

Alaska Heart & Vascular Institute

Cardiovascular Service Line — Performance & Optimization 2026 Strategy Report

A CoachCare Remote Care Service Line (TCM · RPM · PCM · CCM) as the operating spine — and your **ASM heart-failure chassis for January 2027**.

Anchorage, Alaska · Serving Southcentral & rural Alaska

Purpose of this report

This report reads Alaska Heart & Vascular Institute's starting position and makes a single, disciplined case: a managed remote-care service line is the highest-return move available to the practice in 2026 — net-positive on its own economics, and the operational chassis that puts AHVI in control of its heart-failure results before the CMS Ambulatory Specialty Model becomes mandatory on January 1, 2027.

Economics shown are **illustrative and modeled** from a CoachCare Value Analysis; every figure should be verified against the practice's own patient, payer, and utilization data during discovery.

Prepared for: Alaska Heart & Vascular Institute leadership

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Executive Summary

Alaska Heart & Vascular Institute (AHVI) is an independent, physician-owned cardiology group headquartered in Anchorage, with roughly 28 cardiologists and 31 advanced-practice providers spanning interventional and structural cardiology, electrophysiology and device management, advanced heart failure, vascular surgery, and non-invasive imaging. It operates a hub at 3841 Piper St in Anchorage — main, interventional, advanced heart-failure, direct-access, imaging, and EP clinics — and reaches across the state through embedded clinics on the Kenai Peninsula (Soldotna and Homer), a Mat-Su office in Wasilla, and a monthly rural echo clinic. The group owns its cardiac catheterization lab and the Alaska Cardiovascular Surgery Center. Its billing and legal entity — the name that appears in CMS and contracting — is “ALASKA HEART INSTITUTE.”

The starting position — and the 2027 payment shift. The single most important fact in AHVI’s near-term environment is that it appears on the CMS Ambulatory Specialty Model (ASM) heart-failure participant list — on the **preliminary** list dated February 2026.

★ Time-sensitive — verify against the FINAL CMS list

AHVI appears on the CMS Ambulatory Specialty Model (ASM) heart-failure participant list — but this is the PRELIMINARY list (dated February 2026).

Fifteen AHVI cardiologist NPIs are listed under the group’s billing entity “ALASKA HEART INSTITUTE” in the CMS CY2027 Preliminary ASM Participants dataset, verified by National Provider Identifier — including Gene Quinn MD (Medical Director of Quality & Population Health), Herman Feringa MD, William Mayer MD, A. Sami Abuzaid MD, and Alan Skolnick MD. ASM is mandatory, begins January 1, 2027, covers the heart-failure cohort, and carries a first-year Part-B payment adjustment of –9% to +9%.

The final CMS participant list is expected in summer 2026 and names could change — four of the fifteen preliminary NPIs are already off AHVI’s current roster, consistent with a list built on approximately 2024 historical claims. Every ASM statement in this report must be confirmed against the final CMS participant list before it is treated as certain.

Either way, ASM changes the question AHVI should be asking. Today the practice manages heart-failure patients episodically, visit to visit — often across hundreds of miles of Alaska. Under ASM, the practice is accountable for those patients’ cost and quality across the full year. The organizations that do well will be the ones that already run a continuous, data-driven heart-failure operation on January 1, 2027 — not the ones scrambling to stand one up. A remote-care service line is that operation.

The central argument — value two ways at once

A CoachCare remote-care service line pays AHVI **twice on the same work**. First, it is a **standalone, recurring professional-fee business** — RPM, CCM, and PCM billed every month across a near-pure fee-for-service Medicare panel, with TCM at each discharge. Second, that identical monitoring-and-titration engine is the **operating model ASM will score** — the continuous heart-failure management CMS is about to hold the group accountable for. One build; two returns. (ASM per the CMS preliminary list; confirm against the final list.)

The clinical wedge is heart failure. Nationally, heart failure carries the highest 30-day readmission burden of any common condition — the exact patient a cardiology group is best positioned to keep out of the hospital, and the exact cohort ASM makes AHVI accountable for. Continuous weight and blood-pressure monitoring, protocolized alerts, and pharmacist- or nurse-led guideline-directed medical therapy

(GDMT) titration between visits are how remote care moves that number. AHVI already runs a dedicated Advanced Heart Failure Clinic — the natural launch cohort for the overlay.

The panel is unusually clean. Alaska has essentially no Medicare Advantage — roughly 1–3% penetration, the lowest in the nation — so about 99% of AHVI's Medicare patients are traditional fee-for-service. Every RPM, CCM, and PCM code bills across essentially the **entire** Medicare panel with no MA carve-outs, and that same population is what ASM attributes. Few cardiology groups in the country have a cleaner line between the population they bill remote-care codes on and the population they are held accountable for.

