BOSTON MEDICAL CENTER HEALTH SYSTEM

Cardiovascular Service Line · 2026 Strategy Review

Cardiovascular Service Line Performance and Optimization

2026 Strategy Report

A Remote Care Service Line — TCM to short-window RPM to longitudinal RPM, PCM and CCM — as the operating layer for the 30 days after a cardiac discharge, across Boston, Brighton and Brockton.

Purpose of this report

On January 1, 2026 all three Boston Medical Center Health System hospitals entered a mandatory, five-year CMS episode model, and coronary artery bypass graft is one of its five episode categories. This report reads the cardiovascular service line against that change using CMS's own published performance data, and sets out how a managed remote care service line operates the 30 days after discharge — as a margin-positive service line in its own right, and as the shared infrastructure behind every other value lever the system already carries.

Written for cardiovascular service line leadership across the three campuses, and for system clinical, quality, digital and finance leadership.

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Executive Summary

Boston Medical Center Health System runs three acute-care hospitals — Boston Medical Center in the South End, BMC–Brighton, and BMC–South in Brockton — with a cardiovascular program that spans all three and a cardiac surgery and structural heart center of gravity at Brighton. It is the largest safety-net hospital system in New England, with a public payer mix of 77.9 percent at the main campus and a Medicare payer mix of 47.9 percent at BMC–South. The two community hospitals joined the system on October 1, 2024 and were renamed in May 2025; all three went onto one Epic instance on November 1, 2025, and the last legacy read-only window closed on March 31, 2026.

On January 1, 2026 all three hospitals became **mandatory** participants in the CMS Transforming Episode Accountability Model — **CCN 220031 Boston Medical Center, CCN 220036 BMC–Brighton and CCN 220111 BMC–South**, each verified individually on the CMS participant list, each carrying all five episode categories, each running through December 31, 2030. Coronary artery bypass graft is one of those five categories, and the CABG volume sits at Brighton. The model holds the hospital accountable for all Medicare Part A and Part B spend from admission through 30 days after discharge.

The central argument

A managed remote care service line — TCM at the cardiac discharge, short-window RPM through the first two weeks home, then longitudinal RPM with PCM or CCM — delivers value two ways at the same time.

Standalone. It is a recurring, subscription-like professional-fee service line staffed at top of license, carrying its own margin before a single episode is reconciled and before any value-based dollar is counted.

Connective tissue. One shared engine — enrollment, connected devices, 24/7 alert and triage, nurse navigation, documentation and claim generation — simultaneously operates the TEAM CABG episode, moves the one PY1 quality measure a post-discharge program can move, works directly on the readmission measures CMS publishes against all three hospitals, supports an ENHANCED-track Medicare ACO carrying full downside risk, and returns inpatient beds at a system running above 90 percent occupancy. Built once for cardiology, it extends to the next service line without a second build.

The gap is not the care. It is the 30 days after discharge.

This is the cleanest fact in the account. On CMS Care Compare, Boston Medical Center's main campus is rated **Better Than the National Rate on 30-day heart failure mortality — 7.1 percent against a national 11.6 percent**. Very few academic medical centers in the country hold that flag. The inpatient care of heart failure at BMC is, by CMS's own measurement, excellent.

The 30 days after those patients go home look different. On the FY2026 Hospital Readmissions Reduction Program file, BMC–Brighton's excess readmission ratio is **1.2639 for acute myocardial infarction**, **1.1383 for heart failure** and **1.0527 for CABG** — three cardiac measures above CMS's expectation for that hospital's case mix at the same time. BMC–South carries the largest heart failure denominator in the system, 682 discharges, at an excess readmission ratio of **1.1191**. Brighton and South are both flagged Worse Than the National Rate on the hospital-wide all-cause readmission measure. Excellent inpatient outcomes and above-expected 30-day returns is not a contradiction — it is the signature of a gap that opens at the door, and it is the only gap a remote care service line is built to close.

You have already proven this works on your own patients

BMC has run device-based remote patient monitoring embedded in Epic since 2022, on cellular-connected blood pressure cuffs, through the Rimidi platform. The published results are unusually strong: **98.7 percent of 1,000 monitored patients submitted at least one measurement**, averaging 17 measurements each over the six weeks after delivery, and BMC published that Black and Hispanic patients engaged at **statistically similar rates to white patients**. **That result pre-answers the objection every remote monitoring proposal meets — that this population will not engage — using BMC's own data, on BMC's own panel, inside BMC's**

own Epic. The program covers postpartum and gestational hypertension, gestational diabetes, and a hepatology NAFLD cohort.

It does not cover cardiology. Our review found no cardiology remote monitoring, chronic care management or transitional care management program, and no cardiology-specific vendor relationship, anywhere in the system. BMC–Brighton's advanced heart failure program does run a disease management pathway with a minimum of two telemedicine check-ins at day three and day seven after discharge — a real, thoughtful piece of work, and structurally a transitional care program without the monitoring tail. It is visit-based, it carries no device data, and it ends on day seven. The episode CMS reconciles runs to day 30.

The window opened in November

Anyone who called on BMC through most of 2025 would have been told, correctly, that nothing new was starting during the Epic conversion. That objection has expired. Brighton and South went live on BMC's Epic instance on November 1, 2025; legacy Athena and Meditech went read-only within a week; the final view-only window closed March 31, 2026. All three hospitals now sit on one instance, which means a system-wide cardiovascular registry is technically possible for the first time — and Rimidi has already proven the path for a third-party remote monitoring application into BMC's Epic workflow.

What the service line is worth

A Value Analysis computed at Massachusetts Medicare Physician Fee Schedule locality rates for an in-scope cardiovascular population of approximately 2,091 patients projects **$2,684,844 in net reimbursement over 24 months against $1,564,502 in CoachCare fees, leaving $1,120,342 of service line margin at 41.7 percent**. Month one nets negative $265 because implementation and integration fees post in that month; every month from month two forward is positive. No episode reconciliation, no shared-savings contribution, no avoided-cost credit and no Medicaid revenue appears anywhere in those figures. Section 8 sets out the full model, its ceilings, and everything in it that must be validated. ***Illustrative, modeled — verify against practice data.***

2026–2027 priority recommendations

1. **Stand up the cardiac discharge pathway at BMC–South first.** It has the highest Medicare payer mix in the system at 47.9 percent, sits in a county where Medicare Advantage penetration is 32.0 percent — ten points below Suffolk — holds 25.1 percent of all Metro South heart failure discharges, carries a 1.1191 heart failure excess readmission ratio, and has no remote monitoring capability of any kind. Highest need, cleanest fee-for-service reimbursement, no incumbent to displace.
2. **Wrap the CABG episode at BMC–Brighton inside the same pathway.** Brighton is where the TEAM CABG episode lives and where the readmission exposure is widest. A TCM-plus-RPM wrap on the surgical discharge is the standard operating response to an episode reconciled on 30 days of total Part A and Part B spend.
3. **Resolve the CABG question on the public TEAM page.** BMC's patient-facing accountable care page lists four TEAM procedure categories and does not list coronary artery bypass graft, which is one of the five statutory categories. Whether that is a communications gap or a scoping decision is worth settling internally before PY1 reconciliation.
4. **Build the system-wide cardiovascular registry now that one Epic instance exists.** Heart failure, post-CABG, post-PCI and post-structural-heart cohorts across all three campuses, with a single enrollment flag and a single scorecard. This was not buildable before November 2025.
5. **Fund the program from its own professional-fee revenue, not from new BMC headcount.** Given the system's financial position, an on-site enrollment specialist funded by CoachCare and a vendor-staffed monitoring and triage layer are the only structures that clear both the finance test and the labor-relations test.
6. **Treat MassHealth as the second phase, and price the case on Medicare alone.** MassHealth has covered RPM since August 1, 2024 and names congestive heart failure and hypertension as qualifying

conditions. On a Medicaid-heavy panel that is material upside — but it is deliberately excluded from every figure in this report, so the business case does not depend on it.

1. Footprint and Operating Model

1.1 Three hospitals, one system, one Epic instance

BMC Health System operates three acute-care hospitals. All three are Acute Care Hospitals with emergency services on the CMS Hospital General Information file; none is a critical access hospital.

Hospital	CCN	Prior name	Beds	Cardiovascular role
Boston Medical Center	220031	—	539 staffed (CHIA HFY2024); BMC states 511	Academic medical center; cardiovascular center, EP, cardiac surgery, advanced imaging, hypertension center
BMC – Brighton	220036	St. Elizabeth's Medical Center	291 (BMC-stated)	Cardiac surgery and structural heart center of gravity; the TEAM CABG episode sits here
BMC – South	220111	Good Samaritan Medical Center	191 staffed (CHIA HFY2024); BMC states 224	Highest Medicare mix; largest heart failure volume; interventional cardiology and vascular, no cardiac surgery program published

Boston Medical Center reported 27,681 inpatient discharges, 113,480 emergency department visits, an average length of stay of 6.53 days and **91.6 percent occupancy** in health fiscal year 2024, with a case mix index of 1.19 (CHIA hospital profiles, published January 2026). A system running that full has no spare inpatient capacity to absorb avoidable returns.

A data-quality trap worth knowing about

CMS's own files disagree on names. The TEAM participant list already uses the current names for CCN 220036 and CCN 220111. The Care Compare Hospital General Information file does not — CCN 220111 still returns “Good Samaritan Medical Center,” and both acquired CCNs are still coded “Proprietary” ownership, a legacy attribute. Any analysis that matches BMC by name against Care Compare returns one hospital instead of three and understates the system by two-thirds. Everything in this report is matched by CCN on both files.

1.2 Where cardiovascular care is actually delivered

The three campuses do genuinely different work, and a service line design that ignores that will fail. Everything below is taken from BMC's own published program pages.

