MASS GENERAL BRIGHAM

Cardiothoracic Surgery Service Line · 2026 Strategy Review

Cardiothoracic Surgery 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 surgery discharge.

Purpose of this report

Mass General Brigham entered a mandatory, five-year CMS episode model on January 1, 2026, and coronary artery bypass graft is one of five episode categories. This report examines the cardiothoracic surgery service line at Massachusetts General Hospital and Brigham and Women's Hospital against that change, and sets out how a managed remote care service line operates the 30-day post-discharge window — 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 the Heart and Vascular Institute, the Division of Cardiac Surgery, and system finance and value-based care leadership.

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July 2026 · All CMS source files retrieved July 29, 2026

Confidential — prepared solely for Mass General Brigham. Not for distribution. All financial figures in this report are illustrative and modeled, and must be validated against Mass General Brigham's own service line data before any commitment.

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Executive Summary

Mass General Brigham is the largest health system in Massachusetts, and it runs a system-level Heart and Vascular Institute that unified cardiac surgery, vascular surgery and cardiology under one structure. Adult cardiac surgery is consolidated further still: a single chief, Thoralf M. Sundt III, MD, leads the Division of Cardiac Surgery across both academic medical centers, with Patrick T. Ellinor, MD, PhD as executive director of the institute, Christine M. Albert, MD, MPH as chief of the Division of Cardiology and Yolonda L. Colson, MD, PhD as chief of thoracic surgery. There is no separate site-level cardiac surgery chief to negotiate with. **Decision rights for this service line are system-level, and one conversation covers both campuses.**

On January 1, 2026 six Mass General Brigham hospitals became mandatory participants in the CMS Transforming Episode Accountability Model. Coronary artery bypass graft is one of the model's five episode categories, and among those six hospitals only Massachusetts General and Brigham and Women's perform CABG. The model runs to December 31, 2030, holds the hospital accountable for all Medicare Part A and Part B spend from admission through 30 days after discharge, and Mass General Brigham enters it with no prior bundled-payment operating experience of any kind — no BPCI-Advanced in any model year, no CJR. There is no legacy episode-management workflow to unwind. The operating layer gets designed once.

The central argument

A managed remote care service line — TCM at the cardiac surgery 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, margin-positive 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, supports two Enhanced-track ACOs, serves the 2027 Ambulatory Specialty Model heart failure cohort, and relieves a capacity constraint Mass General Brigham has itself quantified in public. Build once, reuse everywhere.

The wedge is not a readmission deficit

This report does not argue that Mass General Brigham has a CABG readmission problem, because the CMS data says it does not. On the FY2026 Hospital Readmissions Reduction Program file, Massachusetts General's CABG excess readmission ratio is **0.7860** and Brigham and Women's is **0.9535** — both below the peer-group median of 1.0091, and neither hospital is penalized on the CABG measure. On CMS Care Compare, Massachusetts General is rated **Better Than the National Rate** on both 30-day CABG readmission (8.3) and 30-day CABG mortality (1.0). **That is a position of strength to protect, not a deficit to fix.**

The argument is different, and it is structural. TEAM does not reconcile against the readmission rate. It reconciles against **all Medicare Part A and Part B spend inside the 30-day window**, so the remaining variance sits where a readmission measure never looks: emergency department presentations that do not convert to admission, observation stays, and unplanned post-acute utilization. Mass General Brigham's own data shows exactly that pattern in an adjacent cohort — Massachusetts General's 30-day excess days in acute care for heart failure is 10.4, rated **More Days Than Average**, while its heart failure readmission rate is better than national. Excess days worse and readmission rate better is the signature of emergency department and observation burden rather than admissions. It is also worth noting that TEAM's Composite Quality Score uses the **Hospital-Wide** All-Cause Readmission measure, not the CABG-specific one, so strong CABG performance does not by itself carry the quality score.

This is a build-versus-partner decision, not a first purchase

Mass General Brigham is not a greenfield remote-monitoring buyer, and this report does not pretend otherwise. Through the Accelerator for Clinical Transformation and the Remote Health team the system has managed 10,000 or more patients in remote programs — a figure published in April 2023; current enrollment is not publicly verifiable — concentrated in hypertension and cholesterol management, plus a navigator- and pharmacist-led program for roughly 1,000 patients with heart failure with reduced ejection fraction, on cellular and Bluetooth cuffs that transmit without requiring a smartphone. That is a well-built chronic-disease layer and a genuinely thoughtful access decision. Home Hospital lists recovery after heart surgery among its supported conditions — while the patient is still classified as an inpatient under the CMS waiver. A 2025 collaboration delivers intensive cardiac rehabilitation virtually and in person, and explicitly does not cover remote monitoring, post-surgical or CABG populations.

What our review did not find is an outpatient, post-discharge remote monitoring program for cardiac surgery patients operating as a billable service line; a structured hospital-to-home cardiac surgery pathway that begins once the inpatient waiver classification ends; or a TCM or RPM billing program attached to the cardiac surgery discharge. That is the wedge — a specific, narrow gap at one handoff, in a system that has already proven it can run everything on either side of it.