The billing tailwind is already here. CY2026 added short-window RPM codes — 99445 (a 2–15 day device code) and 99470 (a first-10-minute monitoring code) — that make brief, high-value monitoring windows immediately after a discharge or procedure billable for the first time. On the high-reimbursement Noridian Alaska locality, those codes and the longitudinal stack pay more per patient-month than in most of the country.

The modeled economics (illustrative). A CoachCare Value Analysis built on AHVI's Alaska (Noridian) locality and a 45,246-patient fee-for-service Medicare panel projects, over 24 months: **\$17,493,598 in net professional-fee reimbursement** to the practice (\$4,269,433 in Year 1, \$13,224,165 in Year 2), with **\$8,102,168 retained by the practice after CoachCare program fees** (\$1,959,594 / \$6,142,574). Per program, 24-month net reimbursement is RPM \$7,542,045, CCM \$7,214,009, and PCM \$2,737,544. The model also projects roughly 436 avoided hospitalizations (~\$6.53M in avoided cost), about 267,328 billed claims and units, 685,988 physiologic readings, and 125,438 care-team hours of remote management delivered by CoachCare — reaching 7,118 unique patients in active remote care by Month 24. Figures are illustrative and locality-modeled; verify against practice data.

2026–2027 Priority Recommendations

- **Stand up the remote-care service line now, heart-failure cohort first.** Treat the ASM heart-failure population — and the existing Advanced Heart Failure Clinic — as the launch cohort so the monitoring, titration, and documentation workflows are live and generating data well before January 1, 2027.
- **Anchor the stack on TCM → short-window RPM → longitudinal RPM / PCM, with CCM for multimorbid patients.** Capture the post-discharge transitional window with 99495/99496 and the new 99445/99470 codes, then carry patients into longitudinal monitoring.
- **Build it native to athenaOne during the migration, not bolted onto the legacy system.** AHVI is moving from athenaPractice (legacy on-premise) to athenaOne (cloud); athenahealth is one of CoachCare's integrated EHRs. Standing the service line up native to athenaOne during the cutover means enrollment, discrete vitals, and automated claims live inside the new system from day one.
- **Confirm AHVI's status on the FINAL CMS ASM list (expected summer 2026) and align the go-live plan to it.** The preliminary selection is the planning basis; the final list is the commitment basis.
- **Set an external-PCP collaboration model for shared heart-failure patients.** ASM anticipates a collaborative-care arrangement with primary care; because AHVI is a cardiology group, this is framed as a shared care plan and data exchange with referring PCPs — not a primary-care billing arm.
- **Use remote monitoring to close Alaska's distances.** For a group that already travels to Soldotna, Homer, and Wasilla and runs a monthly rural echo clinic, continuous monitoring substitutes for windshield time and weather-dependent travel — and protects procedural throughput at the Anchorage hub.

1. Footprint & Operating Model

AHVI operates as Alaska's dominant independent cardiology group, anchored at 3841 Piper St in Anchorage — where main, interventional, advanced heart-failure, direct-access, imaging, and electrophysiology clinics sit on one campus — and extending across the state through embedded clinics inside Central Peninsula Hospital (Soldotna) and South Peninsula Hospital (Homer), a Mat-Su office in Wasilla, and a monthly rural echo clinic. Its roughly 28 cardiologists and 31 advanced-practice providers cover the full cardiovascular range: interventional cardiology (coronary, structural/TAVR, peripheral vascular), electrophysiology and device management (ablation, leadless and conduction-system pacing, ICD, Watchman), advanced heart failure with LVAD and transplant, vascular surgery, and non-invasive imaging (echocardiography, nuclear, cardiac MRI/CT). The group owns its catheterization lab and the Alaska Cardiovascular Surgery Center, and has been expanding outpatient and ambulatory-surgery capacity.

A note on structure and EHR

AHVI brands as “Alaska Heart & Vascular Institute”; its billing and legal entity — the name that appears in CMS, contracting, and the ASM participant file — is “ALASKA HEART INSTITUTE.” The group is independent and physician-owned, with no private-equity or hospital owner. Its EHR is athenahealth: currently on athenaPractice (the legacy on-premise product, formerly GE Centricity) and actively migrating to athenaOne (cloud EHR / practice-management / revenue-cycle). Ownership, exact site count, and the migration timeline should be confirmed on discovery.

Remote-care posture: targeted device monitoring, software whitespace. AHVI runs a dedicated Advanced Heart Failure Clinic and uses implanted CardioMEMS pulmonary-artery pressure monitoring for a narrow advanced-HF population (implanted through Providence, the only Alaska hospital placing the device). That is device-specific, advanced-HF-only monitoring — not scalable, software-based RPM/CCM/PCM across the broader panel. An IntelliChart patient portal handles messaging and refills. There is no general remote-monitoring or chronic-care-management program — clear whitespace for a reimbursement-accurate service line that scales across the whole fee-for-service panel.

