repriced at New York locality 02 on each arm's own billing mix, with enrollment held constant.<sup>23</sup>

| Level                                        | CY2026 basis               | Proposed CY2027 effect                   | Why each step is smaller                                       |
|----------------------------------------------|----------------------------|------------------------------------------|----------------------------------------------------------------|
| <b>Device supply, 99454 and 99445</b>        | \$62.18 a month            | <b>\$49.42 a month, -20.5%</b>           | The code CMS proposes to cut                                   |
| <b>Remote monitoring, both arms</b>          | \$3,215,214 over 24 months | <b>-9.4%, -\$302,762</b>                 | Device supply is about a third of the remote monitoring basket |
| <b>Principal care management, cardiology</b> | \$928,773 over 24 months   | -0.7%, -\$6,272                          | Routine rate changes only; not targeted                        |
| <b>Chronic care management, MD365</b>        | \$1,604,770 over 24 months | -2.3%, -\$37,179                         | Routine rate changes only; not targeted                        |
| <b>The whole service line</b>                | \$5,748,757 over 24 months | <b>-6.0%, -\$346,213, to \$5,402,544</b> | Remote monitoring is 55.9% of the line                         |

<sup>21</sup> CMS, Transforming Episode Accountability Model final rule and participant list (hospitals as of August 18, 2026): five episode categories, a 30-day post-discharge window, Part A and Part B spending reconciled against a target price.

<sup>22</sup> CMS FY2026 Hospital Readmissions Reduction Program supplemental data file (discharges July 2021 to June 2024), matched to the four hospitals on the practice's affiliation page.

<sup>23</sup> CMS-1848-P, published July 2026. CoachCare repricing at New York locality 02, conversion factor \$32.8409 against \$33.4009: device supply 33.0% of the remote monitoring basket on each arm; remote monitoring 55.9% of the line across both arms.

### The CY2027 Proposed Rule, Repriced on This Forecast: Three Numbers, One Scale

Every code repriced at New York locality 02 on each arm's own billing mix; enrollment held constant. Remote monitoring is 55.9% of the line.

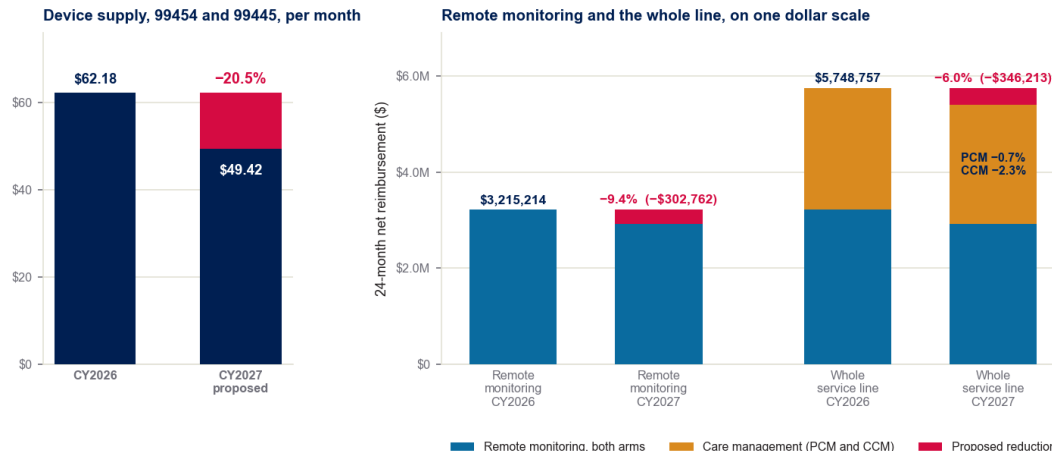


Figure 3. The CY2027 cascade on this forecast: the one code CMS proposes to cut, then remote monitoring across both arms and the whole service line on one dollar scale, with the proposed reduction in red. CoachCare repricing at the proposed CY2027 amounts.

Each number is smaller than the last only because its base is larger, and the two care-management programs, 44.1% of the line, barely move. Section 1848(c)(7) of the Act limits how far a code's relative value can fall in one year. CoachCare will rerun the forecast at the final rates before Brookhaven Heart commits to anything.

