COACHCARE · REMOTE CARE SERVICE LINE

Heart Specialists of Sarasota

Sarasota, Florida · Three locations · Practicing exclusively at Sarasota Memorial Hospital

Cardiovascular Service Line — Performance & Optimization

2026 Strategy Report

A CoachCare Remote Care Service Line (TCM → RPM → PCM) as the operating spine — and the heart-failure chassis for ASM in January 2027

Purpose of this report

This report reads Heart Specialists of Sarasota'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 — self-funding on its own economics, and the operational chassis that puts the group in control of its heart-failure results before the CMS Ambulatory Specialty Model becomes mandatory on January 1, 2027.

Economics shown are illustrative, modeled from a CoachCare Value Analysis; every figure should be verified against the practice's own patient, payer and utilization data during discovery. ASM participation reflects the CMS preliminary CY2027 participant list (published February 2026) — confirm against the final CMS list, expected summer 2026.

Prepared for: Heart Specialists of Sarasota leadership
Prepared by: CoachCare — Remote Care Service Line Strategy
July 2026 · Confidential — prepared for practice leadership

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Executive Summary

Heart Specialists of Sarasota is an independent, physician-owned cardiovascular practice — by its own description Sarasota's largest physician-owned cardiovascular group — with 15 physicians and 9 advanced practice providers across three Sarasota locations: the main office and echocardiography suite at 1950 Arlington Street, a South Osprey Avenue office where stress testing is consolidated, and a third clinical office on Hawthorne Street. The physician roster includes six interventional cardiologists and three electrophysiologists alongside non-invasive, imaging, and advanced heart-failure capability. The group practices exclusively at Sarasota Memorial Hospital, which is simultaneously its referral engine, its procedural home, and — through the health system's own employed cardiology group — its principal local competitor. Its legal and billing entity, the name that appears in CMS files and in contracting, is “Heart Specialists of Sarasota, P.L.” Its EHR is Greenway.

The starting position — and the 2027 payment shift. The single most important fact in the practice's near-term environment is that four of its physicians appear 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**
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> Four clinicians billing under the legal entity “HEART SPECIALISTS OF SARASOTA PL” appear in the CMS CY2027 Preliminary ASM Participants dataset, all in the heart-failure cohort. ASM is mandatory and two-sided: it begins January 1, 2027, runs through 2031, and carries a first-year Part-B payment adjustment of −9% to +9%.
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> The final CMS participant list is expected in summer 2026 and the roster can change. The preliminary list was built on approximately 2024 claims, and at least one listed clinician's national provider record now shows out-of-state practice addresses — so the practice's effective exposure may be three physicians rather than four. Every ASM statement in this report must be confirmed against the final CMS participant list before it is treated as certain. No individual clinician is identified here.

Either way, ASM changes the question the practice should be asking. Today heart-failure patients are managed episodically, visit to visit. 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 already running 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 observation — the heart-failure protocol already runs, on someone else's payroll

Sarasota Memorial's Heart Failure Center already performs frequent symptom and weight tracking by phone for this population, with cardiovascular nurse specialists providing structured education and follow-up for recently discharged patients. That is precisely the clinical protocol remote physiologic monitoring automates — and precisely the protocol Medicare Part B reimburses.

The asymmetry is the point. Beginning January 1, 2027, Heart Specialists of Sarasota carries the ASM accountability for those patients' cost and quality. The interstitial work that keeps them out of the hospital is performed by the hospital's nurses. And no one bills Medicare Part B for it. The practice bears the risk; the labor sits on a partner's cost center; the reimbursement is left on the table entirely.

This is not a criticism of Sarasota Memorial — it is the practice's exclusive hospital partner, its heart-failure program is rated a high performer by U.S. News, and the practice's own physicians help lead it. The point is alignment, not conflict. Standing up an owned, billable remote-care service line converts an uncompensated dependency into practice revenue and gives the accountable entity direct control of the measure it will be judged on. (ASM per the CMS preliminary list; confirm against the final list.)

The central argument — value two ways at once

1. **Standalone value.** Recurring, subscription-like professional-fee revenue — billed by the practice at top-of-license staffing — that funds itself before a single value-based dollar. The stack is TCM at discharge → short-window RPM → longitudinal RPM plus Principal Care Management. Over 24 months the model projects about $5,639,663 in net professional-fee reimbursement, of which about $2,428,850 is retained by the practice after CoachCare's program fees — a 43.1% practice margin.

2. **Connective tissue.** One shared engine — enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, GDMT-titration support, billing capture, analytics — that simultaneously powers ASM heart-failure performance, converts avoided admissions into avoided cost, speeds safe post-procedure discharge, and defends referral relationships. Build once, reuse everywhere.

Proven remote-monitoring capability, zero billable remote care. This practice already runs an in-house cardiac implantable electronic device (CIED) clinic — pacemakers, defibrillators, and what it reports as the largest implantable loop recorder clinic in Florida — alongside Holter and event monitoring at two of its three sites, more than 600 TAVR procedures, and more than 700 left-atrial-appendage occlusion implants. Continuous remote device data and high-volume alert triage are already routine here. What the group has none of is reimbursed physiologic monitoring: no RPM, no Principal Care Management, and no incumbent vendor to displace. The question is not whether this practice can operate remote care. It is whether it will extend a proven operational muscle into the codes that pay for it.

The heart-failure density is documented, not assumed. CMS CY2024 by-provider data for the practice's billing clinicians shows the heart-failure / non-ischemic heart disease flag on 24–54% of each physician's traditional-Medicare beneficiaries and on 31–66% of each advanced practice provider's. Atrial fibrillation runs 36–75%, chronic kidney disease 24–49%, and mean beneficiary age 77–80. Read the advanced-practice rows carefully: the APPs' panels are systematically sicker than the physicians' — the advanced-practice bench is already absorbing the heart-failure and device follow-up load. That is exactly the labor a funded, managed program relieves.

A payer change that strengthens the case. UnitedHealthcare terminated the practice's Medicare Advantage network participation effective December 1, 2025 — a payer-initiated decision, and a real

disruption for patients and revenue alike. Two consequences are worth naming plainly. It leaves a revenue gap the practice needs to replace. And it shifts the remaining Medicare panel further toward traditional fee-for-service — the population on which RPM and Principal Care Management bill cleanly, and the population on which ASM attribution happens. A recurring, practice-owned Part B service line is a direct answer to both.

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. For a group with this much post-procedure and post-discharge volume, that is precisely the window where the most clinical and financial value is created.