Design principles for the service line

Principle	What it means for AHVI
Longitudinal by default	Heart-failure and high-risk cardiac patients are monitored continuously between visits, not managed only at episodic — and often long-distance — appointments.
One scorecard	A single view of enrolled census, alerts, titration actions, billable capture, and avoided admissions — clinical and financial on the same page.
Distance-neutral	Anchorage, the Kenai Peninsula, and the Mat-Su Valley share one remote-care engine; patients are enrolled and managed centrally regardless of how far they live from a clinic.
Top-of-license	Nurses and pharmacists run monitoring and GDMT titration; physicians work at the top of their license on exceptions and escalations.
Native to athenaOne	Enrollment, connected-device vitals, and claim capture run inside athenahealth — stood up in the new cloud system during the migration, not on the legacy platform.

2. The Remote Care Service Line — The Spine

This is the centerpiece. The remote-care service line is not a point solution bolted onto the practice; it is the operating spine that carries recurring revenue, heart-failure performance, and procedural throughput on one shared engine.

2.1 What It Is: The Care-Management Stack

AHVI bills the full care-management stack on its own cardiology patients. Because a cardiology group has no primary-care panel, this is a specialty stack — there is no primary-care management arm, and none is proposed. Where longitudinal wraparound is needed for a patient's primary-care conditions, it is coordinated with the patient's external PCP through a shared care plan, not billed by AHVI.

Layer	Codes	Role in the cardiology stack
TCM	99495 / 99496	Transitional Care Management at discharge — the on-ramp. Two-business-day contact plus a face-to-face visit; the moment a heart-failure or post-procedure patient is most fragile and most winnable.
RPM	99453/99454; 99445; 99457/99470; 99458	Remote Physiologic Monitoring — weight, blood pressure, and symptoms. Short-window codes (99445/99470) cover the 2–15 day window after discharge or procedure; longitudinal codes carry the patient month over month.
PCM	99426 / 99427	Principal Care Management for a single, dominant condition — heart failure — when a patient does not need full multi-condition management.
CCM	99490 / 99439	Chronic Care Management for multimorbid cardiac patients — the majority of an older fee-for-service panel.

The one coordination rule

RPM stacks with PCM or CCM in the same month, but PCM and CCM do not bill together for the same patient-month — a patient is either principal-condition (PCM) or multi-condition (CCM), not both at once. TCM is a per-discharge event that on-ramps a patient into the longitudinal codes. Clean rules like these keep the model reimbursement-accurate and audit-ready.

2.2 Standalone Value: Four Value Layers

Before any value-based dollar, the service line pays for itself through four layers of value.

- **Direct professional-fee revenue.** Recurring monthly RPM / PCM / CCM billing plus TCM at each discharge — a subscription-like revenue line the practice owns, across a near-pure fee-for-service panel.
- **Avoided cost.** Fewer heart-failure admissions and readmissions — modeled at roughly 436 avoided hospitalizations over 24 months (≈\$6.53M at \$15,000/admission) — which also protects referral relationships and hospital-partner performance.
- **Procedural throughput unlocked.** Short post-procedure monitoring windows support faster, safer discharge, freeing catheterization-lab and bed capacity for additional interventional, structural, and device cases at the Anchorage hub.
- **Strategic / model readiness.** A functioning remote-care chassis is the ASM heart-failure operating model — built and generating data before the model becomes mandatory (per the CMS preliminary list; confirm final).

The CY2026 billing stack (illustrative Alaska-locality rates)

Service / code	Type	Rate	Notes
TCM 99495 / 99496	Per discharge	~\$240 / ~\$340	2-business-day contact; face-to-face 14 / 7 days
RPM 99453 setup	One-time	\$22.78	Requires ≥2 days of data
RPM 99454 / 99445	Monthly	\$55.32	99454 = 16–30 days; 99445 = new 2–15 day short window
RPM 99457 / 99470	Monthly	\$63.31 / \$31.91	First 20 min / new first-10-min code (2026)
RPM 99458	Monthly	\$52.29	Each additional 20 min
PCM 99426 / 99427	Monthly	\$85.54 / \$67.08	Single high-risk condition (heart failure)
CCM 99490 / 99439	Monthly	\$83.76 / \$63.03	Two or more chronic conditions

Rates shown are the local Alaska-locality magnitudes (Noridian, carrier 02102, locality 01) used in the Value Analysis model — illustrative, not quotes, and higher than most of the country because of Alaska's geographic-cost adjustment. Actual payment is locality-adjusted and set by the regional MAC; verify current-year PFS. Every rate is user-editable in the model.