## 9. Implementation Roadmap

### 9.1 Who runs what

| Function                                 | CoachCare                                                                                                                                                                                                                                                                        | Brookhaven Heart and MD365                                                                                     |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| <b>Identification and enrollment</b>     | Registry queries in eClinicalWorks for each arm, starting with heart failure and uncontrolled hypertension on cardiology and multi-condition patients on MD365; one on-site enrollment specialist per arm; telephonic outreach; devices shipped, cellular-connected and replaced | Approves the flag criteria and target lists; clinicians order at the visit, after an echo or after a procedure |
| <b>Transitional care</b>                 | Two-business-day contact and medication reconciliation after each discharge the practice learns of; visit booked inside the 7- or 14-day window                                                                                                                                  | Furnishes the visit and bills 99495 or 99496                                                                   |
| <b>Monitoring and escalation</b>         | Reading review, monthly outreach, business-hours alert triage and the post-discharge cadence, at 165 patients per care manager                                                                                                                                                   | <b>Sets thresholds and routing for each arm; receives escalations</b>                                          |
| <b>Today's Connected Care program</b>    | Works beside it from the first enrollment; moves patients across only as the practice decides                                                                                                                                                                                    | Decides how the two run side by side, and with the ACO's care-coordination resources                           |
| <b>Documentation, billing, reporting</b> | Monthly care documents in eClinicalWorks, claims created automatically, operational and clinical outcomes reports by arm                                                                                                                                                         | <b>Reconciles and files under its own NPIs; keeps the revenue; names a program lead for each arm</b>           |

### 9.2 The model inputs

| Input          | Cardiology arm                           | MD365 primary care arm                   |
|----------------|------------------------------------------|------------------------------------------|
| Medicare panel | 3,150 patients, all in scope; all payers | 2,950 patients, all in scope; all payers |

| Input                           | Cardiology arm                                                                                                                                                                            | MD365 primary care arm                                                       |
|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <b>Referring clinicians</b>     | 7: six cardiologists and a nurse practitioner                                                                                                                                             | 17: eight physicians and nine nurse practitioners and physician assistants   |
| <b>Programs</b>                 | Remote monitoring and principal care management                                                                                                                                           | Remote monitoring and chronic care management                                |
| <b>Eligibility · acceptance</b> | Remote monitoring 75% · 35%; principal care management 85% · 30%                                                                                                                          | Remote monitoring 65% · 35%; chronic care management 75% · 30%               |
| <b>Enrollment staffing</b>      | One CoachCare-funded on-site specialist at 80 a month                                                                                                                                     | One CoachCare-funded on-site specialist at 80 a month, rotating across sites |
| <b>Shared on both arms</b>      | 8 referrals per clinician a month at 80% acceptance; telephonic outreach; 70% of care-management patients also monitored; 1.5% monthly attrition; transitional care named at zero dollars | The same                                                                     |
| <b>EMR</b>                      | eClinicalWorks, one instance: \$4,000 setup, \$150 a month, \$1.50 per patient-month                                                                                                      | Covered by the same integration                                              |
| <b>Rates</b>                    | CY2026 fee schedule, non-facility, New York locality 02, ZIP 11772; every patient priced at the Medicare amount                                                                           | The same                                                                     |

### 9.3 Enrollment staffing for both arms

The forecast carries two CoachCare-funded enrollment specialists: one for the cardiology offices in Patchogue and New Hyde Park, and one rotating across the MD365 sites. Both are CoachCare's expense, never the practice's. That staffing fills MD365's programs in months 9 and 10 and cardiology remote monitoring in month 12, and leaves cardiology principal care management growing at month 24. The option worth scoping is a second specialist on the cardiology side, so every follow-up visit, echo and post-procedure check has someone in the building to enroll the patient that day. It costs the practice nothing in staff, reaches the principal care management ceiling by month 16, and adds \$618,319 of net reimbursement and \$266,871 to the practice over 24 months. A second specialist on MD365 adds little, because MD365's panel, not its pace, sets its ceilings.

### 9.4 The first 90 days, and after

| Window                                                  | What happens                                                                                                                                                                                                             | Result                                                       |
|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <b>Weeks 0–6<br/>Integrate and charter</b>              | eClinicalWorks workshop with the cardiology, MD365 and billing leads; chart counts by payer for each arm; today's Connected Care program and the discharge workflow mapped; thresholds, routing and flag criteria agreed | Integration live, protocol signed, both specialists in place |
| <b>Weeks 6–12<br/>Launch both arms</b>                  | Enrollment at Patchogue and New Hyde Park cardiology and the first MD365 sites from the first week; heart failure and uncontrolled hypertension first; the post-discharge cadence live                                   | 97, 160 and 224 new enrollments in months 1 to 3             |
| <b>Months 3–12<br/>Build the census</b>                 | MD365 sites rotated in; atrial fibrillation, post-procedure and device patients with heart failure added on cardiology; care managers added as the census grows                                                          | 2,525 enrollments, 1,806 unique patients at month 12         |
| <b>Months 13–24<br/>Grow cardiology care management</b> | Three programs at their ceilings; cardiology principal care management keeps growing to 717; transitional care volume reviewed with each hospital's discharge feed                                                       | Year 2: \$1,600,083 to the practice at 42.7%                 |