The modeled economics (illustrative). A CoachCare Value Analysis built on the practice's Florida MAC locality and a discovery-stage Medicare panel projects, over 24 months: $5,639,663 in net professional-fee reimbursement ($1,386,180 in Year 1, $4,253,483 in Year 2), of which $2,428,850 is retained by the practice after CoachCare fees — a 43.1% practice margin. Per program, 24-month net reimbursement is RPM $4,225,940 and Principal Care Management $1,413,723. The same program is modeled to avoid roughly 293 hospitalizations over 24 months — about $4.40 million in avoided cost at $15,000 per admission — while generating 106,825 reimbursable claims and units, 461,831 physiologic readings, and 47,734 care-team hours of remote management delivered by CoachCare, reaching 3,933 Enrolled Patients in active remote care by Month 24 across 4,816 active program enrollments. Every figure is illustrative, modeled — verify against practice data.

2026–2027 Priority Recommendations

1. **Stand up the remote-care service line now, heart-failure cohort first.** Treat the ASM heart-failure population as the launch cohort so monitoring, titration and documentation workflows are live and generating data well before January 1, 2027. Enrollment must precede the performance period, which means contracting in the second half of 2026.
2. **Move the heart-failure monitoring protocol inside the accountable entity.** The weight-and-symptom tracking that keeps these patients stable is already happening at the hospital, unbilled and outside the practice's control. Own it, bill it, and instrument it — in partnership with Sarasota Memorial, not in competition with it.
3. **Anchor the stack on TCM → short-window RPM → longitudinal RPM plus Principal Care Management.** Capture the post-discharge transitional window with 99495 / 99496 and the new 99445 / 99470 codes, then carry patients into longitudinal monitoring with a PCM wrapper on the named principal cardiac condition.
4. **Bill PCM, not primary-care chronic-care management.** A specialist's care management is focused on one principal condition, or on cardiovascular disease as a single domain — which is what Principal Care Management is written for. It fits the practice's actual scope and does not collide with the referring PCP's claim.
5. **Extend the device clinic's operating muscle into the reimbursed codes.** The CIED and loop-recorder clinics already run high-volume remote transmission review and alert triage. Physiologic RPM is the same discipline applied to weight, blood pressure and symptoms — with a Part B revenue line attached.
6. **Confirm the practice's status on the FINAL CMS ASM list (expected summer 2026) and align go-live to it.** The preliminary selection is the planning basis; the final list is the commitment basis. Raise the roster discrepancy with CMS in the same pass.
7. **Build native to the practice's Greenway platform, and confirm the product edition in contracting.** CoachCare is the care-coordination partner behind Greenway Care Coordination Services, with integration built for the Greenway platform. Confirm which Greenway ambulatory

product the practice runs so enrollment, discrete vitals and automated claim creation are configured correctly from day one.

8. **Set an external-PCP collaboration model for shared heart-failure patients.** ASM anticipates a collaborative-care arrangement with primary care; because this is a cardiology group, that is framed as a shared care plan and structured data exchange with referring PCPs — coordination, never a billing arm of this practice.

1. Footprint & Operating Model

The practice operates as an independent, physician-owned partnership across three Sarasota offices — 1950 Arlington Street (main office, echocardiography, Holter and event monitoring), 1435 South Osprey Avenue (all stress testing consolidated), and 2068 Hawthorne Street (echocardiography, Holter and event monitoring) — with all hospital-based procedural and surgical work performed at Sarasota Memorial Hospital. Its 15 physicians and 9 advanced practice providers cover the full ambulatory and interventional cardiovascular range: interventional coronary work, peripheral and renal/carotid intervention, structural heart (TAVR), left-atrial-appendage occlusion, a full electrophysiology service (ablation, EP studies, pacemakers, defibrillators, implantable loop recorders), advanced heart-failure device therapy, and a deep imaging bench including echocardiography, transesophageal echo, cardiac PET, nuclear and stress imaging, and vascular studies. Third-party and practice-reported recognitions include more than 600 TAVR procedures, more than 700 left-atrial-appendage occlusion implants, accreditation of its imaging labs, and regional “top doctors” recognition.

A note on structure, hospital relationship, and EHR

The group brands as “Heart Specialists of Sarasota”; the entity that appears in CMS files and contracting is “HEART SPECIALISTS OF SARASOTA PL,” a Florida professional limited liability company founded in 2000 with physician managers of record. Public sources show no private-equity, MSO, or hospital ownership — consistent with a straight physician partnership, though absence of a public signal is not proof and ownership should be confirmed in discovery.

The practice states plainly that it practices only at Sarasota Memorial Hospital, and that its cardiologists are on staff there; this report treats that as a single, exclusive hospital relationship rather than a split admitting pattern. The EHR is Greenway — confirmed independently through the practice's Greenway-operated patient portal. Which Greenway ambulatory product the practice runs is not determinable from public evidence and is flagged as a contracting item in Section 8.

Remote-care posture: proven device monitoring, billable-software whitespace. The device side of remote care is mature here. The practice runs its own CIED clinic and tells patients directly that implanted-device monitoring travels with them if they change cardiologists — you do not write that sentence unless you own the device clinic. It reports the largest implantable loop recorder clinic in Florida, which is among the highest-volume remote-transmission and alert-triage workloads in cardiology. Holter and event monitoring run in-house. No third-party device-monitoring vendor is named anywhere in public materials, which reads as an in-house, manufacturer-portal-based operation: staff-intensive and unconsolidated.

What does not exist is the reimbursed software layer. There is no physiologic RPM program — no connected blood-pressure cuffs, scales, or pulse oximeters — and no Principal Care Management program of any kind. There is no incumbent remote-care vendor to displace. That combination is unusual and favorable: proven operational competence in remote monitoring, and a completely clean build for the codes that actually pay. A managed service that owns enrollment, monitoring labor and billing capture is the right form factor here, because the practice's constraint is staffing capacity, not clinical capability.

Design principles for the service line

Principle	What it means for this practice
Longitudinal by default	Heart-failure and high-risk cardiac patients are monitored continuously between visits, not managed only at episodic appointments.

Principle	What it means for this practice
Owned where the risk sits	The monitoring that drives the measure the practice is accountable for runs inside the practice — billed by the practice, instrumented by the practice, coordinated with the hospital partner.
One scorecard	A single view of enrolled census, alerts, titration actions, billable capture, practice margin and avoided admissions — clinical and financial on the same page.
Hub-and-spoke	Arlington, Osprey and Hawthorne share one remote-care engine; patients are enrolled wherever they are seen and managed centrally.
Top-of-license	Nurses and pharmacists run monitoring and GDMT titration to protocol; physicians work at the top of their license on exceptions and escalations.
Digital as care	Connected devices and structured data are part of the care model — feeding both clinical decisions and ASM performance measurement.