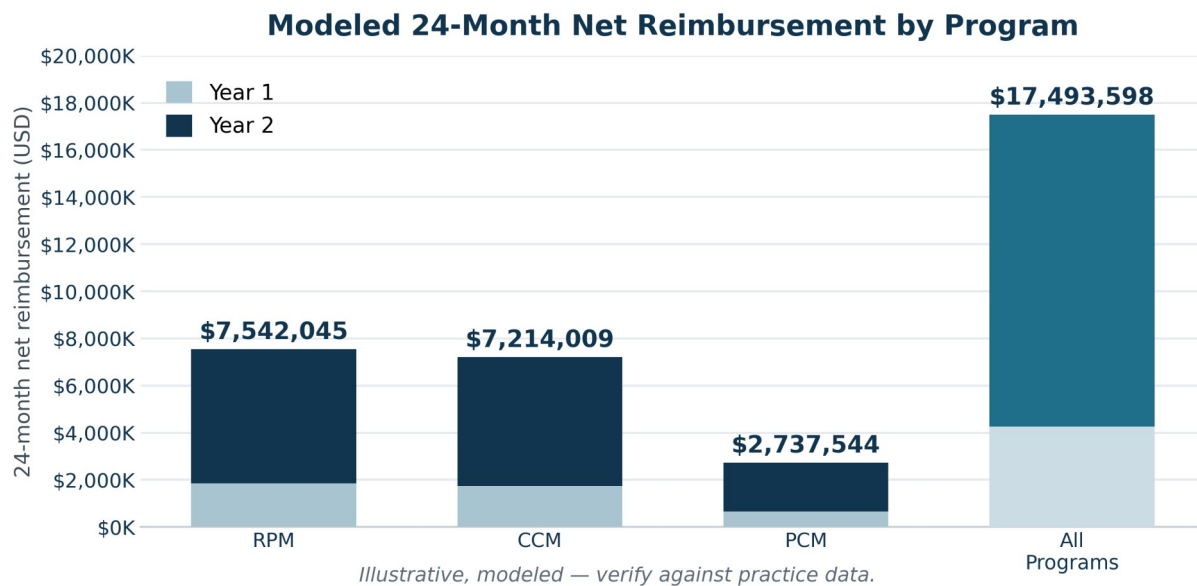


Figure 1. Modeled 24-month net professional-fee reimbursement by program, split Year 1 / Year 2. Illustrative, modeled from a CoachCare Value Analysis on AHVI's 45,246-patient fee-for-service Medicare panel — verify against practice data.

How the recurring-revenue math works

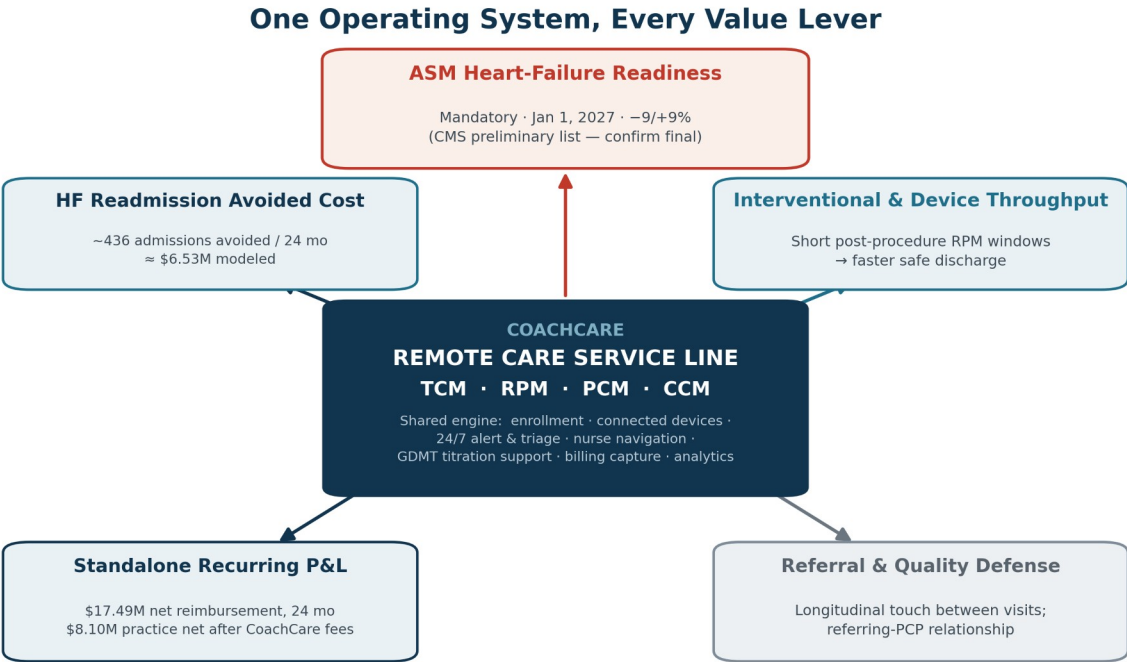
Each enrolled patient generates a predictable monthly professional fee for as long as they remain clinically appropriate and engaged. Scale the enrolled census across a 45,246-patient fee-for-service panel and the recurring line compounds: the model reaches roughly 5,280 RPM, 4,186 CCM, and 1,940 PCM patients under active management by Month 24 — 7,118 unique patients once dual enrollments are de-duplicated, and 11,406 total program enrollments. Because Alaska is almost entirely fee-for-service, there is no Medicare Advantage cohort to carve out of that census.