Campus	Published cardiovascular capability
Boston Medical Center	Arrhythmia Center and electrophysiology laboratory; cardiac surgery; heart failure and cardiomyopathy program; hypertrophic cardiomyopathy clinic; preventive cardiology with cardiac rehabilitation and lipid clinic; Comprehensive Hypertension Center (multi-specialty); vascular medicine; Amyloidosis Center; cardiac catheterization laboratory operating 24/7/365 to a 90-minute door-to-balloon target; pacemaker and cardiac device clinic; ACGME-accredited cardiovascular medicine fellowship.
BMC – Brighton	Advanced Heart Failure Program; cardiac arrhythmia center; Kosowsky cardiovascular rehabilitation center with Pritikin intensive cardiac rehabilitation; interventional cardiology and structural heart — published list includes TAVR, transcatheter edge-to-edge mitral repair, PFO and ASD closure, left atrial appendage closure, PCI, ablation, carotid stenting and percutaneous mechanical support; Center for Advanced Cardiac Surgery — CABG, aortic valve replacement, mitral repair, Cox MAZE, minimally invasive approaches; published volume of more than 1,500 cardiac catheterization procedures annually.
BMC – South	Interventional cardiology with a published volume of more than 1,000 procedures each year; catheterization laboratory and electrophysiology clinic; 24/7 emergency primary angioplasty for STEMI; angiography suite covering peripheral vascular and dialysis access; vascular medicine, described by BMC as the only hospital in the Brockton area and one of two in southeastern Massachusetts approved by CMS for carotid stenting; non-invasive diagnostics. No cardiac surgery program is published.

Clinical leadership, from BMC's own directories: each campus publishes a Chief of Cardiovascular Medicine — Boston Medical Center, Brighton and BMC–South — alongside a System Chief of Cardiac Surgery for the health system, a Brighton advanced heart-failure lead and a heart-failure program director at BMC. **No cardiovascular service line administrative director is published anywhere across the system, and no Chief Medical Information Officer is publicly named.** Both are open discovery questions, and the administrative dyad partner is usually the economic buyer for a program of this shape.

1.3 The volume basis, and its limits

Two independent sources describe the cardiovascular volume, and they measure different things. The CMS Medicare Inpatient Hospitals file (data year 2024) counts Medicare fee-for-service discharges only and suppresses any provider-DRG cell below 11 discharges, so every figure it produces is a floor. The Massachusetts CHIA hospital discharge data (health fiscal year 2024) counts all payers.

Cohort	BMC Boston	BMC – Brighton	BMC – South	Combined
Total circulatory (MDC 5, MS-DRG 215–316)	386	484	732	**1,602**
Heart failure and shock (291–293)	163	51	225	**439**
Acute myocardial infarction (280–282)	31	28	165	**224**

Cohort	BMC Boston	BMC – Brighton	BMC – South	Combined
CABG — the TEAM episode (231–236)	—	**65**	—	65
Endovascular / transcatheter valve (266, 267)	—	107	—	107
Cardiac valve and other major cardiothoracic (216–221)	—	35	—	35
Arrhythmia and pacemaker (242, 243, 308–310)	55	44	108	207
Circulatory with cardiac catheterization (286, 287)	40	47	34	121

On the all-payer CHIA data the same picture is larger and sharper. **System heart failure volume is 1,623 discharges** — 788 at the main campus (10.8 percent of all Metro Boston heart failure discharges), 137 at Brighton and **698 at BMC–South, which is 25.1 percent of every heart failure discharge in the Metro South region**. Brighton recorded **286 coronary bypass discharges**, capturing between 13.5 and 17.8 percent of all Metro Boston CABG volume depending on the DRG. Heart failure is the fifth-largest inpatient DRG at the main campus and the third-largest at BMC–South.

Two caveats that apply to every volume figure in this report

The 2024 data predates full integration. For most of calendar and fiscal 2024, Brighton was St. Elizabeth's and South was Good Samaritan. These are the same physical programs under new ownership, but the reporting entity changed mid-year, and CHIA notes that only eight or nine months of HFY2024 data was submitted for the former Steward hospitals.

The Medicare file shows no CABG cell at the main campus. That means fewer than 11 Medicare CABG discharges, not zero — Care Compare returns a three-year CABG readmission denominator of 30 for CCN 220031. The correct statement is that the CABG volume sits at Brighton, not that the main campus does not perform it.

1.4 Design principles for the service line

Principle	What it means in practice
Longitudinal by default	The cardiac patient is enrolled at discharge, not re-recruited at the next clinic visit. The pathway runs continuously from day zero rather than restarting at each encounter.
One scorecard across three campuses	Boston, Brighton and Brockton report the same enrollment, capture and outcome measures on one dashboard. Site variation becomes visible instead of inferred.
Hub and spoke, not one-size-fits-all	Brighton anchors the surgical and structural-heart pathway; South anchors the heart failure and interventional pathway; the main campus anchors advanced heart failure, device and hypertension cohorts. One engine, three intake patterns.

Principle	What it means in practice
One front door for the patient	A single enrollment conversation, a single device kit, a single number to call, regardless of which campus discharged them or which cardiologist follows them.
Digital as care, not as a channel	Device data lands in Epic as discrete vitals that a clinician acts on, with documented clinical time — not as an attachment nobody opens.
Multilingual by default	BMC provides in-house interpretation in more than 30 languages and telephonic or video interpretation in over 240, with Spanish, Haitian Creole and Portuguese Creole most requested. On this panel that is a design requirement, not an enhancement.

2. What Is Already Built, and What It Does Not Reach

2.1 The remote care assets that exist today

BMC is not a greenfield remote-monitoring buyer, and this report does not pretend otherwise. The system has built more remote and virtual care capability than most academic medical centers of its size, and it built it on a safety-net panel, which is harder.

Asset	What it is	Vintage
Rimidi remote patient monitoring	Device-based blood pressure monitoring on cellular-connected cuffs, launched inside BMC's Epic workflow through the Epic app marketplace. Now covers postpartum and gestational hypertension, gestational diabetes, and a hepatology NAFLD cohort.	Announced August 2022
BMC Hospital at Home	Physician-led acute care at home with a partner technology platform: around-the-clock monitoring through a command center, daily physician e-visits, a minimum of two in-person clinician visits per day, 245 qualifying diagnoses including congestive heart failure.	Launched April 3, 2024
BMC–Brighton heart failure disease management	A minimum of two telemedicine check-in appointments, at three and seven days after discharge, to improve follow-up and reduce readmissions.	Published program
Complex Care Management	Nurse- or social-worker-led teams with community wellness advocates, pharmacy and housing partners; panels of 45 to 75 patients; median time to graduation 15.2 months. Serves the MassHealth ACO population.	Published program
BMC Telehealth	Video and phone visits across specialties including cardiology. The patient-facing page conditions hypertension management on the patient already having a blood pressure cuff at home.	Current

Two of these are directly relevant to timing. The federal Acute Hospital Care at Home waiver lapsed on September 30, 2025 and was restored, and extended through September 30, 2030, under the Consolidated Appropriations Act, 2026 signed February 3, 2026. Whether and how BMC's program was affected is not published, and we have not assumed it. The relevant structural point is that **the remote care service line described in this report depends on no waiver at all** — TCM, RPM, PCM and CCM are permanent Medicare Physician Fee Schedule benefits.

2.2 Cardiology is the one place the engine does not reach

Capability	Exists at BMC?	Covers cardiology?
Device-based RPM, embedded in Epic, proven on this panel	**Yes** — since 2022	**No** — obstetrics and hepatology only
Acute care at home with 24/7 remote monitoring	**Yes** — since April 2024	Acute episode only; no chronic tail after the episode closes

Capability	Exists at BMC?	Covers cardiology?
Post-discharge heart failure follow-up	**Yes** — Brighton, two telemedicine visits	Visit-based, ends day 7, no device data, no 16-day capture
Multidisciplinary complex care management	**Yes** — panels of 45–75	MassHealth ACO population; no billing codes described; not cardiology-specific
Chronic care management billing program (99490 family)	**None found**	—
Transitional care management program (99495 / 99496)	**None found**	—
Cardiology-specific remote monitoring vendor	**None found**	—

Searches for a cardiology remote monitoring, chronic care management or transitional care management relationship at BMC Health System returned no evidence of one. The remote care vendors we could confirm are the hospital-at-home platform and Rimidi. Absence of public evidence is not proof of absence, and this belongs in discovery rather than in an assertion — but the pattern is consistent across every published program page, every specialty clinic listing and every press release we reviewed. **The whitespace is not whether BMC does remote care. It is that BMC does remote care everywhere except cardiology.**

2.3 The objection your own data already answers

BMC has already published the engagement result

98.7 percent of 1,000 monitored patients submitted at least one blood pressure measurement, averaging 17 measurements over the six weeks after delivery. Across a six-month reporting window the program logged 8,922 blood pressure readings from 505 unique patients, generating 913 high-blood-pressure alerts and 700 care team messages.

No racial engagement gap. BMC published that Black and Hispanic patients engaged and transmitted measurements at statistically similar rates to white patients. A subsequent preeclampsia-risk cohort enrolled 114 pregnant patients, 81 percent of whom identify as non-Hispanic Black or Hispanic, and the Health Equity Accelerator funded a dedicated full-time position to bridge inpatient cuff distribution to outpatient result management.

What that settles. The three objections a remote monitoring proposal usually has to survive — our patients will not engage, the technology will not sit inside Epic, and it will widen a disparity — have all been answered at BMC, by BMC, on BMC's own population. What has not been answered is why the same capability has never been pointed at the cardiac discharge.

There is a fair internal counter-argument, and it should be met directly rather than avoided: extend the existing platform to cardiology. It is worth taking seriously. What it requires is not a device — it is condition-specific heart failure logic on weight, blood pressure and symptom trajectory; a transitional care sequence that starts inside two business days of discharge; a clinical staffing model that reliably produces and documents 20 minutes of qualifying time per patient per month; and a billing engine that generates 99453, 99454, 99457, 99458, 99490, 99439, 99426, 99427, 99495 and 99496 correctly, at volume, across three campuses and two payer regimes. That is a service line, not an application. The question to ask internally is not whether the platform could carry cardiology, but who would run the enrollment, the monitoring, the triage and the claim.