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

## 9.5 What we would confirm together

1. **The Medicare chart count, by payer, for each arm.** Traditional Medicare against each Medicare Advantage plan, and how many patients carry heart failure, hypertension, diabetes or atrial fibrillation. It sets three of the four ceilings in Section 6.
2. **Today's remote care program.** How Connected Care and the cardiology-side billing are staffed today, how many patients are active on each program now, and which of them move across.
3. **Chronic care management or principal care management.** Which cardiology patients stay on chronic care management with MD365 and which move to principal care management under their cardiologist.
4. **The heart-failure and hypertension flag criteria.** Ejection fraction, diuretic use, recent admissions and office readings: the rules that put a patient on the worklist.
5. **Transitional care and discharge notices.** Who runs the discharge workflow today, how notifications arrive from each of the four hospitals, and how many discharges a year reach the practice in time for the two-business-day contact.
6. **The ACO's care-coordination resources.** What the ACO already provides for assigned patients, and how the service line fits beside it so that no patient is called twice.
7. **The eClinicalWorks version and modules.** The version, the healow and care-management modules licensed, and any device connection already in place.
8. **Coinurance at consent.** How the monthly Part B coinsurance is explained at enrollment, and who answers billing questions afterwards.
9. **Bilingual outreach.** Which MD365 sites and patients need outreach and materials in Spanish, and how the practice handles language today.

## 10. Recommendations

1. **Launch both arms together, on one eClinicalWorks integration.** \$2,444,801 to the practice over 24 months at a 42.5% margin, positive from month 2, with nobody hired.
2. **Pull both Medicare chart counts by payer in week one.** The eligible panel sets three of the four ceilings, and MD365's count moves its arm almost one-for-one.
3. **Scope a second enrollment specialist on the cardiology side.** It reaches the principal care management ceiling by month 16 instead of after month 24, and adds \$618,319 of net reimbursement.
4. **Build on Connected Care rather than around it.** Map today's program first, and move patients across at the practice's pace.
5. **Settle chronic care versus principal care management for cardiology patients.** One dominant cardiac condition goes to the cardiologist; several conditions stay with MD365.
6. **Start with heart failure and uncontrolled hypertension.** A cellular scale and cuff for the readings, a care plan every month, and the follow-up visit or the echo as the enrollment conversation.
7. **Put the 30 days after discharge on the care team.** CoachCare makes the two-business-day call after every discharge the practice learns of; the practice bills 99495 or 99496, and each hospital's CABG episode gets its post-discharge layer.
8. **Aim the monthly work at the ACO's measures.** About 188 admissions avoided over 24 months, with blood pressure, diabetes and depression follow-up documented every month.

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The two Medicare panels Brookhaven Heart already manages support a \$5,748,757 service line at a 42.5% practice margin over 24 months, on staff the practice does not hire and devices it does not buy,

before any shared-savings dollar. The eligible panel sets most of the ceiling, and the cardiology side's pace is CoachCare's to supply.

## About CoachCare

### The experience to get it right

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

- **It builds on what Brookhaven Heart already does.** The practice bills remote monitoring and chronic care management today, follows implanted devices remotely and runs a heart failure clinic. The service line adds the capacity, the cardiology protocol and the staffing to reach both full panels.
- **It runs inside the chart the practice already uses.** Readings, documentation and claims live in one eClinicalWorks instance, and enrollment status is visible at every cardiology office and MD365 site.
- **Fully staffed, no hiring.** Care managers at 165 patients each, enrollment, devices, business-hours alert triage and billing preparation on CoachCare's payroll, with fees per active patient per month and no capital outlay.
- **Clinicians stay in charge.** The cardiologists and MD365's clinicians set the protocols, sign the care plans and make every clinical decision. Claims go out under Brookhaven Heart's own billing entity and NPIs.
- **Published cardiology results.** A 29.1 mmHg drop in Stage 2 hypertension across 2,738 patients at Cardiac Solutions, half the 30-day readmission rate across 26,689 patients at the same practice, and zero readmissions among 450 advanced heart-failure patients at Iowa Heart.

The ask is a working session to confirm both panels' Medicare chart counts, map today's remote care program, agree on the cardiology flag criteria, and scope the eClinicalWorks integration before the first patient enrolls.

### Contact

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## References & Data Sources

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- **Medicare payment rules:** the CY2026 Physician Fee Schedule final rule, Addendum B, RVU file and New York locality 02 geographic indices; CMS-1848-P, the CY2027 proposed rule.
- **Market:** CMS Medicare Advantage State/County Penetration, October 2026; CMS Medicare Monthly Enrollment, July 2026; American Community Survey 2020–2024; CDC PLACES, 2025 release.

- **CoachCare:** eClinicalWorks integration overview, 2026; Care Management Programs standard operating procedures, March 2026; Cardiac Solutions and Iowa Heart case studies; and the Value Analysis for Brookhaven Heart, 2026, cardiology and MD365 workbooks, the source of every financial, enrollment, clinical-output and operational figure in Sections 6 to 10.

**Unique patients and program enrollments are different numbers.** At month 24 the program holds 2,880 active program enrollments belonging to 1,913 unique patients, because a patient may hold both a care-management and a monitoring enrollment. The Medicare panels cover every cardiology office and MD365 site and all payers; the CY2024 claims profile is traditional Medicare only.