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 accountability and procedural throughput on one shared engine.

2.1 What It Is: The Care-Management Stack

The practice bills the specialty 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 this practice.

A note on terminology — two different uses of “CCM”

On this practice's own service list, “CCM” means Cardiac Contractility Modulation — the Optimizer device therapy the group implants for patients who remain symptomatic on optimal medical therapy. The care-management code modeled throughout this report is Principal Care Management (99426 / 99427), which is a different service entirely. The two are unrelated, and the acronym collision is worth naming once so it never causes confusion in a workflow, a chart note, or a claim. No claim is made or implied about the practice's Cardiac Contractility Modulation volumes.

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. Separately billable and excluded from every modeled figure in this report — upside on top.
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 post-discharge or post-procedure window; 99454 / 99457 carry longitudinal monitoring month over month.
PCM	99426 / 99427	Principal Care Management for the single dominant high-risk condition — heart failure above all — managed for three months or more. The specialist's care-management code, and the natural home for GDMT titration time.

Why PCM, and not Chronic Care Management

A specialist's care management is focused on one principal condition — resistant hypertension, coronary disease, heart failure — or on cardiovascular disease as a single domain, which is precisely what Principal Care Management is written for. Chronic Care Management assumes management of all of a patient's conditions, and it is increasingly billed by the patient's primary care practice, or absorbed into a prospective payment there. PCM is the code that fits the specialist's actual scope and does not collide with the PCP's.

This is a coding position of strength. It keeps the cardiology claim clean, keeps the referral relationship collaborative, and attaches the practice's care-management revenue to the condition it actually manages — the same condition ASM will score it on.

The one coordination rule

RPM stacks with Principal Care Management for the same patient in the same month (distinct time and documentation), and the two together are the whole longitudinal layer. Set a single attribution policy: every enrolled patient runs RPM plus one PCM wrapper against the named principal cardiac condition, on one shared care plan in Greenway, so the PCM claim never overlaps a primary-care care-management claim. TCM sits at each qualifying discharge as the on-ramp. For patients co-managed with an external PCP, agree who owns the longitudinal primary-care wrapper so no patient-month is double-counted.

2.2 Standalone Value: Four Value Layers

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

1. **Direct professional-fee revenue.** Recurring monthly RPM plus Principal Care Management billing — a subscription-like revenue line the practice owns, and a direct replacement for revenue lost when a Medicare Advantage contract goes away. TCM at each qualifying discharge is billable on top and is not in the forecast.
2. **Avoided cost.** Fewer heart-failure admissions and readmissions — modeled at roughly 293 avoided hospitalizations over 24 months (≈ $4.40 million at $15,000 per admission) — which also protects the hospital partner's performance and the referral relationships that feed the practice. Shown as clinical value and excluded from every revenue figure.
3. **Procedural throughput unlocked.** Short post-procedure monitoring windows support faster, safer discharge after structural, interventional and device cases, freeing catheterization-lab, EP-lab and inpatient-bed capacity for additional volume.
4. **Strategic / model readiness.** A functioning remote-care chassis is the ASM heart-failure operating model — built, staffed and generating data before the model becomes mandatory (per the CMS preliminary list; confirm final).

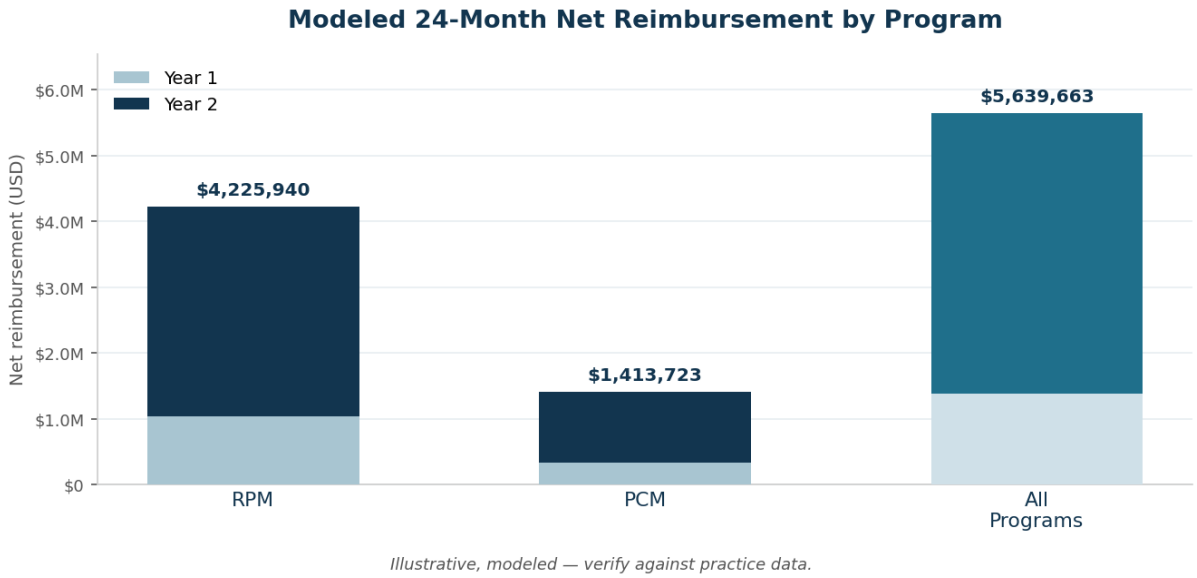

Figure 1. Modeled 24-month net professional-fee reimbursement by program, split Year 1 / Year 2. Illustrative, modeled from a CoachCare Value Analysis on a discovery-stage Medicare panel — verify against practice data.

The CY2026 billing stack (local Florida-locality rates)

Service / code	Type	Rate (FL 09102-99)	Notes
TCM 99495 / 99496	Per discharge	Not modeled — upside	Two-business-day contact; face-to-face 14 / 7 days. Excluded from every figure in this report
RPM 99453 setup	One-time	$21.12	Requires at least two days of data
RPM 99454 / 99445	Monthly	$50.00	99454 = 16–30 days; 99445 = new 2–15 day short-window code
RPM 99457 / 99470	Monthly	$51.12 / $25.73	First 20 minutes / new first-10-minute code (2026)
RPM 99458	Monthly	$41.22	Each additional 20 minutes
PCM 99426 / 99427	Monthly	$67.57 / $53.69	The single high-risk condition (heart failure) for three months or more

Rates shown are the local Florida-locality values (carrier 09102, locality 99; zip 34239) used in the Value Analysis — illustrative, not quotes. Actual payment is locality-adjusted and set by the regional MAC; verify current-year Physician Fee Schedule values in contracting. Every rate in the model is user-editable. Because a cardiology group has no primary-care panel, the primary-care management codes are intentionally out of scope and appear nowhere in this model.