Modeling assumptions (read before quoting any figure)

Figures are modeled from a CoachCare Value Analysis using AHVI's Noridian Alaska locality, a 45,246-patient fee-for-service Medicare panel, and standard enrollment-ramp, eligibility, and engagement assumptions. Avoided-hospitalization value is illustrative at \$15,000/admission. Every input — panel size, ramp, eligibility mix, and local rates — is user-editable and should be reconciled with the practice's own patient, payer, and utilization data during discovery. Nothing here is a quote or a guarantee of reimbursement.

2.3 Connective Tissue: One Engine, Every Lever

The reason to build this as a service line — rather than a series of disconnected point programs — is that one shared engine powers every lever AHVI cares about. Enroll a patient once; monitor, triage, titrate, document, and bill on the same infrastructure; and that same infrastructure simultaneously improves ASM heart-failure performance, avoids admissions, speeds procedural discharge, and defends referral relationships across a vast service area.



Build the remote-care chassis once; the same enrollment, device, triage, titration and billing infrastructure powers each lever.

Figure 2. One operating system, every value lever. The ASM lever reflects the CMS preliminary participant list (February 2026) — confirm against the final CMS list.

How the same infrastructure powers each lever

Lever	What the shared engine contributes
ASM heart failure (2027)	Continuous monitoring, protocolized GDMT titration, and structured documentation across the attributed HF cohort — the exact capability ASM scores. Preliminary list; confirm final.

Lever	What the shared engine contributes
HF readmission avoided cost	Weight/BP trend alerts catch decompensation early — before a long-distance emergency transport or hospital admission.
Interventional & device throughput	Short post-procedure RPM windows support faster, safer discharge from a busy interventional, structural, and EP practice.
Referral & quality defense	A visible, continuous touch between visits strengthens the referring-PCP relationship across the state and keeps patients in the AHVI network.
Standalone P&L	Recurring RPM/PCM/CCM + TCM revenue — modeled at \$17,493,598 net over 24 months on a near-pure fee-for-service panel.

3. The 2027 Payment Shift — Ambulatory Specialty Model

The Ambulatory Specialty Model (ASM) is the CMS Innovation Center's mandatory, specialty-focused payment model. For cardiology, the accountable condition is heart failure. ASM begins January 1, 2027, runs through 2031, and adjusts participating clinicians' Part-B payments based on cost and quality performance — a -9% to +9% adjustment in the first payment year. It holds the cardiologist accountable for a heart-failure patient's cost and quality across the year, and it anticipates an electronic collaborative-care arrangement with the patient's primary-care clinicians.

★ ASM verification status — PRELIMINARY

AHVI is on the CMS **preliminary** CY2027 ASM heart-failure participant list (released February 12, 2026, built on approximately 2024 claims). Fifteen AHVI cardiologist NPIs are confirmed on that list under the billing entity "ALASKA HEART INSTITUTE." The **final** participant list is expected in summer 2026; four of the fifteen preliminary NPIs are already off the current roster, which is consistent with a list built on historical claims. Lead planning with ASM, but confirm every clinician and the group's inclusion against the final CMS list before any commitment.

Why the service line is the ASM operating model. ASM does not ask the practice to do anything philosophically new — it asks the practice to manage heart failure continuously and measurably, and then pays on the result. A remote-care service line is exactly that capability: enrollment and risk stratification, continuous weight/BP monitoring, protocolized alerting, GDMT titration between visits, and the structured data that both drives care and documents performance. Standing it up now means AHVI enters 2027 with the workflows live and a year of data behind it. And because Alaska is almost entirely fee-for-service, the population AHVI bills remote-care codes on is essentially the same population ASM attributes — the readiness work and the revenue work are the same work.

The primary-care collaboration — framed correctly. ASM anticipates a collaborative-care arrangement with primary care. Because AHVI is a cardiology group with no primary-care panel, this is not a CoachCare-billed primary-care arm. It is a shared care plan and structured data exchange with each heart-failure patient's external, referring PCP — the cardiology practice owns the specialty wrapper (TCM at discharge, RPM, PCM/CCM), and coordinates the primary-care wrapper with the PCP who owns it. Across a state this large, that electronic exchange is often the only practical way to keep a shared patient's cardiologist and PCP on the same page.

A scope note

Because AHVI is a cardiology group, this report scopes remote care to the specialty stack the group can bill on its own patients — TCM, RPM, PCM, and CCM — and treats primary-care collaboration strictly as coordination with external PCPs, never as a service AHVI bills. One geographic contrast worth noting: Anchorage sits outside every TEAM bundled-payment CBSA, so mandatory accountability reaches AHVI through the ambulatory/cardiology door (ASM), not the hospital door.