3. The Remote Care Service Line — The Spine

3.1 One continuous pathway from the discharge outward

The service line is one pathway, not a set of products. It begins in the hospital before the patient leaves and runs continuously outward. Each stage has its own billing basis, and each hands off to the next without the patient having to be recruited again.

Stage	Window	Codes	What actually happens
Transitional care management	Discharge to day 30	99495 · 99496	Contact within two business days of discharge; medication reconciliation; a face-to-face visit inside 14 days (99495) or 7 days (99496) for high-complexity patients. This is the handoff that currently ends on day seven at Brighton.
Short-window remote monitoring	Days 1–15	99445 · 99470	Device set-up at discharge and daily physiologic data through the highest-risk two weeks. CY2026 introduced 99445 for a 2–15 day data window and 99470 for the first 10 minutes of management time, so a short post-discharge window is billable on its own terms rather than being lost because it did not reach 16 days.
Longitudinal remote monitoring	Month 1 onward	99453 · 99454 · 99457 · 99458	Set-up, the 16-of-30-day device supply, and 20-minute increments of clinical management time. Weight, blood pressure, heart rate, oxygen saturation and symptom trajectory land in Epic as discrete vitals.
Principal care management	Month 1 onward	99426 · 99427	For the single high-risk condition — heart failure being the archetype — managed by the specialty. Thirty-minute increments of clinical staff time under the cardiologist's direction.
Chronic care management	Month 1 onward	99490 · 99439	For the multi-morbid cardiac patient with two or more chronic conditions expected to last at least twelve months. Twenty-minute increments of clinical staff time.

The one coordination rule that has to be set before go-live

RPM stacks with PCM and with CCM — the time and documentation must be discrete, but they can be billed for the same patient in the same month.

PCM and CCM do not stack with each other for the same patient in the same month, and TCM occupies the 30-day post-discharge window with its own service period. The cardiac patient therefore needs an explicit attribution policy: which service the patient carries in the transition month, which they carry from month two, and who owns the care plan of record in Epic when a patient is followed by both cardiology and a primary care practice. Set it as policy, in writing, before the first enrollment — not per patient, per month, in arrears.

3.2 Standalone value: five layers

The service line creates value in five distinct layers. The first stands entirely on its own; the others compound on top of it and are not counted anywhere in the financial model in Section 8.

1. **Direct professional-fee revenue.** Recurring monthly reimbursement for services BMC's cardiology patients are already clinically eligible for and are not currently receiving. This is the layer the Value Analysis models, and it is the only one that appears in the numbers.
2. **Avoided cost and reduced penalty exposure.** Every avoided readmission is a bed returned at a hospital running 91.6 percent occupancy, a data point removed from the excess readmission ratio, and spend removed from a 30-day episode window that CMS reconciles. None of this is booked as revenue in Section 8.
3. **Procedural and clinic throughput.** Remote monitoring supports earlier, safer discharge after structural heart and interventional procedures at Brighton, and it absorbs the routine post-procedure follow-up that currently consumes clinic slots. The freed capacity converts to cases.
4. **Model and quality-rating readiness.** TEAM's PY1 composite quality score, the hospital-wide readmission measure, CMS star ratings and the public safety grades all move in the same direction as the same operational work. Two of the three hospitals are currently flagged Worse Than the National Rate on the hospital-wide measure.
5. **Enterprise leverage.** This is the layer that only exists at a health system. One enrollment engine, one device logistics chain, one 24/7 triage layer, one documentation standard and one billing engine, built for cardiology, extend to the next service line — pulmonology, nephrology, the employed ambulatory network — without a second build, a second contract or a second Epic integration. Section 8 shows the cardiovascular cohort saturating inside a year. That is not an argument for inflating this service line; it is the argument for the next one.

3.3 The CY2026 billing stack

Rates below are the CY2026 Medicare Physician Fee Schedule amounts used in the Value Analysis, resolved to Massachusetts MAC locality 14212-01 from ZIP 02118. They are locality-specific and subject to annual rulemaking, and must be confirmed for each billing site in contracting.

Code	Service	Basis	CY2026 locality amount
99495 / 99496	Transitional care management, moderate / high complexity	Per discharge	Not modeled — see §8.5
99453	Remote monitoring — set-up and patient education	One-time	$25.72

Code	Service	Basis	CY2026 locality amount
99445	Remote monitoring — device supply, 2–15 day window (new for CY2026)	Per 30 days	$62.11
99454	Remote monitoring — device supply, 16–30 day window	Per 30 days	$62.11
99470	Remote monitoring — first 10 minutes of management (new for CY2026)	Per calendar month	$29.32
99457	Remote monitoring — first 20 minutes of management	Per calendar month	$58.29
99458	Remote monitoring — each additional 20 minutes	Per calendar month	$45.93
99426	Principal care management — first 30 minutes, clinical staff	Per calendar month	$75.14
99427	Principal care management — each additional 30 minutes	Per calendar month	$60.47
99490	Chronic care management — first 20 minutes, clinical staff	Per calendar month	$73.14
99439	Chronic care management — each additional 20 minutes	Per calendar month	$56.13

Why this behaves like recurring revenue

Once a cardiac patient is enrolled and a device is transmitting, the monthly codes recur for as long as the patient remains clinically eligible and engaged. The service line's revenue is a function of **census times capture rate**, not of visit volume — which means it grows without consuming a clinic slot, and it does not fall when the schedule is full. Two of the codes above, 99445 and 99470, are new for CY2026 and exist specifically to make short post-discharge windows billable. For a service line whose central problem is the 30 days after discharge, that is a direct policy tailwind.

3.4 Connective tissue: one infrastructure, every lever

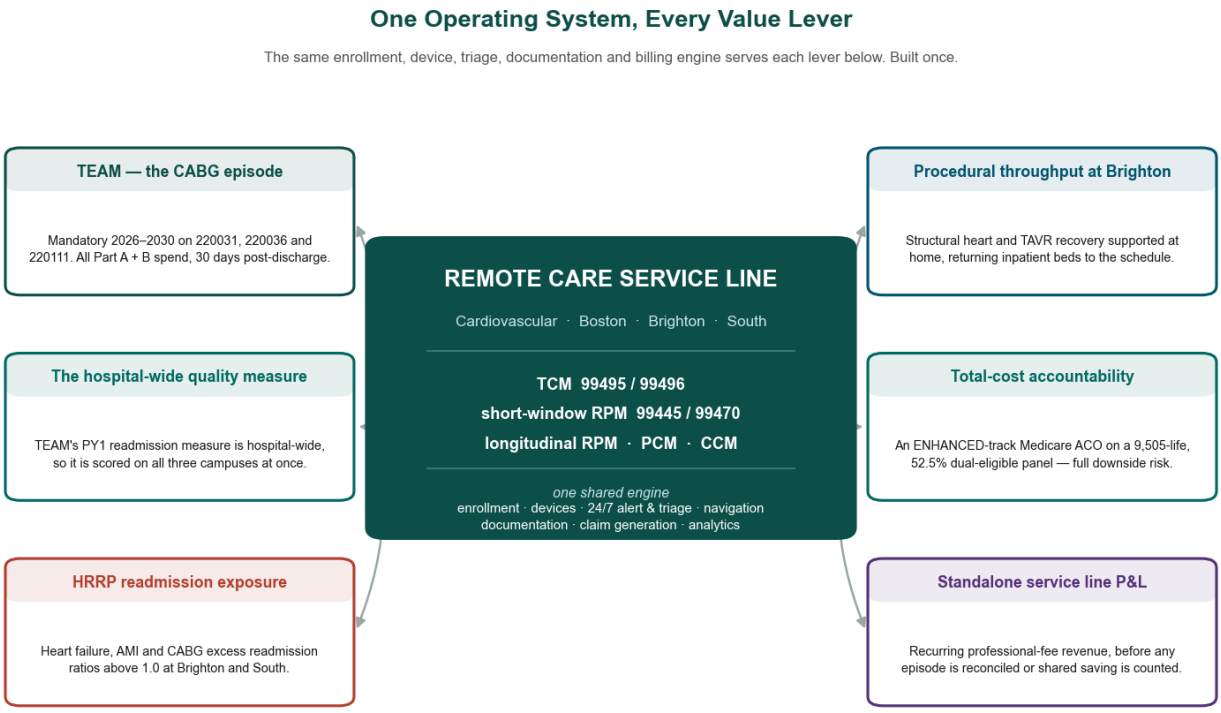

Figure 1. *The same enrollment, device, triage, documentation and billing engine serves every lever in the cardiovascular service line. The levers shown are the ones verified for BMC Health System: TEAM participation confirmed by CCN, the hospital-wide quality measure that applies to all three campuses, published HRRP performance, procedural throughput at Brighton, an ENHANCED-track Medicare ACO, and the standalone service line P&L.*

Lever	What the shared engine contributes	Status for BMC
TEAM — the CABG episode	TCM at discharge plus device-based monitoring through the 30-day window; escalation before an emergency department presentation becomes an admission; episode-level documentation.	**Verified — mandatory on all three CCNs**
TEAM composite quality score	The PY1 quality measure a post-discharge program moves is the hospital-wide all-cause readmission measure, and it is hospital-wide, so it is scored on all three campuses rather than only the surgical one.	Verified from the CMS PY1 quality specification
HRRP readmission exposure	Heart failure, AMI and CABG cohorts monitored continuously after discharge, with structured escalation and titration support.	Excess readmission ratios above 1.0 published for Brighton and South
Procedural throughput at Brighton	Monitored recovery after structural heart and interventional procedures supports earlier discharge and returns bed-days to the surgical and cath lab schedule.	107 transcatheter valve and 1,500-plus catheterization procedures published

Lever	What the shared engine contributes	Status for BMC
Total-cost accountability	Avoided admissions and reduced post-acute utilization flow straight into total cost of care on an ENHANCED-track panel carrying full downside risk.	BMC Integrated Care Services, 9,505 assigned lives, 52.5 percent dual
Quality-rating defense	Star ratings and public safety grades are downstream of the same readmission and utilization measures.	3 / 3 / 2 CMS stars across the three hospitals (May 2026 release)
Standalone service line P&L	Recurring professional-fee revenue at top-of-license staffing.	**$1.12M modeled 24-month margin at 41.7 percent**

4. The 2026 Policy and Payment Environment

4.1 TEAM: mandatory, CABG-inclusive, on all three CCNs

The Transforming Episode Accountability Model began on January 1, 2026 and runs through December 31, 2030. Participation is mandatory for selected hospitals in selected core based statistical areas, and it is assigned by CCN. Boston-Cambridge-Newton, MA-NH — CBSA 14460 — is a selected area, and **all three BMC hospitals appear individually on the CMS participant list as mandatory participants for the full five-year term**. This was verified CCN by CCN against the CMS TEAM participant list rendition published in June 2026, carrying hospital data as of April 15, 2026.