How the recurring-revenue math works

Each enrolled heart-failure or high-risk cardiac patient generates a recurring monthly professional fee — RPM device and monitoring, plus Principal Care Management — for as long as they remain clinically appropriate and engaged. As the enrolled census ramps from month one across 24 months, that recurring line compounds, which is why modeled Year 2 net reimbursement ($4,253,483) is roughly 3.1× Year 1 ($1,386,180).

By Month 24 the model reaches about 3,554 active RPM enrollments and 1,262 active Principal Care Management enrollments — 4,816 active program enrollments (enrolled services), or 3,933 Enrolled Patients once dual enrollments are de-duplicated. The practice bills; CoachCare supplies the enrollment, connected devices, monitoring labor and billing capture as a service.

Enrolled Patients and Enrolled Services are never interchangeable. Roughly 70% of PCM enrollees also carry RPM, so those patients count once as a patient and twice as a service. Census figures in this report are labeled enrollments where they count program enrollments and patients where they count individuals.

Financial summary

Program (24-month)	Net reimbursement	CoachCare fees	Practice margin
RPM — remote physiologic monitoring	$4,225,940	$2,404,876	$1,821,064
PCM — principal care management	$1,413,723	$744,556	$669,167
Implementation, integration & ancillary	—	$61,381	−$61,381
24-month total	**$5,639,663**	**$3,210,813**	**$2,428,850**

	Year 1	Year 2	24-month
Net reimbursement	$1,386,180	$4,253,483	$5,639,663
CoachCare fees	$795,216	$2,415,597	$3,210,813
Net to practice (after fees)	$590,965	$1,837,886	$2,428,850
Practice margin (%)	**42.6%**	**43.2%**	**43.1%**

Practice margin is net to the practice expressed as a percentage of net reimbursement. Per-program year split (net reimbursement, exact workbook reads):

Program	Year 1	Year 2	24-month
RPM	$1,043,514	$3,182,427	$4,225,940
PCM	$342,667	$1,071,056	$1,413,723
All programs	**$1,386,180**	**$4,253,483**	**$5,639,663**

Values are rounded to the nearest dollar, so a program column may differ from its total by $1. Program rows show value before shared implementation, integration and ancillary items, which are carried on their own line. Net to the practice turns positive in month two and stays positive — month one carries the one-time implementation and integration setup, so there is no negative-margin quarter. Illustrative, modeled — verify against practice data.

Modeling assumptions (read before quoting any figure)

- **Panel is a discovery-stage estimate.** The model runs on approximately 22,600 Medicare patients — roughly 11,300 in traditional fee-for-service, plus a comparable Medicare Advantage population at Sarasota County's ~43% Medicare Advantage penetration. The fee-for-service figure derives from CMS CY2024 claims for the practice's billing providers at its main office address, with non-cardiology tenants of that shared medical office building excluded. Four recently added physicians and the nurse practitioners have no CY2024 record at those addresses, so the underlying figure is a floor.
- **Fee-for-service is where these codes bill cleanly.** RPM and Principal Care Management bill without negotiation on the traditional-Medicare portion of the panel. Medicare Advantage is modeled at Medicare fee-for-service rates; coverage of these services requires plan-by-plan confirmation, and the December 2025 UnitedHealthcare termination changes the surviving plan map — establish it in discovery.
- **Program eligibility and enrollment mechanics.** Cardiology eligibility of the panel is modeled at 75% for RPM (16,967 eligible patients) and 85% for Principal Care Management (19,229 eligible patients), with enrollment acceptance of 35% and 30% respectively — producing active-enrollment ceilings of approximately 5,938 (RPM) and 5,769 (PCM). Neither program saturates inside the 24-month window, so the forecast is pace-limited, not ceiling-limited. Enrollment runs on physician referral across 24 referring providers (eight referrals per provider per month at 80% acceptance), one CoachCare-funded on-site enrollment specialist (~80 enrollments per month) and telephonic outreach, beginning in month one and net of approximately 1.5% monthly attrition.
- **The on-site enrollment specialist is CoachCare's expense.** It is embedded value in the program and is never subtracted from practice margin.
- **Revenue is stated net.** A 3% denial rate and 20% coinsurance with 25% coinsurance bad debt are already deducted, along with approximately 1.5% monthly attrition and 3% annual panel growth. Rates are Florida 2026 locality values (carrier 09102, locality 99) — verify current-year values against the fee schedule and local MAC in contracting.
- **Avoided-admission value is directional.** Modeled at ~$15,000 per admission against an assumed baseline admission rate and an RPM-attributable reduction. It is a planning estimate, not a

guarantee, and no facility-specific readmission rate is claimed for Sarasota Memorial or any other hospital.

- **Care-team hours are CoachCare-delivered work.** The 47,734 hours of remote management over 24 months (≈ 22.9 FTE-equivalent) describe labor CoachCare performs on the practice's behalf — not headcount the practice hires, and not hours removed from the practice's existing payroll.

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 the practice 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 post-procedure discharge, and defends the referral relationships an independent group depends on.