4. Operating System for Service Line Performance

Running the service line well means managing it like a service line — with a balanced scorecard that puts clinical, operational, and financial measures on one page.

Dimension	Representative measures
Remote-care service line	Enrolled census (by program); time-to-first-billable-enrollment; monthly billable-capture rate; net revenue per patient per month.
Heart-failure quality	GDMT titration to target; 30-day HF readmission rate; alert-to-action time; percent of HF cohort on continuous monitoring.
Access & throughput	Post-procedure length of stay; same/next-day discharge rate; travel visits avoided through remote monitoring.
Financial	Recurring RPM/PCM/CCM revenue; TCM capture at discharge; avoided-admission cost; net reimbursement to the practice.
ASM readiness	HF cohort enrolled and monitored; titration-protocol adherence; structured-data completeness; reconciliation to the final CMS list.

ASM readiness checklist

- **Cohort defined and enrolled** — every attributed heart-failure patient on continuous weight/BP monitoring.
- **Titration as a production process** — nurse/pharmacist-led GDMT titration to protocol, with physician escalation paths.
- **PCP collaborative care** — shared care plans and data exchange with external referring PCPs (a coordination relationship, not a billing arm).
- **Documentation & data capture** — structured monitoring and titration data feeding ASM performance measurement, captured natively in athenaOne.
- **Final-list confirmation** — go-live plan reconciled to the final CMS ASM participant list expected summer 2026.

5. Performance Snapshot

AHVI publishes little practice-level quality data of the kind a hospital carries (a physician group does not receive a CMS Overall Hospital Star Rating). Rather than assert ratings the practice does not publish, this section frames the clinical opportunity through the national readmission picture and the heart-failure wedge — and flags what must be pulled from primary sources before any local claim.

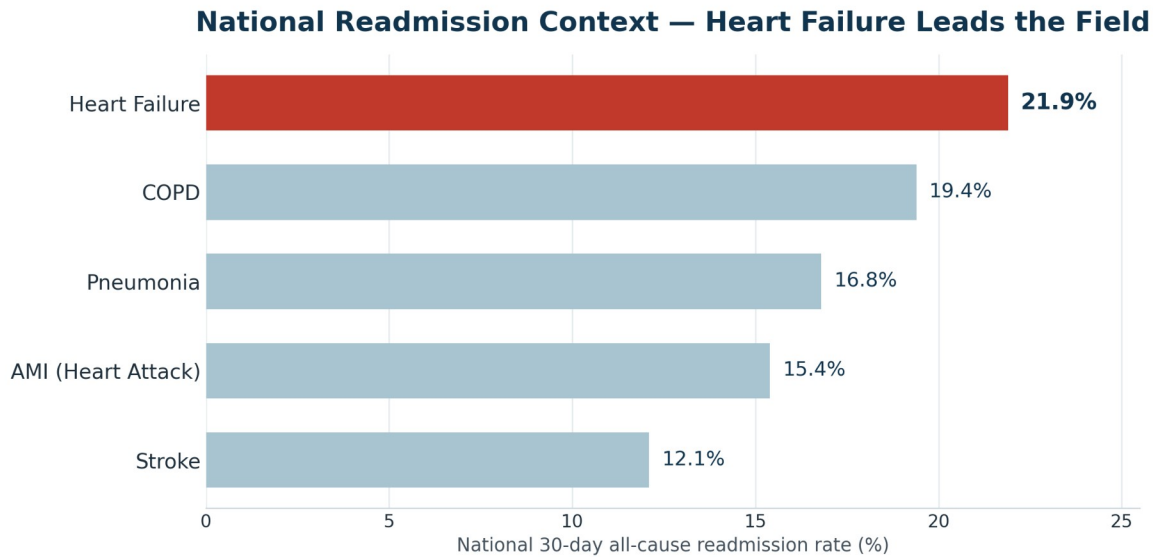


Figure 3. National CMS/HRRP 30-day readmission reference magnitudes by condition. These are national benchmarks only — not AHVI or facility-specific — and are shown to illustrate where remote care moves the needle.

The heart-failure wedge. Across the country, heart failure carries the highest 30-day readmission rate of any common inpatient condition. It is also the condition most responsive to exactly what a remote-care service line does: early detection of fluid overload through daily weights, blood-pressure trends, and symptom check-ins, paired with rapid GDMT titration. In Alaska the stakes are higher still — a decompensation caught late can mean a weather-dependent medevac, not a short drive to the hospital. For a cardiology group that already owns these patients clinically, closing that gap is both a quality win and — under ASM — a payment one.