CCN	Hospital	TEAM status	Term	CABG volume
220031	Boston Medical Center	**Mandatory**	01/01/2026 – 12/31/2030	Below the CMS reporting threshold in the 2024 Medicare file
220036	BMC – Brighton	**Mandatory**	01/01/2026 – 12/31/2030	**The system's CABG center**
220111	BMC – South	**Mandatory**	01/01/2026 – 12/31/2030	No cardiac surgery program published

All three hospitals carry all five episode categories — lower extremity joint replacement, surgical hip and femur fracture treatment, spinal fusion, major bowel procedure and coronary artery bypass graft. Only the CABG episode is cardiology-specific, and the cardiology-relevant volume sits at Brighton.

A discrepancy worth settling internally

BMC's own patient-facing accountable care page lists TEAM's covered procedures as joint replacement, hip fracture repair, spine surgery and major bowel surgery. **It does not list coronary artery bypass graft**, which is one of the five statutory episode categories and the one that attaches to 286 bypass discharges a year at Brighton. This is stated here as a fact about the public page, not as a claim about internal readiness — but whether it reflects a communications gap or a scoping decision is worth resolving before PY1 reconciliation.

4.2 What TEAM reconciles against, and what moves it

The episode runs from admission through 30 days after discharge and reconciles against **total Medicare Part A and Part B spend** compared to a CMS target price, adjusted for quality. That definition matters more than it first appears: the model does not reconcile against the readmission rate. It reconciles against everything that happens in those 30 days — readmissions, but also emergency department presentations that never convert to an admission, observation stays, and unplanned post-acute utilization. Those are precisely the events a readmission measure cannot see and a monitored post-discharge pathway is designed to prevent.

CMS has published PY1 preliminary target prices at the census-division level rather than per hospital. For New England, at the CABG discount factor of 1.5 percent:

MS-DRG	Benchmark	Trend factor	PY1 preliminary target price
231	$86,534	1.0344	**$88,167**
232	$53,977	1.0296	**$54,740**
233	$69,564	1.0374	**$71,084**
234	$49,061	1.0396	**$50,238**

MS-DRG	Benchmark	Trend factor	PY1 preliminary target price
235	$52,525	1.0281	**$53,193**
236	$37,814	1.0386	**$38,685**

These are regional, not hospital-specific, and they are preliminary. They are shown to establish scale: a single avoidable readmission inside a CABG episode consumes a meaningful share of the margin between actual spend and a target price in this range.

The PY1 quality measure a post-discharge program actually moves

TEAM's PY1 composite quality score is built from three measures: the **hospital-wide all-cause readmission measure** (claims-only in PY1), the CMS PSI 90 patient safety composite, and the hip and knee patient-reported outcome measure. Only the first is meaningfully movable by a post-discharge remote care program — and because it is a ***hospital-wide*** measure weighted by TEAM episode volume, it is scored on all three BMC hospitals, not just the one performing CABG. Both BMC–Brighton and BMC–South are currently flagged Worse Than the National Rate on that measure.

4.3 The readmissions program running underneath it

TEAM sits on top of a readmissions program that has been running for over a decade. The Hospital Readmissions Reduction Program applies a payment adjustment based on excess readmission ratios across six condition cohorts, with heart failure, acute myocardial infarction and CABG all in scope. The FY2026 file, covering the performance period July 1, 2021 to June 30, 2024, is the evidence base for Section 5.

What this report does not state is BMC's HRRP payment reduction percentage. The percentage is not published in the CMS Provider Data Catalog readmissions dataset; it lives in the IPPS final rule tables, which we could not retrieve programmatically. It cannot be derived from the excess readmission ratios, because the calculation is peer-group relative on dual-eligibility share and weighted by cohort volume. No estimate has been made anywhere in this report, and the actual figure should be pulled from BMC's own IPPS impact file.

4.4 MassHealth coverage, which is not in the model

MassHealth has reimbursed remote patient monitoring since **August 1, 2024**, under Transmittal Letter PHY-170 to the Physician Manual. The letter makes CPT 99091, 99453, 99454, 99457 and 99458 payable, and the list of qualifying conditions explicitly names **congestive heart failure and hypertension** alongside asthma, COPD, diabetes and perinatal states. Eligibility requires demonstrated instability — more than two hospitalizations or emergency department visits for the condition in 24 months, or documented risk factors including recent discharge from an inpatient stay. That eligibility trigger is a near-verbatim description of the cardiac cohort this report is about.

Two operational rules matter commercially: a provider may use a vendor to manage the devices, but billing must be done by the MassHealth-enrolled provider; and to bill 99454 the member must receive the device from the provider rather than from a DME supplier or pharmacy. Both are compatible with the operating model in Section 9.

Deliberately excluded from every number in this report

The Value Analysis in Section 8 is Medicare-only. No MassHealth revenue appears in it. On a system with a 39.6 percent Medicaid case mix at the main campus and a Medicare ACO panel that is 52.5 percent dual-eligible, MassHealth RPM coverage is material upside — but it is also exposed to federal Medicaid policy, and a business case that depends on it is a business case with a policy dependency. This one does not. Whether MassHealth separately reimburses chronic care management or transitional care management as distinct benefits was **not verified** — PHY-170 addresses remote monitoring only, and that gap must be closed before any Medicaid-side care management revenue is modeled.

5. Performance Snapshot

5.1 Quality and recognition

Measure or recognition	BMC Boston	BMC – Brighton	BMC – South
CMS Overall Hospital Quality Star Rating (released May 13, 2026)	**3 of 5**	**3 of 5**	**2 of 5**
Leapfrog Hospital Safety Grade, Spring 2026	**B**	**A**	**C**
30-day heart failure mortality (national 11.6)	**7.1 — Better Than National**	12.2 — No Different	12.0 — No Different
30-day AMI mortality (national 12.2)	11.7 — No Different	11.8 — No Different	11.6 — No Different
30-day CABG mortality (national 2.6)	2.2 — No Different	1.9 — No Different	Not available this period
U.S. News, 2025–26	#42 nationally in Cardiology, Heart & Vascular Surgery; High Performing in heart failure and pacemaker implantation	High performing — aortic valve surgery, heart bypass surgery, arrhythmia treatment, pacemaker implantation	High performing — heart attack care
Other cardiac recognition	—	Society of Thoracic Surgeons three-star rating (rating period not published); Healthgrades cardiac care recognition since 2012	Healthgrades Coronary Intervention Excellence Award; 2025 Patient Safety Excellence Award

The Leapfrog and CMS results diverge for Brighton — an A grade against a 3-star rating with two Worse Than National flags. They use different measure sets and different vintages, and they should not be treated as corroborating each other. Both are reported here as published.

One absence is worth noting because it is addressable. BMC's own awards page lists American Heart Association Get With The Guidelines recognition for ***stroke only*** in both 2025 and 2026. The only heart-failure quality recognition anywhere in the system is at Brighton, and its award year is not published. For a system with 1,623 heart failure discharges a year and 30-day heart failure mortality better than the national rate, the absence of a heart-failure quality designation at the flagship is a conspicuous and fixable gap — and the registry, documentation and follow-up discipline that a remote care service line installs is most of what such a designation requires.

5.2 Readmission performance across three campuses

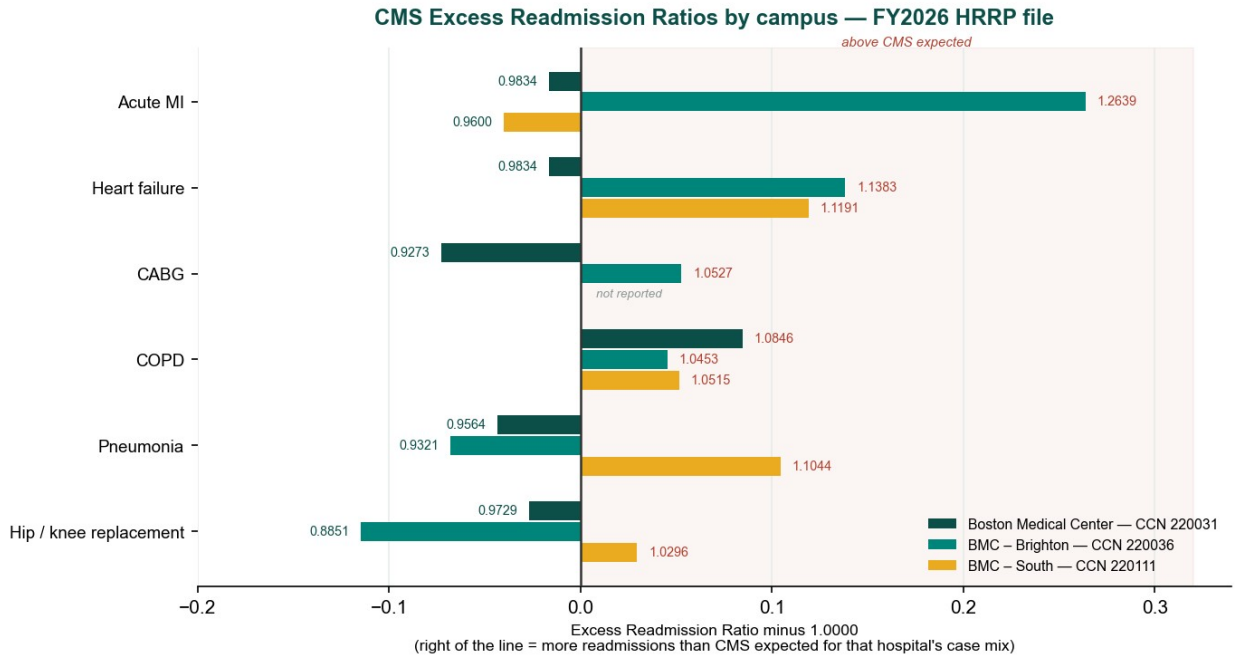

Figure 2. *CMS excess readmission ratios by campus, FY2026 Hospital Readmissions Reduction Program file, performance period July 1, 2021 to June 30, 2024. A ratio above 1.0000 means more readmissions than CMS expected for that hospital's case mix. CABG is not reported for CCN 220111 in this release. These are CMS risk-adjusted figures — see §5.4.*