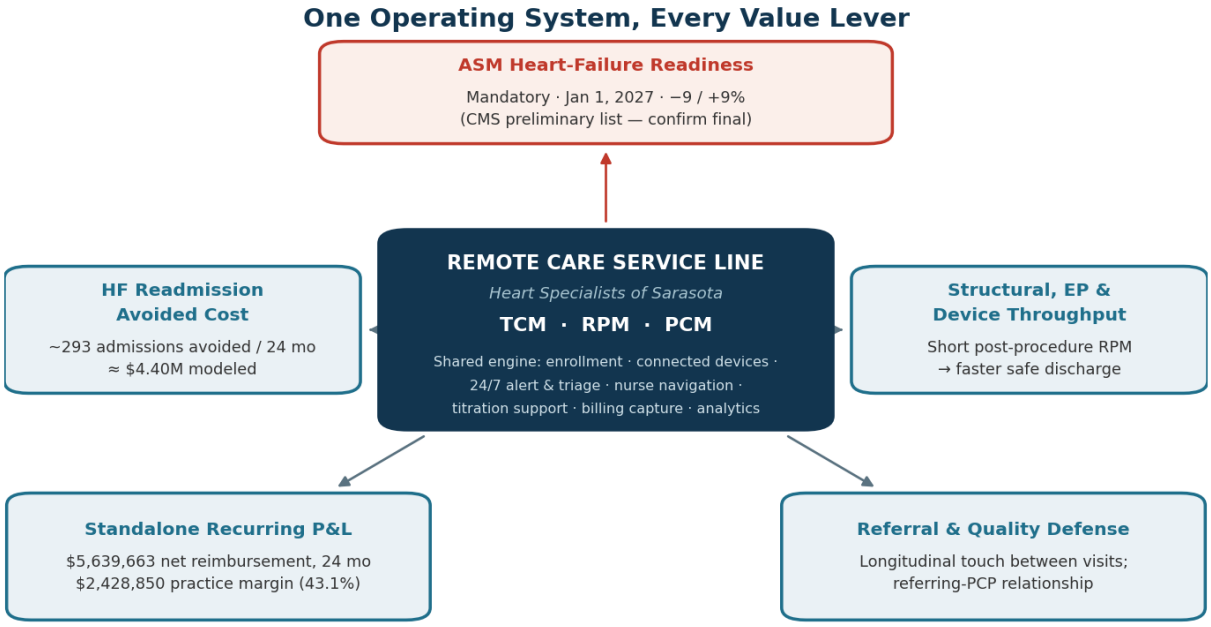

Figure 2. One operating system, every value lever. The ASM lever reflects the CMS preliminary participant list (February 2026) — confirm against the final CMS list. Illustrative, modeled — verify against practice data.

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 heart-failure cohort — the operating model ASM scores, run inside the entity that carries the risk. Preliminary list; confirm final.
HF readmission avoided cost	Weight and blood-pressure trend alerts catch decompensation early; ~293 admissions avoided over 24 months (≈ $4.40 million modeled), shown as clinical value rather than revenue.
Structural, EP & device throughput	Short post-procedure RPM windows support faster safe discharge after TAVR, LAA occlusion, ablation and device implant → freed lab and bed capacity for more cases.

Lever	What the shared engine contributes
Device-clinic consolidation	The same alert-and-triage layer that handles physiologic data is the discipline the CIED and loop-recorder clinics already run manually across manufacturer portals — one operating model instead of several.
Referral & quality defense	A visible, continuous touch between visits strengthens referring-PCP relationships and makes an independent group structurally harder to replace in its hospital partner's cardiac program.
Standalone P&L	Recurring RPM plus Principal Care Management revenue — modeled $5,639,663 net reimbursement over 24 months, $2,428,850 retained by the practice after CoachCare fees, a 43.1% practice margin.

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, quality, improvement activities and interoperability — a −9% to +9% adjustment in the first payment year. It is two-sided risk: this is downside exposure, not a bonus program. It holds the cardiologist accountable for a heart-failure patient's cost and quality across the full year, and it anticipates an electronic collaborative-care arrangement with the patient's primary-care clinicians.

★ ASM verification status — PRELIMINARY

Four of the practice's physicians appear on the CMS preliminary CY2027 ASM heart-failure participant list (released February 2026, built on approximately 2024 claims), listed under the legal entity “HEART SPECIALISTS OF SARASOTA PL.” The final participant list is expected in summer 2026, and the roster can change — at least one listed clinician's national provider record now shows out-of-state practice addresses, which would put effective exposure at three physicians rather than four.

Treat the preliminary selection as the planning basis, confirm the final list before any commitment that depends on participation, and raise the roster discrepancy with CMS in the same pass. Individual clinicians are deliberately not named here for that reason.

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 and blood-pressure monitoring, protocolized alerting, GDMT titration between visits, and the structured data that both drives care and documents performance. Standing it up now means entering 2027 with the workflows live and a year of data in hand, rather than building the plane while flying it. It matters here more than usual, because the practice has never had to produce this kind of performance data: its public quality profile is built on procedural volume, not on registry or outcomes reporting. ASM will score domains the group has not previously had to evidence.

The concentration problem — and why the answer is a group-wide chassis. ASM's heart-failure cohort excludes the interventional, electrophysiology, and advanced heart-failure/transplant specialty designations. With six interventional cardiologists and three electrophysiologists on a 15-physician roster, that means the model's payment adjustment attaches to a minority of the partnership — while the heart-failure population itself is spread across the entire group, and the advanced practice providers carry the densest heart-failure panels of anyone. A few physicians cannot solve this with a personal workaround. The mismatch between where the risk lands and where the patients sit is an argument for one shared, group-wide infrastructure rather than a departmental fix.

Market context: this is a land-grab, not a compliance chore

Most of the Sarasota–Manatee cardiology market is entering the same mandatory model on the same day. Florida's entire ASM heart-failure cohort is 412 clinicians; the local concentration is well above what that statewide number would suggest. Being early with the infrastructure is a competitive position, not merely compliance — and in a market where an independent group practices exclusively at one hospital whose employed cardiology group is also selected, being the practice that already runs the chassis is a defensible position.

Group (CMS legal name)	ASM heart-failure clinicians
Intercoastal Medical Group Inc	5
SMH Physician Services Inc (Sarasota Memorial's employed group)	4
Heart Specialists of Sarasota PL	4 (preliminary; effective exposure may be 3)
Manatee Cardiology Associates LLC	4
Cardiovascular Specialists of Sarasota	2
Heart & Vascular Center of Sarasota Inc	1
The Heart Institute of Venice PLLC	1

Counts are from the CMS preliminary CY2027 ASM participant file and are subject to the same final-list caveat that applies to this practice's own selection.

The primary-care collaboration — framed correctly. ASM anticipates an electronic collaborative-care arrangement with primary care. Because this is a cardiology group with no primary-care panel, that 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), and coordinates with the clinician who owns the primary-care wrapper. That keeps attribution clean and avoids double-counting any patient-month.

A scope note

This report scopes remote care to the specialty stack a cardiology group can bill on its own patients — TCM, RPM and Principal Care Management. Primary-care management is out of scope throughout, and collaborative care with referring PCPs is treated strictly as coordination, never as something this practice bills. No claim is made about hospital-side payment models, which do not apply to an independent physician group. A smaller, honest scope beats an inflated one.

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, reviewed on a fixed cadence by a named owner.

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; alerts actioned within target.
Heart-failure quality	GDMT titration to target; 30-day heart-failure readmissions; days at home; symptom-driven visit avoidance; percent of the heart-failure cohort on continuous monitoring.
Access & throughput	Post-procedure length of stay; same/next-day discharge rate; catheterization- and EP-lab utilization; new-patient access time.
Device-clinic operations	Remote transmissions reviewed per FTE; alert-to-action time; transmission-billing capture at full allowable frequency.
Financial	Recurring RPM and Principal Care Management revenue; denial rate; net reimbursement retained by the practice; practice margin as a percentage of net reimbursement.
ASM readiness	Heart-failure cohort enrolled and monitored; titration protocol live; PCP collaborative-care arrangements in place; performance data captured. Reconcile against the final CMS list.