What to confirm before citing local numbers

Figure 3 shows national reference magnitudes, not AHVI- or Alaska-specific rates. Before any local claim, pull facility-specific readmission and heart-failure data for Providence Alaska Medical Center, Alaska Regional, and Mat-Su Regional, along with AHVI's own attributed-cohort outcomes, and date each source. The national picture establishes the wedge; local data sizes it.

6. Powering ASM: Heart Failure + PCP Collaboration

This section makes the ASM connection concrete. The remote-care service line is not adjacent to ASM readiness — it is the ASM operating model, expressed as day-to-day workflow. (ASM participation reflects the CMS preliminary list of February 2026; confirm against the final CMS list expected summer 2026.)

The heart-failure operation, as a production process:

- **Identify & enroll** — every attributed heart-failure patient is risk-stratified and enrolled onto connected weight and blood-pressure monitoring, most efficiently at a TCM touch after discharge or at the existing Advanced Heart Failure Clinic.
- **Monitor & alert** — daily physiologic data flows into a 24/7 alert-and-triage layer; weight and BP trends surface decompensation days before a symptomatic crash — critical when the patient is hours from the nearest cardiology clinic.

- **Titrate to target** — nurse- and pharmacist-led GDMT titration runs to protocol between visits, turning guideline-directed therapy into a repeatable process instead of an every-few-months office event.
- **Document & measure** — structured monitoring and titration data both drive care and produce the performance record ASM is scored on, captured natively in athenaOne.

The collaborative-care arrangement, done right. ASM anticipates an electronic collaborative-care arrangement with primary care. For AHVI this is a coordination relationship, not a billing arm: a shared heart-failure care plan and structured data exchange with each patient's external referring PCP. AHVI owns the cardiology wrapper (TCM, RPM, PCM/CCM); the PCP owns the primary-care wrapper. This keeps attribution clean and avoids any double-counting of the same patient-month.

Design decisions to lock before go-live

Attribution and cohort definition (which HF patients, by which rule); the PCP-collaboration data-exchange method in athenaOne; titration protocols and escalation thresholds; and the reconciliation step against the final CMS list. Locking these before go-live keeps the ASM operating model clean and auditable from day one.

7. Powering Procedural Growth: Interventional & Device Throughput

The same engine that manages heart failure also protects the procedural economics of a busy interventional, structural, and device practice. AHVI's cardiologists perform coronary and structural interventional work (including TAVR), peripheral vascular procedures, and electrophysiology/device implants at its Anchorage catheterization lab and the Alaska Cardiovascular Surgery Center. Remote care is a throughput multiplier for that work.

How the throughput math works. The 2026 short-window RPM codes (99445 for a 2–15 day device window, 99470 for the first 10 minutes of monitoring) make it billable — and clinically defensible — to monitor a patient closely for the first two weeks after a procedure. That short, structured window supports faster, safer same- or next-day discharge: the patient goes home sooner with a monitoring safety net, which frees catheterization-lab and inpatient-bed capacity for additional cases. In Alaska it does something more — it lets a patient who traveled hundreds of miles for a procedure return home sooner, monitored remotely, instead of staying near Anchorage to be watched. Build the monitoring chassis once for heart failure, and the post-procedure window is already covered.

Scope discipline

This lever is deliberately last and deliberately bounded. The service line's core is longitudinal heart-failure and chronic-care management; procedural throughput is a real but secondary benefit, and the report does not model incremental procedure volume. Treat it as strategic upside, not a line in the revenue forecast.

8. Implementation Playbook

Goals & scope

Stand up a managed remote-care service line that is self-funding on its own economics and ASM-ready before January 1, 2027. Scope: TCM + RPM + PCM + CCM, billed by AHVI, on the heart-failure and high-

risk cardiac panel across Anchorage, the Kenai Peninsula, and the Mat-Su Valley — stood up native to athenaOne during the migration.

Target populations (in launch order)

- **Attributed ASM heart-failure cohort (launch first)** — the patients AHVI will be measured on in 2027, including the existing Advanced Heart Failure Clinic population.
- **Post-discharge and post-procedure patients** — captured at the TCM / short-window RPM on-ramp.
- **Broader high-risk cardiac panel** — multimorbid patients for CCM, single-dominant-condition patients for PCM, across the full fee-for-service panel.

Staffing, technology & billing architecture

- **Top-of-license clinical model** — nurses and pharmacists run monitoring and GDMT titration; CoachCare supplies the enrollment (including three funded on-site enrollment specialists), connected-device logistics, monitoring labor, and billing capture as a service, so the practice adds program capacity without adding headcount it must hire and manage. The model projects roughly 125,438 care-team hours of remote management delivered over 24 months (≈60.3 FTE-equivalent of work CoachCare performs, not practice headcount).
- **Native athenaOne integration, day one** — CoachCare is an integrated athenahealth partner; enrollment, orders, discrete vitals, and claims run inside athenaOne. Bidirectional enrollment-by-service and exchange of health history flag and enroll eligible Medicare patients from inside the existing clinical workflow; integrated ordering triggers device orders by service; discrete vitals and the integrated care summary flow back as structured data; and CoachCare's billing engine generates monthly claims automatically — eliminating the manual per-patient claim step. Standing this up during the athenaPractice → athenaOne cutover puts remote care in the new system from the start.

athenaOne integration — confirm in contracting

AHVI's EHR is athenahealth (currently athenaPractice, migrating to athenaOne). athenahealth is one of CoachCare's integrated EHRs, and CoachCare is the care-management partner that generates automated claims inside the athenahealth environment. Confirm the exact athenaOne edition, the migration timeline, and integration scope in contracting so the service line goes live native to the new system.