Read across the three campuses, the pattern is consistent and it is cardiac. **BMC–Brighton is above CMS expectation on heart failure, acute myocardial infarction and CABG simultaneously**, with an AMI ratio of 1.2639 that is the highest single figure anywhere in the system. **BMC–South carries the largest heart failure denominator in the system — 682 discharges — at 1.1191**, and is above expectation on four of its five reported measures. The academic campus is the strong performer of the three, above expectation only on COPD.

Care Compare 30-day measure	BMC Boston	BMC – Brighton	BMC – South	National
Heart failure readmission	19.3 — No Different	22.4 — No Different	22.1 — No Different (n = 682)	19.7
AMI readmission	13.4 — No Different	**16.8 — Worse Than National**	13.0 — No Different	13.6
CABG readmission	9.8 — No Different	11.1 — No Different (n = 270)	Not available	10.6
Hybrid hospital-wide readmission	15.3 — No Different	**16.4 — Worse Than National**	**16.1 — Worse Than National**	15.0

5.3 Excess days: the signal a readmission rate misses

The readmission rate counts one thing: whether a patient came back and was admitted. The excess days in acute care measure counts the whole burden — emergency department visits, observation stays and readmissions together — expressed as days per 100 discharges relative to expectation. It is the cleanest available proxy for what TEAM actually reconciles, and it is where BMC's exposure is widest.

Excess days in acute care, 30 days	BMC Boston	BMC – Brighton	BMC – South
After heart failure	−4.2 — average	**+31.7 — More Days Than Average**	**+22.0 — More Days Than Average**
After acute myocardial infarction	**−22.6 — Fewer Days Than Average**	**+56.7 — More Days Than Average**	+1.1 — average
After pneumonia	**+25.8 — More Days Than Average**	—	**+20.9 — More Days Than Average**

BMC–Brighton's +56.7 excess days per 100 acute myocardial infarction discharges is the single largest utilization signal in the account, and it sits at the hospital that performs the CABG. A remote care service line is not a general-purpose quality intervention; it operates on exactly this measure, in exactly this window, by catching physiologic deterioration before it becomes an unplanned presentation.

5.4 How this report treats these numbers

Risk adjustment, stated plainly

Every readmission figure in this section is CMS risk-adjusted, and CMS's risk adjustment is widely argued to under-correct for social risk. On the CMS Medicare enrollment file for April 2026, 43.6 percent of Suffolk County Medicare beneficiaries are dual-eligible, and BMC's Medicare ACO panel is 52.5 percent dual. That is the most plausible driver of the figures above, and it is a fact about the adjustment methodology as much as about the care.

So this report presents these numbers as the exposure BMC is measured against under the rules it is scored by — not as a clinical failing. The distinction is not a courtesy. It is the reason the intervention that works is operational rather than clinical: the inpatient care is already good, as the better-than-national heart failure mortality shows. What is missing is a structured presence in the 30 days after the patient goes home — which is also the only part of the measure a hospital can change without changing its population.

Data vintage for this entire section: CMS Hospital Readmissions Reduction Program and Unplanned Hospital Visits datasets, performance period July 1, 2021 to June 30, 2024, released May 13, 2026; hybrid hospital-wide readmission measure, July 1, 2023 to June 30, 2024. Star ratings released May 13, 2026. Leapfrog Spring 2026 grades released in May 2026. All of these refresh annually and should be re-pulled before any commitment is made against them.

6. Powering TEAM: The CABG Episode

6.1 What changes operationally

Under a fee-for-service model, the hospital's accountability effectively ends at discharge. Under TEAM it ends 30 days later, and every dollar of Medicare Part A and Part B spend in between belongs to the episode. That single change converts a set of discharge-day tasks into a managed 30-day operating window, and it requires four things the current pathway does not systematically produce.

What the episode requires	What exists today	What the service line adds
Contact within two business days of discharge, every time	Brighton runs telemedicine check-ins at days three and seven for heart failure. No system-wide equivalent is published for the surgical discharge.	A structured TCM sequence on every cardiac discharge across all three campuses, with the contact documented and the code captured.
Physiologic visibility between visits	No device-based monitoring in cardiology. The telehealth page tells hypertension patients to have their own cuff.	Cellular-connected weight, blood pressure, heart rate and oxygen saturation transmitting daily into Epic as discrete vitals from the day of discharge.
Someone watching, at all hours, who can act	Not published for the cardiac cohort.	24/7 alert and triage against condition-specific thresholds, with a defined escalation path to the cardiology team and documented clinical response.
Episode-level documentation and reporting	Fragmented across three campuses newly consolidated onto one Epic instance.	One care plan of record, one documentation standard, one scorecard reporting enrollment, capture, escalation and outcome by campus.

6.2 The episode bundle

For a CABG discharge at Brighton, the billable pathway through the 30-day episode window is a specific, ordered sequence — and CY2026's new codes make the highest-risk part of it billable for the first time.

Day	Action	Code
Day 0	Device kit issued and set-up completed before the patient leaves.	99453
Days 1–2	Interactive contact within two business days of discharge; medication reconciliation.	TCM service period begins
Days 1–15	Daily physiologic transmission through the highest-risk window; clinical management time captured from the first ten minutes.	**99445 · 99470**
Day ≤7 or ≤14	Face-to-face visit — within 7 days for high-complexity, 14 for moderate.	99496 · 99495
Days 16–30	Monitoring continues through the close of the episode window; management time accrues in 20-minute increments.	99454 · 99457 · 99458

Day	Action	Code
Month 2 onward	Patient transitions to the longitudinal pathway — principal care management for heart failure, or chronic care management for the multi-morbid patient, with monitoring continuing.	99426 · 99427 · 99490 · 99439

The structural point is that the episode window and the billing window now line up. Before CY2026, a two-week post-discharge monitoring period generated no device-supply revenue because it did not reach the 16-day threshold. 99445 closes that gap, and 99470 makes the first ten minutes of management time billable rather than requiring a full twenty. The riskiest fortnight of the episode is now the best-supported part of the pathway.

6.3 The same engine at the structural heart discharge

Brighton's published interventional and structural heart program covers TAVR, transcatheter edge-to-edge mitral repair, PFO and ASD closure, left atrial appendage closure and carotid stenting, and the CY2024 Medicare file shows 107 transcatheter valve discharges. Those patients are not in a TEAM episode, but they are in the same operational position: recovering at home, with a monitoring need that currently falls to the patient and the clinic phone.

Monitored recovery does two things there. It supports discharge on the earlier of two clinically acceptable days, which returns bed-days to a hospital that cannot easily add them; and it absorbs routine post-procedure follow-up that would otherwise consume clinic slots at the same structural heart program that generates the referrals. **No procedural volume growth is claimed or modeled anywhere in this report.** It is named here because it uses the same engine, at no additional build cost, and because throughput is the constraint a system at 91.6 percent occupancy actually feels.

6.4 Build once, reuse everywhere

Every capability the CABG episode requires — enrollment, device logistics, 24/7 triage, documentation, claim generation, reporting — is the same capability the heart failure cohort requires, the same one the post-PCI and post-structural-heart cohorts require, and the same one the next service line will require. That is the whole argument for treating this as a service line rather than as an episode-management project. An episode project ends when the episode does. A service line keeps producing revenue, keeps the census, and is already standing when the next model or the next cohort arrives.

7. An Operating System for Service Line Performance

7.1 The balanced scorecard

One scorecard, reported monthly, by campus. The remote care rows are the ones most often left off, and they are the ones that tell you whether the program is working before the clinical measures move.