ASM readiness checklist

- **Cohort defined and enrolled** — every attributed heart-failure patient on continuous weight and blood-pressure monitoring, with the launch cohort drawn from post-discharge TCM touches.
- **Titration as a production process** — nurse- and pharmacist-led GDMT titration to protocol, with defined physician escalation paths, billed as Principal Care Management time.
- **Monitoring owned by the accountable entity** — the interstitial heart-failure work billed and instrumented by the practice, coordinated with the hospital's heart-failure program rather than duplicated by it.
- **PCP collaborative care** — shared care plans and structured 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 Greenway.
- **Final-list confirmation** — go-live plan reconciled to the final CMS ASM participant list expected summer 2026, with the roster discrepancy raised.

5. Performance Snapshot

A physician group does not receive a CMS Overall Hospital Star Rating, and this practice publishes no registry outcomes or accreditation-based quality data of the kind a hospital carries — its public profile rests on procedural volume and regional recognition. Rather than assert ratings the practice does not publish, this section frames the clinical opportunity two ways: the national readmission picture that establishes the heart-failure wedge, and the practice's own CMS-derived panel data that sizes it.

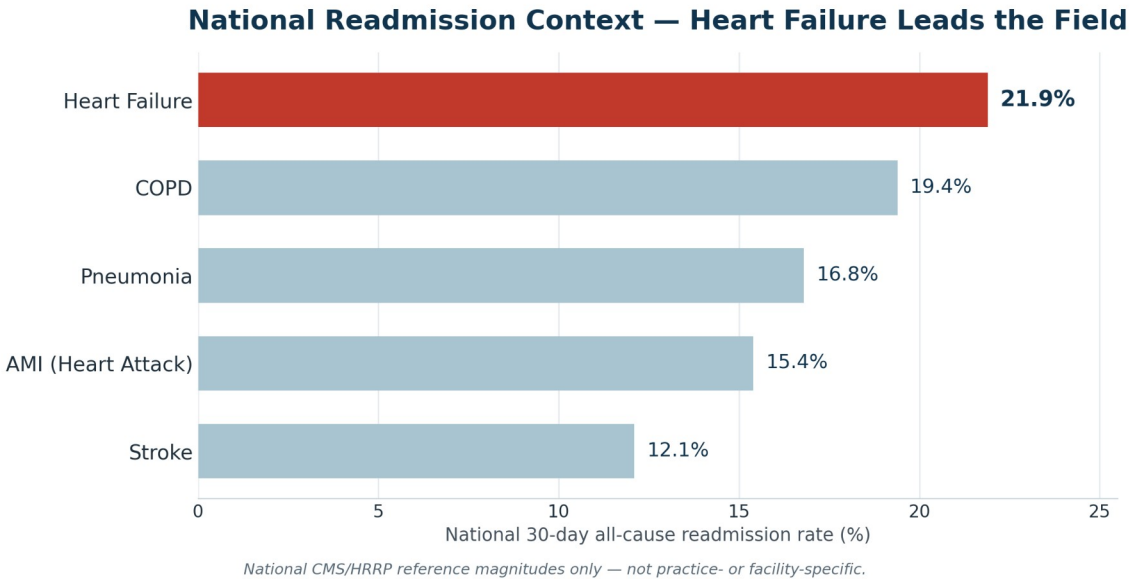

Figure 3. National CMS/HRRP 30-day readmission reference magnitudes by condition. These are national benchmarks only — not practice- or facility-specific — and are shown to illustrate where remote care moves the needle.

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. For a cardiology group that already owns these patients clinically — and that will shortly be accountable for their total cost — closing that gap is both a quality win and a payment one.

Chronic-disease density in the practice's own Medicare panels

The following are drawn from the CMS Medicare Physician & Other Practitioners by-provider file, data year 2024, for the practice's billing clinicians. They are presented as ranges across providers rather than by individual, and they describe traditional fee-for-service beneficiaries only.

Panel characteristic	Physicians	Advanced practice providers
Heart failure / non-ischemic heart disease	24% – 54%	31% – 66%
Atrial fibrillation	36% – 75%	42% – 75%
Chronic kidney disease	24% – 49%	30% – 49%
Mean beneficiary age	77 – 80	77 – 80
CMS HCC risk score	1.29 – 2.10	1.46 – 2.34

Read the advanced-practice column. The APPs' panels are systematically sicker than the physicians' — higher heart-failure prevalence, higher atrial-fibrillation prevalence, higher risk scores. That is not an anomaly; it is the visible signature of a practice where the advanced-practice bench absorbs the chronic heart-failure and device follow-up load between physician visits. It is also precisely the work a managed remote-care service line takes on, and precisely the capacity a funded program gives back. Public signals suggest this group is staffing-constrained rather than capability-constrained, which is the strongest possible argument for the managed form factor over a software-only tool the practice would have to hire against.

What to confirm before citing local numbers

Figure 3 shows national reference magnitudes, not practice- or facility-specific rates. Before any local readmission claim, pull facility-specific 30-day heart-failure readmission data for Sarasota Memorial Hospital from CMS Care Compare and note the data vintage. The panel figures above are CMS CY2024 by-provider data for clinicians billing at the practice's main office address, with non-cardiology tenants of that shared building excluded; four physicians who have joined recently have no CY2024 record at those addresses, so the underlying volume figures are a floor, not a ceiling. County Medicare Advantage penetration (~43%) should be confirmed from the current CMS county file, along with the surviving Medicare Advantage plan map after the December 2025 UnitedHealthcare termination.

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 a Sarasota Memorial discharge, or at a routine office visit.
- **Monitor & alert** — daily physiologic data flows into a 24/7 alert-and-triage layer; weight and blood-pressure trends surface decompensation days before a symptomatic crash. This is the same triage discipline the CIED and loop-recorder clinics already run, applied to a different data stream.
- **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, with Principal Care Management covering the management time.
- **Document & measure** — structured monitoring and titration data both drive care and produce the performance record ASM is scored on — the record this practice has not previously had to generate.

Moving the protocol inside the accountable entity

This is the operational heart of the argument, so it is worth stating precisely rather than rhetorically. Today, the interstitial heart-failure work for this population — telephonic symptom and weight tracking, post-discharge nurse follow-up, education, medication-access support — is performed by Sarasota Memorial's Heart Failure Center. It is good care, delivered by a program the practice's own physicians help lead. But three things are true about it at once:

- It is manual and telephonic, not device-driven — which caps how many patients it can reach and how early it detects decompensation.
- It is not billed to Medicare Part B by anyone. The professional-fee revenue Medicare makes available for exactly this protocol is being captured by neither the hospital nor the practice.
- It sits outside the entity that carries the risk. From January 1, 2027, the payment adjustment for these patients' cost and quality lands on this practice's Part B billing — while the day-to-day management levers sit on another organization's cost center.