Clinical workflow (steady state)

Enroll at a TCM touch, an Advanced Heart Failure Clinic visit, or a clinic referral → ship and activate connected devices → daily physiologic data into 24/7 alert-and-triage → protocolized GDMT titration between visits → structured documentation in athenaOne → monthly billable capture (RPM + PCM/CCM) and TCM at each qualifying discharge.

KPI dashboard

Clinical	Operational	Financial
GDMT titration to target; 30-day HF readmission; percent of HF cohort monitored; alert-to-action time.	Enrolled census; time-to-first-billable-enrollment; device-activation rate; travel visits avoided.	Net revenue per patient per month; billable-capture rate; net reimbursement to the practice; avoided-admission cost.

Expected impact & 12-month roadmap

Modeled 24-month impact (illustrative; verify against practice data): \$17,493,598 net professional-fee reimbursement, \$8,102,168 retained by the practice after CoachCare fees, roughly 436 avoided hospitalizations (~\$6.53M avoided cost), about 267,328 billed claims and units, 685,988 physiologic readings, and 125,438 care-team hours of remote management delivered — reaching 7,118 unique patients in active remote care by Month 24.

- **Months 1–2 — Stand up and start enrolling.** Contract and confirm the athenaOne edition and migration timeline; integrate; define the HF cohort; set attribution and the PCP-collaboration model; train staff — and begin enrolling heart-failure patients in month 1. The model assumes no onboarding delay: enrollment begins in month 1.
- **Months 3–6 — Enroll & ramp.** Scale enrollment across the ASM heart-failure cohort and the Advanced Heart Failure Clinic via TCM on-ramps and clinic referral, with monitoring, titration, and billing capture running in athenaOne.
- **Months 7–12 — Scale & prove.** Widen to the broader high-risk panel across Anchorage, the Kenai Peninsula, and Mat-Su; stand up the balanced scorecard; accumulate the ASM performance-data record and reconcile the plan to the final CMS list.
- **Into 2027 — ASM go-live.** Enter January 1, 2027 with a live heart-failure operation and a year of data, not a standing start.

References & Data Sources

- CMS Innovation Center — Ambulatory Specialty Model (ASM) Participants dataset, data.cms.gov (CY2027 Preliminary, updated February 2026); NPI-verified selection of 15 AHVI cardiologists under “ALASKA HEART INSTITUTE.”
- CMS — Ambulatory Specialty Model program design (mandatory; heart-failure cohort; PY2027–2031; first-year Part-B adjustment –9% to +9%).
- NPES / NPI Registry — AHVI entity and clinician records (Anchorage, Soldotna, Homer, Wasilla).
- CMS Care Compare / HRRP — national 30-day readmission reference magnitudes (Figure 3); facility-specific rates for Providence Alaska Medical Center, Alaska Regional, and Mat-Su Regional to be pulled and dated on discovery.
- CMS CY2026 Physician Fee Schedule — remote-care billing codes (TCM, RPM incl. new 99445/99470, PCM, CCM); local Alaska-locality magnitudes (Noridian, carrier 02102, locality 01) used in the model.
- CoachCare Value Analysis (2026) — modeled economics for AHVI on a 45,246-patient fee-for-service Medicare panel; source of all illustrative financial, clinical, and operational figures.
- CoachCare / athenahealth integration overview — bidirectional enrollment by service, exchange of health history, integrated discrete vitals and ordering, integrated care summary, and automated claim generation via the CoachCare billing engine.
- KFF / Kiplinger — Medicare Advantage penetration by state (Alaska ~1–3%, lowest in the nation), supporting the near-pure fee-for-service panel assumption.
- CoachCare — program scale references (managed conditions, providers, implementations, claims, and vitals recorded).

Verification & validation caveat

This report combines public-source research with a modeled CoachCare Value Analysis. Every figure — panel size, local rates, enrollment ramp, avoided-admission value, and clinical and operational metrics — is illustrative and user-editable, and should be reconciled with AHVI's own patient, payer, and utilization data during discovery. ASM participation reflects the CMS preliminary list of February 2026 and must be confirmed against the final CMS participant list expected summer 2026. Nothing herein is a quote, a guarantee of reimbursement, or legal, coding, or investment advice.