Domain	Measure	Why it is on the list
Clinical	30-day readmission and excess days in acute care, by cohort and campus	The measures CMS scores, and the ones TEAM's quality score depends on
Clinical	Heart failure guideline-directed medical therapy titration rate	The clinical work remote monitoring is actually enabling
Clinical	Time from discharge to first clinical contact	The single strongest operational predictor of the 30-day outcome
Episode	Total Part A and Part B spend per CABG episode versus target price	The reconciliation basis for TEAM
Remote care	Enrolled census by program and campus	The revenue base; also the denominator for every other remote care measure
Remote care	Time to first billable enrollment after discharge	Measures whether the pathway is actually connected to the discharge
Remote care	Capture rate — claims billed against clinically eligible patient-months	The difference between a program that runs and a program that is paid
Remote care	Net revenue per enrolled patient per month	The unit economic that makes the service line reportable as a P&L
Operational	Alert-to-clinical-response time	Whether the monitoring layer is producing action or producing noise
Operational	Device return and reissue rate	The logistics measure that quietly determines program cost on a mobile panel
Financial	Service line contribution margin, by campus	The number the finance organization will ask for first

7.2 TEAM readiness checklist

Readiness item	Status to confirm in discovery
CCN-level participation confirmed and communicated internally for all three hospitals	Verified externally against the CMS list; internal awareness not verified
CABG explicitly in scope in internal episode planning	**Open — BMC's public page omits CABG from its listed procedures**
Baseline episode spend analysis against the PY1 regional target prices	Not verifiable externally
Two-business-day post-discharge contact standardized across all cardiac discharges	Published only for the Brighton heart failure pathway, days 3 and 7
Device-based physiologic monitoring available to the cardiac cohort	**Not present — no cardiology remote monitoring found**

Readiness item	Status to confirm in discovery
24/7 alert and triage coverage with a defined cardiology escalation path	Not published for the cardiac cohort
Post-acute network steering and skilled nursing utilization visibility	Not verifiable externally
One cardiovascular registry across all three campuses in Epic	Newly possible since the November 2025 consolidation; existence not verified
Hospital-wide readmission measure tracked as a TEAM quality input, not just an HRRP input	Both community hospitals currently flagged Worse Than National

7.3 Clinical governance: what makes it safe

- **Physician ownership.** Every enrolled patient has a named accountable cardiologist. The monitoring layer escalates to that clinician's team, not to a generic queue.
- **Written escalation protocol per cohort.** Heart failure weight and symptom thresholds, post-surgical vitals thresholds, hypertension thresholds — each with a defined action, a defined responder and a defined time to response, approved by the service line before go-live.
- **Documented clinical time, not implied time.** The management-time codes require documented, discrete clinical work. The documentation standard is a compliance control, not an administrative preference.
- **Alert-load discipline.** Thresholds are tuned to produce actionable alerts. A program that generates alerts clinicians learn to ignore is worse than no program, and the alert-to-response measure on the scorecard exists to catch that early.
- **Equity monitoring built in from day one.** Enrollment, engagement and outcome reported by race, ethnicity, language and insurance type from the first month. BMC already publishes this discipline for its obstetric monitoring program; the cardiac program should inherit it rather than reinvent it.
- **A single care plan of record.** One plan in Epic, visible to cardiology, the monitoring team and the patient's primary care practice, with an explicit attribution policy for patients followed by more than one service.

8. Value Analysis: Illustrative Service Line Economics

This section presents a computed forecast for a remote care service line operated on the cardiovascular population across the three BMC hospitals. It is built at Massachusetts Medicare Physician Fee Schedule locality rates — MAC locality 14212-01, resolved from ZIP 02118 — with CoachCare pricing held at list. ***Every figure in this section is illustrative and modeled, and must be verified against BMC's own service line data before it is used for any purpose.***

8.1 How the population was sized

Step	Basis	Figure
Circulatory inpatient volume, Medicare fee-for-service	CMS Medicare Inpatient Hospitals — by Provider and Service, data year 2024, across CCNs 220031, 220036 and 220111: 1,602 MDC 5 circulatory discharges plus 11 extracorporeal membrane oxygenation cases.	**1,613**
Clinically eligible subset	The portion of that volume in cohorts appropriate for a longitudinal remote care pathway — heart failure, acute coronary and post-procedural cardiac populations.	**1,316**
Total Medicare population, fee-for-service plus Medicare Advantage	Medicare fee-for-service claims exclude Medicare Advantage entirely. The catchment Medicare Advantage penetration is 37.05 percent, weighted across Suffolk County (42.3 percent) and Plymouth County (32.0 percent) by BMC discharge volume, from the CMS Medicare Monthly Enrollment file for April 2026.	**~2,562**
Year-one in-scope population	The cardiovascular population the service line draws from in the first twelve months.	**2,091**
Referring providers assumed	Cardiologists and advanced practice providers across the three campuses. BMC does not publish a cardiology headcount; this is an estimate, not a count.	**55**

Two figures that are estimates, and are labeled as such

The in-scope population is a discovery-stage estimate, and a floor. It is built from CMS fee-for-service claims plus Medicare Advantage at the local penetration rate. CMS suppresses provider-DRG cells below 11 discharges, so the underlying claims counts are themselves floors, and the 2024 file predates full integration of the two acquired hospitals. This number must be validated against BMC's own chart counts in discovery, and the model re-run on the validated figure. It is the single most important open item in this report.

The 55 referring providers is an estimate, not a finding. BMC publishes no cardiologist or advanced-practice headcount. The forecast is largely insensitive to it because the model is limited by program ceilings rather than by referral pace: at 25 providers the 24-month margin falls by 6.3 percent, and at 90 it rises by 3.1 percent. The number should still be replaced with the service line's actual count.

8.2 Financial summary

Measure	Year 1	Year 2	24 months
Net reimbursement	$1,203,050	$1,481,795	**$2,684,844**
CoachCare fees	$708,404	$856,098	**$1,564,502**
Service line margin	$494,645	$625,697	**$1,120,342**
Margin %	41.1%	42.2%	**41.7%**

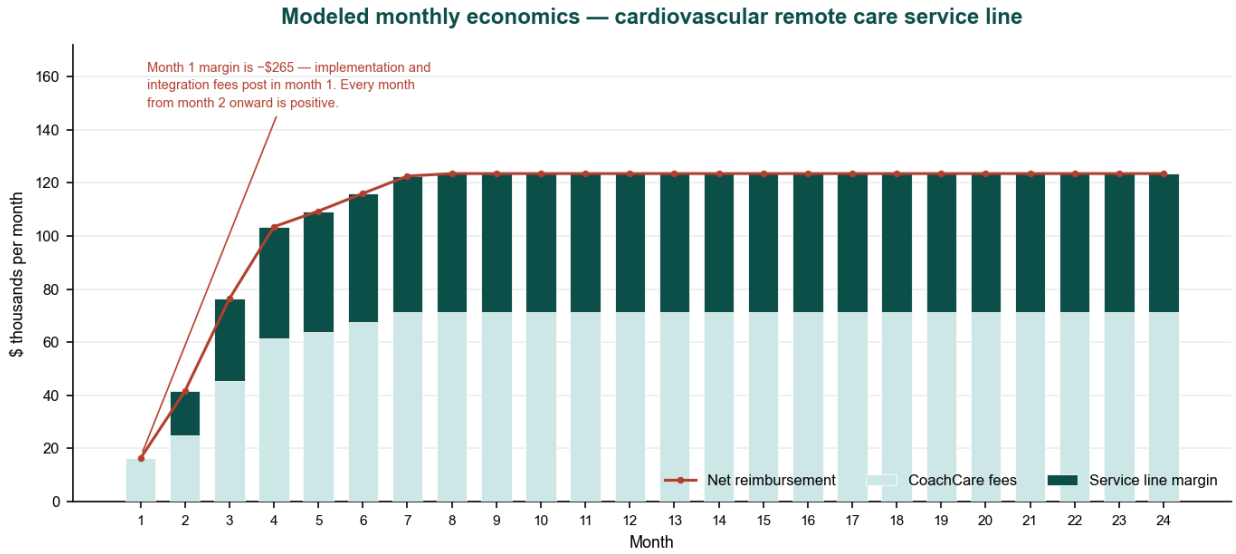

Figure 3. *Modeled monthly economics over 24 months. The stacked bars sum to net reimbursement; the dark segment is service line margin. Month one nets negative $265 because implementation and integration fees post in that month; every month from month two forward is positive. The monthly contribution flattens at approximately $123,000 in net reimbursement from month eight. Illustrative, modeled — verify against practice data.*

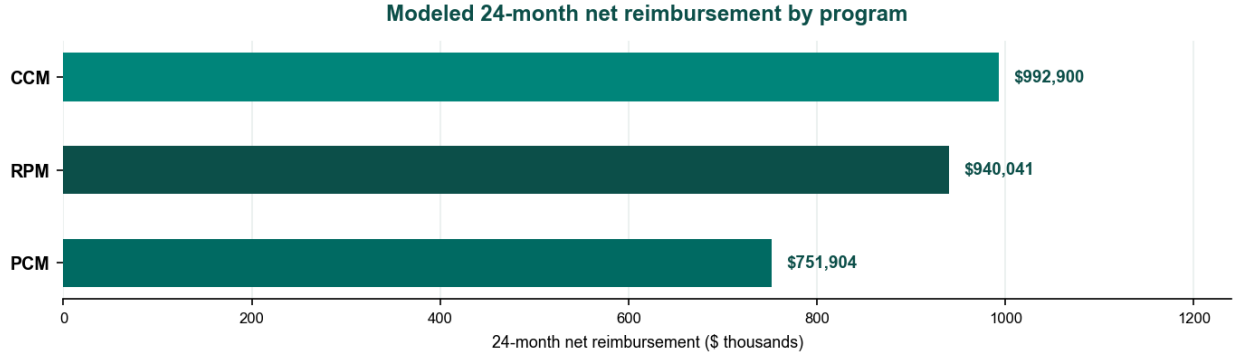

Figure 4. *Modeled 24-month net reimbursement by program: CCM $992,900, RPM $940,041, PCM $751,904. RPM covers 99453, 99445, 99454, 99470, 99457 and 99458; CCM covers 99490 and 99439; PCM covers 99426 and 99427. Transitional care management is billed per discharge rather than on a monthly census and is not included in these figures. Illustrative, modeled — verify against practice data.*

The enrollment specialist is CoachCare's expense

A CoachCare-funded on-site enrollment specialist is included in the model at CoachCare's cost. It is embedded value in the program — **not a cost deducted from the service line's margin, and not a headcount BMC funds.** That matters twice over here: it is why the program does not require capital at a system with constrained capital access, and it is why the program can be stood up without adding work to an existing nursing establishment.

8.3 Enrollment, clinical and operational outcomes

Measure at month 24	Modeled value	What it means
Active program enrollments	**1,109**	RPM 377, CCM 366, PCM 366. A patient may carry more than one program.
Unique patients in active remote care	**732**	Deduped across programs on the model's dual-enrollment assumption. This is the patient count; 1,109 is the service count.
Hospitalizations avoided (24 months)	**56**	Modeled from RPM patient-months at a published-literature rate. A modeled outcome, not a guarantee — and the figure that moves both the TEAM episode and the excess-days measure.
Physiologic readings captured	**88,687**	Landing in Epic as discrete vitals over 24 months — trendable and reportable, not attachments.
Billable claims and units generated	**43,971**	Generated automatically rather than assembled per patient per month by staff.
Care team hours returned	**22,211**	Approximately 10.7 full-time equivalents of clinical and administrative time over 24 months.