A practice-billed remote-care service line resolves all three at once. It converts a manual protocol into a monitored one, converts unbilled labor into a Part B revenue line, and puts the levers under the entity that will be measured. Done well, it also makes the hospital partner's heart-failure program better rather than redundant: the practice takes the ambulatory, between-visit monitoring load; the hospital keeps the inpatient and advanced-therapy program; the two share a care plan and the same data. Set that boundary explicitly and early — including whether any co-management or medical-directorship agreement covers the current arrangement — so the program reads as alignment rather than encroachment.

The collaborative-care arrangement, done right. ASM anticipates an electronic collaborative-care arrangement with primary care. For this practice that is a coordination relationship, not a billing arm: a shared heart-failure care plan in Greenway and structured data exchange with each patient's external referring PCP. The practice owns the cardiology wrapper (TCM, RPM, PCM); 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:** every enrolled patient runs RPM plus one Principal Care Management wrapper against a named principal cardiac condition; the referring PCP owns primary-care management for shared patients.
- **Targeting:** launch with the attributed ASM heart-failure cohort and post-discharge patients, then widen to the broader high-risk cardiac panel across all three offices.
- **Hospital boundary:** an explicit division of labor with Sarasota Memorial's Heart Failure Center — who monitors, who titrates, who documents, and how the shared care plan is exchanged.
- **Shared care plan:** one plan of record in Greenway, with an agreed data-exchange method for referring PCPs.
- **Readiness:** workflows live and generating data during 2026; go-live reconciled to the final CMS ASM list expected summer 2026.

7. Powering Procedural Growth: Structural, EP & Device Throughput

The same engine that manages heart failure also protects the procedural economics of a device-heavy, high-acuity practice. This group performs structural heart work (with more than 600 TAVR procedures reported), left-atrial-appendage occlusion with both available device platforms (more than 700 implants reported), coronary and peripheral intervention, and a full electrophysiology service including ablation, device implant, and what it reports as Florida's largest implantable loop recorder clinic. Remote care is a throughput multiplier for all of it.

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, EP-lab and inpatient-bed capacity at the hospital for additional cases. Build the monitoring chassis once for heart failure, and the post-procedure window is a reuse, not a new build. For a group whose procedural volume is its economic engine and whose hospital partner controls the capacity, that is a shared win worth naming in the conversation with Sarasota Memorial.

The device-clinic adjacency. There is a second, quieter opportunity here. A high-volume CIED and loop-recorder clinic run across manufacturer portals is staff-intensive and hard to scale. The alert-and-triage layer that a managed remote-care service line brings is the same operating discipline applied to a different data stream — and it is worth asking, in discovery, how many implanted-device patients are on remote transmission today, how many staff hours go into triage, and whether the remote-transmission codes are being billed to their full allowable frequency. That conversation earns the physiologic-monitoring conversation.

> **Scope discipline**
>
> This lever is deliberately last and deliberately bounded. The service line's core is longitudinal heart-failure and principal-condition management; procedural throughput is a real but secondary benefit, and this report does not model incremental procedure volume or claim any revenue from it. Procedural volumes cited are practice-reported figures carried by a secondary aggregator, not independently audited registry data — confirm them in discovery. Treat this section 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 at discharge plus RPM and Principal Care Management, billed by the practice, on the heart-failure and high-risk cardiac panel across the Arlington, Osprey and Hawthorne offices, integrated with the practice's Greenway platform.

Target populations (in launch order)

- **Attributed ASM heart-failure cohort (launch first)** — the patients the practice is expected to be measured on in 2027 (per the CMS preliminary list; confirm against the final list), including those currently followed through the hospital's heart-failure program.
- **Post-discharge and post-procedure patients** — captured at the TCM and short-window RPM on-ramp after a Sarasota Memorial discharge, TAVR, LAA occlusion, ablation, or device implant.
- **Broader high-risk cardiac panel** — arrhythmia, device follow-up, CKD and hypertension patients on RPM, with a Principal Care Management wrapper on the named principal condition, and the advanced-practice panels prioritized because they carry the densest chronic burden.

Staffing, technology & billing architecture

- **Top-of-license clinical model** — nurses and pharmacists run monitoring and GDMT titration; CoachCare supplies the enrollment (including a CoachCare-funded on-site enrollment specialist, at CoachCare's expense and never subtracted from practice margin), connected-device logistics, monitoring labor and billing capture as a service, so the practice adds program capacity without adding headcount it must recruit, train and retain. The model projects roughly 47,734 care-team hours of remote management delivered by CoachCare over 24 months (≈ 22.9 FTE-equivalent of CoachCare-performed work — not practice headcount).
- **Native Greenway integration, day one** — CoachCare is the care-coordination partner behind Greenway Care Coordination Services. The integration provides bidirectional enrollment by service, integrated ordering, integrated discrete vitals, an integrated care summary with compliance documentation, escalation tasks, and automated claim generation — all inside the existing clinical workflow, with telephonic patient enrollment and cellular-connected devices with real-time vitals. Eligible Medicare patients are flagged and enrolled from within the clinical workflow, and monthly claims are generated automatically rather than assembled by hand.

Greenway integration — confirm the product edition in contracting

Greenway ships this integration for both of its ambulatory products, Intergy and Prime Suite. Public evidence does not establish which one this practice runs: the MyHealthRecord patient portal that the practice links to is the shared, product-agnostic entry point for both, and no public artifact names the product. No product is asserted here.

Intergy is the likelier fit for a multi-site specialty group with heavy in-house ancillaries — imaging, nuclear, PET, vascular, and a device clinic — and Greenway has been consolidating its customer base onto Intergy. If the practice is in fact on Prime Suite, the pending migration is itself the timing argument: stand remote care up native to the target system rather than rebuilding it twice. Confirm the product edition, version and integration scope as a contracting item, and confirm whether the patient portal is broadly adopted or largely dormant, since that determines how much of enrollment must run telephonically.

Clinical workflow (steady state)

Enroll at a TCM touch, a post-procedure follow-up, or a clinic visit → ship and activate cellular-connected devices → daily physiologic data into 24/7 alert-and-triage → protocolized GDMT titration between visits, with defined escalation to the treating cardiologist → structured documentation in Greenway and exchange with the referring PCP → monthly billable capture (RPM plus Principal Care Management) and TCM at each qualifying discharge.