8.4 Ceiling-limited, not pace-limited

This forecast behaves differently from most, and the difference is worth stating plainly rather than leaving in the chart. The cardiovascular cohort is concentrated — a defined, identifiable set of patients rather than a broad panel — so enrollment does not ramp gradually toward a distant ceiling. It hits the ceiling and stops.

Program	Ceiling	Month the ceiling binds	Behavior after that
Remote patient monitoring	376.5	**Month 4**	Flat for the remaining 20 months
Chronic care management	366	**Month 5**	Flat for the remaining 19 months
Principal care management	366	**Month 8**	Flat for the remaining 16 months

What that actually means, said honestly

The revenue line in Figure 3 flattens in month eight and never rises again. That is not a modeling artifact and it is not conservatism — it is what a concentrated specialty cohort does. The service line reaches its full run rate inside the first year and then holds it.

The correct response is not to inflate this service line. It is to recognize that the engine reaches full utilization with capacity left over, and that the marginal cost of pointing it at the next cohort — pulmonology, nephrology, or the employed ambulatory network — is a fraction of the cost of the first build. The enrollment engine, the device chain, the triage layer, the Epic integration and the billing engine are already paid for by month eight. That is the enterprise argument, and it is the reason a health system gets more out of this than a single practice does.

8.5 Assumptions and what must be validated

- **Reimbursement.** Calculated at Massachusetts MAC locality 14212-01 rates for each CY2026 code in the stack. Rates are locality-specific, subject to annual rulemaking, and should be confirmed for each billing site in contracting.
- **Programs modeled.** Remote patient monitoring, chronic care management and principal care management only. Transitional care management is part of the clinical pathway described in Sections 3 and 6 but is billed per discharge rather than on a monthly census, and no TCM revenue is included in any figure in this section.
- **Enrollment.** Modeled through three pathways — provider referral, the on-site enrollment specialist, and telephonic outreach — each with its own ramp and program mix, against per-program eligibility and conversion ceilings. Remote monitoring conversion is modeled at 30 percent and care management at 25 percent of the in-scope population.
- **Census.** Carries a 1.5 percent monthly attrition assumption. Programs cap at eligibility multiplied by conversion against the in-scope population, which is why the census saturates in months four to eight.
- **Hospitalizations avoided.** Modeled from RPM patient-months at a published-literature-based rate. These are modeled outcomes, not guarantees, and they are not booked as revenue anywhere in the financial summary.
- **Unique patients.** Deduped across programs using a 70 percent dual-enrollment assumption. Figure 3 and the enrollment figures show active program enrollments, which is the larger number.
- **Not modeled.** No TEAM reconciliation upside, no shared-savings contribution, no readmission penalty avoidance, no length-of-stay reduction, no procedural volume growth and no MassHealth revenue appears anywhere in these figures. The margin stands on Medicare professional-fee revenue alone.

Illustrative, modeled — verify against practice data. Every financial and operational figure in Section 8 depends on population size, enrollment conversion, clinical eligibility and locality reimbursement. None of it is a quote, a commitment, or a guarantee of outcome.

9. Implementation Playbook

9.1 Scope and target populations

Scope small, prove it, then extend. BMC has spent nearly two years absorbing two hospitals, converting an electronic medical record and rebuilding referral networks. A proposal that asks for a three-campus simultaneous launch competes against a full transformation portfolio and loses. A proposal that asks for one campus and one condition can be running inside a quarter.

Phase	Population	Campus	Why this order
Phase 1 — months 1–3	Heart failure discharges, Medicare fee-for-service	BMC – South	Highest Medicare mix in the system at 47.9 percent; Plymouth County Medicare Advantage penetration is 32.0 percent, so the population is predominantly fee-for-service; 698 heart failure discharges a year and 25.1 percent regional share; excess readmission ratio 1.1191; no incumbent remote monitoring to displace.
Phase 2 — months 4–6	CABG and acute myocardial infarction discharges	BMC – Brighton	Where the TEAM CABG episode sits and where the readmission exposure is widest — AMI excess readmission ratio 1.2639, +56.7 excess days per 100 discharges.
Phase 3 — months 7–12	Advanced heart failure, device clinic and hypertension cohorts	Boston Medical Center	The academic campus already performs best on readmissions; here the program adds longitudinal management depth, supports the Comprehensive Hypertension Center, and builds the registry that a heart-failure quality designation would require.
Phase 4 — month 12 onward	Post-structural-heart and post-PCI recovery; then the next service line	System-wide	By month eight the cardiovascular census has saturated and the engine has spare capacity. Extending it costs a fraction of the first build.

9.2 Staffing and the enrollment engine

Two constraints shape the staffing model, and both are real. The system's capital position means anything requiring investment ahead of return will not clear finance. And Boston Medical Center nurses picketed in July 2026 with understaffing as a stated grievance and no contract in place, which means any proposal that reads as more work for existing nursing staff is politically untenable. **The program must therefore be staffed by the partner or by net-new roles funded from program revenue — and that has to be said first, not last.**

Role	Who provides it	What they do
On-site enrollment specialist	**CoachCare — at CoachCare's cost**	Identifies eligible patients from the discharge list and the clinic schedule, enrolls at the bedside or by phone, issues the device, completes set-up documentation.
Monitoring and triage team	**CoachCare**	24/7 review of transmitted data against agreed thresholds; first-line patient contact; escalation to the BMC cardiology team on protocol.
Health coaches / care managers	**CoachCare**	The recurring monthly clinical contact that produces and documents qualifying management time; adherence support; multilingual by default on this panel.
Accountable cardiologist	BMC	Clinical ownership of each enrolled patient, threshold approval, response to escalations. No net-new clinical FTE required.
Service line dyad — physician and administrative	BMC	Program governance, scorecard ownership, cross-campus standardization. The administrative half of this dyad is not currently published and needs to be named.
Billing and claim generation	**CoachCare**	Automated claim creation from documented service, submitted under BMC's billing identity.

9.3 Technology, data and billing architecture

All three hospitals have run on one Epic instance since November 1, 2025, and Rimidi has already proven the integration path for a third-party remote monitoring application into BMC's Epic workflow. The integration model below is the one CoachCare deploys on Epic accounts, and it is designed so that the program lives inside the Epic environment rather than beside it.

Integration pillar	What it means at BMC
Integrated enrollment	Enrollment flags and trigger ordering sit inside the existing clinical workflow. Enrollment status is visible in Epic in real time, and the CoachCare team enrolls qualified patients on the service line's behalf.
Exchange of health history	Bi-directional at intake, so the monitoring team starts with the chart rather than with a questionnaire.
Integrated discrete vitals	Device readings land in the chart as discrete, trendable vitals — not as PDFs a clinician has to open to read a number.
Compliance documentation	An integrated care summary and audit-ready documentation of the clinical time that supports each billed code, in the record.
Automated claim generation	Claims are created automatically from documented service, which removes the manual per-patient, per-month claim assembly step that quietly caps most care-management programs.

Patients begin receiving care management and remote monitoring services within five days of being flagged, and CoachCare is the only care-management application integrated with Epic that provides automated claims creation. “Key to achieving a program that is efficient, effective and sustainable is creating a seamless, intuitive user experience for the patient and provider — and that is what our integration with Epic accomplishes.”

Three architecture decisions should be made in the first two weeks, because they are expensive to change later: whether devices are issued at the bedside before discharge or shipped (bedside is materially better for engagement on this panel, and for MassHealth compliance later, since 99454 requires the device to come from the provider); which cardiology cohorts get a standing enrollment flag rather than a per-patient decision; and who owns the care plan of record in Epic for patients followed by both cardiology and a primary care practice.

9.4 Clinical workflow

1. **Identify.** Standing cohort logic on the Epic instance flags eligible cardiac discharges and clinic patients across all three campuses — the registry work that only became possible in November 2025.
2. **Enroll.** The on-site specialist enrolls at the bedside before discharge wherever possible, in the patient's own language, and issues the device kit with set-up completed and documented.
3. **Transition.** Interactive contact within two business days; medication reconciliation; face-to-face visit scheduled inside 7 or 14 days by complexity.
4. **Monitor.** Daily physiologic transmission into Epic as discrete vitals. Thresholds tuned per cohort. Alerts triaged 24/7 against the written protocol.
5. **Manage.** Recurring monthly clinical contact producing documented management time; titration support against guideline-directed therapy; adherence and social-need escalation, including to BMC's own food pantry and teaching kitchen where the cohort qualifies.
6. **Escalate.** Defined path from monitoring team to cardiology team, with response time measured on the scorecard.
7. **Bill and report.** Automated claim generation from documented service; monthly scorecard by campus.

9.5 KPI dashboard

The balanced scorecard in Section 7.1 defines what is measured. What follows is the narrower set of targets that should be fixed at go-live, because each one is a leading indicator that moves before any clinical measure does.

Indicator	Target to set at go-live
Time from discharge to first clinical contact	Within two business days, on every cardiac discharge — the single strongest operational predictor of the 30-day outcome
Time to first billable enrollment after discharge	Days, not weeks. The earliest reliable signal of whether the pathway is genuinely connected to the discharge
Device transmission adherence, 16 of 30 days	Benchmark against BMC's own published 98.7 percent engagement result rather than against an industry average
Alert-to-clinical-response time	Set per cohort inside the written escalation protocol before go-live
Capture rate — claims billed against eligible patient-months	The difference between a program that runs and a program that is paid
Enrollment and engagement by race, ethnicity, language and insurance type	No disparity in engagement — the standard BMC has already published for its obstetric monitoring program

9.6 Twelve-month roadmap

Window	Milestones
Weeks 1–4	Name the service line dyad, including the administrative lead. Confirm CCN-level TEAM scope internally, including the CABG question. Agree cohort definitions and escalation protocols. Pull BMC's own IPPS impact file for the actual HRRP payment adjustment. Validate the in-scope population against BMC chart counts and re-run the model.
Weeks 5–8	Epic integration build and validation. Enrollment flag logic for the Phase 1 cohort. Device logistics and multilingual patient materials. Billing and documentation standards signed off by compliance.
Weeks 9–12	Go live at BMC–South on the heart failure discharge cohort. First enrollments, first transmissions, first claims. Weekly operating review.
Months 4–6	Extend to BMC–Brighton across CABG and AMI discharges, wrapping the TEAM episode. First full scorecard by campus. First readmission and excess-days baseline comparison.
Months 7–9	Extend to the main campus across advanced heart failure, device clinic and hypertension cohorts. Census approaches its ceiling across all three programs. Review MassHealth expansion on verified coverage.
Months 10–12	Full three-campus operation at steady state. Twelve-month outcome review against the scorecard. Scope the next service line onto the same engine and decide whether a heart-failure quality designation is now in reach.

Who does the work

CoachCare operates remote care programs covering more than 400 managed conditions for over 500,000 patients, with 10,000-plus providers, 1,000-plus implementations, more than 5 million claims generated and over 100 million vitals recorded.

The relevant point for BMC is not the scale but the shape: the enrollment, monitoring, triage, documentation and billing work is done by the partner, the clinical accountability stays with BMC's cardiologists, and the program is funded from the revenue it generates rather than from BMC capital or BMC headcount.

References and Data Sources

All CMS source files were retrieved on July 29, 2026. Where a figure could not be verified against a primary or reliable secondary source it is flagged in the text and repeated below.

CMS model participation and payment

- CMS TEAM Participant List (XLSX), rendition published June 2026, hospital data as of April 15, 2026 — cms.gov/team-model-participant-list. CCNs 220031, 220036 and 220111 each verified individually as Mandatory participants, 01/01/2026–12/31/2030, CBSA 14460 Boston-Cambridge-Newton, MA-NH. CMS updates this list quarterly.
- FY2025 IPPS/LTCH PPS final rule — TEAM model parameters: five-year term, mandatory participation by CCN in selected CBSAs, five episode categories including coronary artery bypass graft, episode window from admission through 30 days post-discharge reconciled on total Medicare Part A and Part B spend.
- CMS TEAM PY1 Preliminary Target Prices workbook, dated December 10, 2025 — New England (Census Division 1) MS-DRG-level CABG target prices at a 1.5 percent discount factor, baseline 2022–2024, standardized dollars. Regional, not hospital-specific, and preliminary.
- CMS TEAM PY1 quality specification — composite quality score built from the hospital-wide all-cause readmission measure (claims-only in PY1), CMS PSI 90 and the hip and knee patient-reported outcome measure.
- CMS Provider Data Catalog, Hospital General Information dataset (xubh-q36u), modified April 28, 2026, released May 13, 2026 — CCN verification, hospital type, ownership coding and overall star ratings. Note that CCN 220111 is still carried under its pre-acquisition name in this file.
- CMS Medicare Shared Savings Program Accountable Care Organization Participants PUF (file modified February 4, 2026) and Performance Year Financial and Quality Results PUF (revised file dated July 17, 2026) — BMC Integrated Care Services, Inc., ACO ID A2666, ENHANCED track, 9,505 assigned beneficiaries, 52.52 percent dual eligible, PY2024 gross savings 2.26 percent against a 2.00 percent minimum savings rate.

Volumes, quality and readmissions

- CMS Medicare Inpatient Hospitals — by Provider and Service, data year 2024 (dataset 690ddc6c-2767-4618-b277-420ffb2bf27c), queried by CCN 220031, 220036 and 220111. Medicare fee-for-service only; CMS suppresses provider-DRG cells below 11 discharges, so all figures are floors.
- CMS Hospital Readmissions Reduction Program dataset (9n3s-kdb3), FY2026 file modified January 26, 2026, released May 13, 2026 — performance period July 1, 2021 to June 30, 2024. Excess readmission ratios for all six condition cohorts at all three CCNs.
- CMS Care Compare — Unplanned Hospital Visits (632h-zaca) for 30-day readmission rates, hybrid hospital-wide readmission and excess days in acute care; Complications and Deaths (ynj2-r877) for 30-day mortality and PSI measures. Both released May 13, 2026; READM and EDAC measurement period July 1, 2021 to June 30, 2024, hybrid measures July 1, 2023 to June 30, 2024.
- Massachusetts Center for Health Information and Analysis, FY2024 Hospital Profiles and Hospital Profiles Databook, published January 2026 — all-payer discharge volumes by DRG and regional share, payer mix, occupancy, average length of stay, case mix index and staffed beds. CHIA notes that only eight or nine months of HFY2024 data was submitted for the former Steward hospitals.
- CMS Medicare Monthly Enrollment Public Use File, April 2026 — county-level Medicare beneficiary, Medicare Advantage and dual-eligible counts for Suffolk and Plymouth counties. Used in place of the MA State/County Penetration file, which could not be retrieved; the two definitions differ by approximately one percentage point.
- The Leapfrog Group Hospital Safety Grade, Spring 2026 release — verified per hospital against CMS-registered addresses and, for CCN 220111, against the CCN-keyed URL.
- U.S. News & World Report Best Hospitals 2025–26 and BMC's own published recognitions.

Boston Medical Center published sources

- BMC Cardiovascular Center program pages and specialty clinic contact listing; BMC–Brighton cardiovascular medicine, interventional and structural heart, advanced heart failure and Center for Advanced Cardiac Surgery pages; BMC–South cardiology and vascular medicine pages; BMC executive leadership and clinical directory pages.
- BMC Health System Provider Reference Guide: Epic Transition — November 1, 2025 go-live for BMC–Brighton and BMC–South, legacy Athena and Meditech read-only from November 8, 2025, Meditech view-only access ending December 31, 2025 and Athena March 31, 2026.

- Rimidi and BMC published program metrics for remote blood pressure monitoring in postpartum hypertension (announced August 2022): 505 unique patients and 8,922 readings over a six-month window, 98.7 percent of 1,000 monitored patients submitting at least one measurement, and statistically similar engagement across racial and ethnic groups. Program since extended to gestational hypertension, gestational diabetes and a hepatology NAFLD cohort.
- BMC Hospital at Home program materials (launched April 3, 2024), including the 245 qualifying diagnoses and the inclusion of congestive heart failure; BMC Complex Care Management, BMC Telehealth, Preventive Food Pantry and Health Equity Accelerator program pages.
- BMC accountable care organizations page, which lists TEAM participation for all three hospitals and lists four covered procedure categories without naming coronary artery bypass graft.
- MassHealth Transmittal Letter PHY-170 (July 2024), Physician Manual Subchapter 6 — remote patient monitoring payable from August 1, 2024 for CPT 99091, 99453, 99454, 99457 and 99458; qualifying conditions include congestive heart failure and hypertension; device must be supplied by the provider; billing must be done by the MassHealth-enrolled provider even where a vendor manages the devices.
- Consolidated Appropriations Act, 2026 (signed February 3, 2026), Section 6210 — extension of the Acute Hospital Care at Home waiver through September 30, 2030.

What is not verified, and must be treated as such

- BMC's HRRP payment reduction percentage for any of the three CCNs. The figure is not present in the CMS Provider Data Catalog readmissions dataset and the IPPS final rule tables could not be retrieved programmatically. It cannot be derived from the published excess readmission ratios. No estimate appears anywhere in this report.
- The number of cardiologists and cardiology advanced practice providers employed across the three campuses. BMC publishes no headcount; the Value Analysis uses 55 referring providers as an estimate, with the sensitivity stated in Section 8.1.
- The cardiovascular service line's administrative director or dyad partner. No such role is published anywhere across BMC's sites, and it is typically the economic buyer for a program of this shape.
- BMC Health System's Chief Medical Information Officer. No one is publicly named; the Chief Digital Information Officer is the senior digital executive. A related job posting surfaced in search results, which may indicate the role is open or newly created.
- Whether BMC is actively managing CABG episodes under TEAM. BMC's public accountable care page omits CABG from its listed procedures; whether that reflects internal scope is not externally verifiable.
- Whether any cardiology remote monitoring, chronic care management or transitional care management program exists at BMC today. Our review found none across published program pages, specialty clinic listings and press releases; absence of public evidence is not proof of absence, and this is a discovery question rather than an assertion.
- Whether BMC's Hospital at Home program was suspended or curtailed during the waiver lapse between September 30 and November 2025, its current census, and whether it operates at all three campuses. No assumption has been made.
- The remote monitoring platform behind BMC's cardiac device clinic. No cardiac implantable electronic device monitoring vendor is published.
- Whether MassHealth separately reimburses chronic care management or transitional care management as distinct benefits. Transmittal Letter PHY-170 addresses remote patient monitoring only. This must be closed before any Medicaid-side care management revenue is modeled — and no such revenue appears in this report.
- The award year for BMC–Brighton's American Heart Association heart failure quality award and the rating period for its Society of Thoracic Surgeons three-star rating. Both are published without dates.
- Whether the main campus performs transcatheter aortic valve replacement, and whether the system performs left ventricular assist device implantation or heart transplantation. BMC's published pages describe the procedures without locating them, and the discharge data is consistent with concentration at Brighton but is not proof.
- Current CY2026 Medicare Physician Fee Schedule amounts for each billing site, which must be confirmed in contracting.

Global caveat. All financial projections in this report are illustrative and modeled. They depend on population size, enrollment conversion, clinical eligibility and locality reimbursement, and must be validated against BMC's own data before any commitment. Modeled clinical outcomes, including hospitalizations avoided, are projections and not guarantees. CMS model participation statements reflect CMS files retrieved on July 29, 2026; the TEAM participant list is updated quarterly, and the readmission, mortality and star rating datasets refresh annually. Medicare Physician Fee Schedule amounts are locality-specific and subject to annual rulemaking. This document is confidential, prepared solely for Boston Medical Center Health System, and is not for distribution.