KPI dashboard

Clinical	Operational	Financial
GDMT titration to target; 30-day heart-failure readmissions; days at home; percent of HF cohort monitored	Enrolled census; time-to-first-billable-enrollment; device-activation rate; alerts actioned on time	Net revenue per patient per month; billable-capture rate; denial rate; net reimbursement retained by the practice; practice margin (%)

Expected impact & 12-month roadmap

Modeled 24-month impact (illustrative; verify against practice data): $5,639,663 net professional-fee reimbursement, $2,428,850 retained by the practice after CoachCare fees — a 43.1% practice margin — roughly 293 avoided hospitalizations (≈ $4.40 million in avoided cost, shown as clinical value), 106,825 reimbursable claims and units, 461,831 physiologic readings, and 47,734 care-team hours of remote management delivered by CoachCare, reaching 3,933 Enrolled Patients in active remote care by Month 24 across 4,816 active program enrollments.

1. **Months 1–2 — Stand up and start enrolling.** Contract; confirm the Greenway product edition and integration scope; integrate; define the heart-failure cohort; set attribution, the PCP-collaboration model and the boundary with the hospital's heart-failure program; train staff. Enrollment begins in month one — the ASM heart-failure cohort and post-discharge patients first, via TCM on-ramps and clinic referral — with no onboarding pause before the first billable patient.
2. **Months 3–6 — Ramp.** Scale the enrolled census across the heart-failure and post-discharge populations; go live on monitoring, titration and billing capture inside Greenway. Net to the practice is positive from month two onward.
3. **Months 7–12 — Scale & prove.** Widen to the broader high-risk panel across all three offices, prioritizing the advanced-practice panels; stand up the balanced scorecard; accumulate the ASM performance-data record and reconcile the plan to the final CMS list. The model reaches roughly 2,437 active program enrollments (about 1,990 Enrolled Patients) by month 12, on Year-1 net reimbursement of $1,386,180.
4. **Into 2027 — ASM go-live.** Enter January 1, 2027 with a live heart-failure operation, a monitored cohort and a year of data — not a standing start against two-sided risk. Year 2 bills the full book: $4,253,483 modeled net reimbursement.

The bottom line for Heart Specialists of Sarasota

A 15-physician independent cardiovascular group with a mature in-house device clinic, documented heart-failure density, no billable remote-care program and no incumbent vendor — and four physicians on the CMS preliminary CY2027 ASM heart-failure list — is an unusually clean setting for a partner-built remote care service line. The Value Analysis shows $2,428,850 of modeled 24-month net to the practice on $5,639,663 of net reimbursement — a 43.1% practice margin — with no negative-margin quarter, and the same chassis is the heart-failure operating model ASM will score from January 2027. ASM participation reflects the CMS preliminary CY2027 participant list (published February 2026) — confirm against the final CMS list, expected summer 2026.

The right next step is a discovery session to replace the panel, eligibility and payer-grid inputs with the practice's own data, and to confirm the final CMS ASM list and the Greenway product edition.

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References & Data Sources

1. CMS Innovation Center — Ambulatory Specialty Model (ASM) Participants dataset, data.cms.gov (CY2027 Preliminary list, published February 2026); four clinicians returned for the legal entity “HEART SPECIALISTS OF SARASOTA PL,” all in the heart-failure cohort. Preliminary — confirm against the final CMS list expected summer 2026.
2. CMS — Ambulatory Specialty Model program design (mandatory, two-sided; heart-failure and low-back-pain cohorts; PY2027–2031; first-year Part-B adjustment −9% to +9%; scored on cost, quality, improvement activities and interoperability; electronic collaborative-care arrangement with primary care required).
3. American College of Cardiology — ASM cohort construction, including the exclusion of interventional cardiology, electrophysiology, and advanced heart-failure/transplant designations from the heart-failure cohort.
4. CMS Medicare Physician & Other Practitioners — by Provider, data year 2024; chronic-condition prevalence, beneficiary counts, mean age and HCC risk scores for the practice's billing clinicians at its main office address (non-cardiology tenants of the shared medical office building excluded).
5. NPPES / NPI Registry — entity and clinician records for the practice's Sarasota locations; source of the out-of-state address signal noted in the ASM caveat.
6. Heart Specialists of Sarasota — practice website: provider directory, locations, services, patient notices (including the December 1, 2025 UnitedHealthcare Medicare Advantage network termination and the implanted-device monitoring transfer notice), and patient portal.
7. Sarasota Memorial Health Care System — Heart Failure Center and Cardiac Services program descriptions, including telephonic symptom and weight tracking, device-based fluid monitoring, and post-discharge nurse follow-up.
8. CMS Care Compare / HRRP — national 30-day readmission reference magnitudes (Figure 3); facility-specific rates for Sarasota Memorial Hospital to be pulled and dated on discovery.
9. CMS CY2026 Physician Fee Schedule — remote-care billing codes (TCM; RPM including the new 99445 and 99470; Principal Care Management 99426 / 99427); local Florida-locality values (carrier 09102, locality 99) used in the model.
10. CMS Medicare Advantage county penetration file and public plan-year data — Sarasota County Medicare Advantage penetration of approximately 43%.
11. CoachCare Value Analysis — Heart Specialists of Sarasota (2026). Modeled economics on a discovery-stage Medicare panel of approximately 22,600 patients; source of all illustrative financial, clinical and operational figures in this report. All rates and inputs user-editable.
12. Greenway Health / CoachCare — Greenway Care Coordination Services integration overviews for Greenway Intergy and Greenway Prime Suite (bidirectional enrollment by service, integrated ordering, integrated discrete vitals, integrated care summary and compliance documentation, escalation tasks, automated claim generation, telephonic enrollment, cellular-connected devices).
13. CoachCare — program scale references (managed conditions, patients, providers, implementations, claims generated, and vitals recorded).

Verification & validation caveat

This report is a planning artifact, not an audited financial or legal document, and every present-day fact should be re-verified before it is relied upon. In particular: (1) ASM participation reflects the CMS preliminary list of February 2026 — confirm against the final list expected summer 2026, including the roster discrepancy that may reduce effective exposure from four physicians to three; (2) all economics are illustrative, modeled on a discovery-stage panel estimate, with Medicare Advantage priced at traditional-Medicare rates and requiring plan-by-plan confirmation — re-run against actual practice data; (3) Transitional Care Management is billable at each qualifying discharge and is excluded from every modeled figure; (4) the Greenway product edition, the contracting entity and ownership structure, the surviving Medicare Advantage plan map after December 2025, any co-management or medical-directorship arrangement with Sarasota Memorial, practice-reported procedural volumes, and any facility-specific readmission figures must be confirmed on discovery. Nothing herein is a quote, a guarantee of reimbursement, or legal, coding, or investment advice.