The institution has already published the clinical case

A prospective study led from Brigham and Women's, reported in August 2025, fitted more than 100 patients recovering from open-heart surgery with a wearable ECG patch at discharge. **Twenty-seven percent had atrial fibrillation detected after they went home, and nearly a quarter of those patients had no documented arrhythmia at any point during the hospital stay.** Most episodes were brief enough that routine follow-up would not have caught them. The work remains a research study; it has not been operationalized into a standing clinical program. The evidence base and the service line sit inside the same institution and are not yet connected.

The CY2026 billing tailwind

Two CY2026 remote physiologic monitoring codes make this pathway newly practical. **99445** prices device supply and data transmission over a 2-to-15-day window rather than requiring 16 days, and **99470** prices a first 10 minutes of treatment-management time rather than requiring 20. Together they make the first two weeks after a surgical discharge billable in their own right — which is precisely the window in which readmission risk concentrates and precisely the window TEAM measures. Before CY2026, a short post-surgical monitoring episode was clinically sensible and financially awkward. It is no longer awkward.

What the service line is worth

Modeled on the cardiothoracic surgical and heart failure populations at Massachusetts General and Brigham and Women's, at Massachusetts Medicare Physician Fee Schedule locality rates, the service line produces **$3,687,766** in 24-month net reimbursement against **$2,146,243** in CoachCare fees, for **$1,541,523** in service line margin — a 41.8 percent margin, with no negative-margin month, because CoachCare funds the enrollment engine. Section 9 sets out the full model, its assumptions and its limits. ***Every figure is illustrative and modeled, and must be verified against service line data.***

2026–2027 priority recommendations

1. **Stand up a cardiothoracic post-discharge remote care pathway at both campuses, scoped first to the TEAM 30-day window.** One pathway, one escalation engine, one set of thresholds, applied to CABG, valve and other major cardiothoracic discharges at Massachusetts General and Brigham and Women's.
2. **Validate the population against your own chart counts before anything is committed.** Our year-one in-scope estimate of 3,052 patients is built from CMS fee-for-service claims and a Medicare Advantage gross-up. It is a discovery-stage estimate, not a finding.

3. **Instrument the 30-day window for total episode cost, not for readmissions.** Emergency department presentations, observation stays and post-acute utilization are where the variance lives, and none of them appear in the readmission measure you already win on.
4. **Bill the transition you are already partly performing.** TCM at the cardiac surgery discharge, short-window RPM through days 0–14 using 99445 and 99470, then longitudinal monitoring for the patients who convert to chronic cardiac management.
5. **Build it inside Epic, once.** Enrollment flags in the existing workflow, device readings landing as discrete vitals rather than PDFs, audit-ready documentation in the record, and automated claim generation — so the service line does not become a second system for the clinical teams to learn.
6. **Design the heart failure extension at the same time, not later.** The same infrastructure serves the surgical episode, the heart failure cohort behind it, and — from January 1, 2027 — the three Mass General Brigham-affiliated cardiologists who appear on the CMS preliminary Ambulatory Specialty Model list in western Massachusetts.
7. **Put the CMS list re-verification on a standing cadence.** CMS updates the TEAM participant list quarterly, and the CY2027 ASM participant list is still preliminary. Both should be re-checked — TEAM by CCN, ASM by NPI — before any figure in this report is used in a board or budget document.

1. Footprint and Operating Model

1.1 The institute, and where the decision actually sits

Mass General Brigham created the Heart and Vascular Institute as a system-level entity, one of three disease-focused institutes — Cancer, Heart and Vascular, and Neuroscience — that are the vehicle for unifying the two academic medical centers. Patrick T. Ellinor, MD, PhD was named its inaugural executive director, charged with unifying the divisions of cardiac surgery, vascular surgery and cardiology. Christine M. Albert, MD, MPH was named inaugural chief of the Division of Cardiology. The institute's stated priorities include implementing digital health solutions.

For a cardiothoracic conversation the structural fact that matters most is the single divisional chief. Thoralf M. Sundt III, MD is listed as Chief, Division of Cardiac Surgery, Mass General Brigham — one chief across both academic medical centers — and Yolonda L. Colson, MD, PhD is chief of thoracic surgery system-wide. Capital follows the same logic: the Ragon Building at Massachusetts General will house the cardiovascular institute in a tower anchored by a $100 million New Balance Foundation gift, with phased completion beginning in 2027.

A note on Mass General Brigham's self-reported volumes

The Heart and Vascular Institute page reports more than 25,000 heart and vascular procedures and more than 5,000 minimally invasive and open-heart surgeries annually, while the system's cardiac surgery page reports more than 3,000 cardiac procedures. Both figures are undated, both are authored by Mass General Brigham, and they are not reconciled. **Neither is used as a basis for anything in this report.** All volumes used here come from CMS claims files, cited in Section 1.3.

1.2 Where cardiac surgery is actually performed

Six Mass General Brigham hospitals are TEAM participants. Only two of them perform adult cardiac surgery. Cross-referencing the CMS TEAM participant list against CMS Care Compare's CABG measures — a reported CABG measure means the hospital performs CABG at reportable Medicare volume — confirms that Massachusetts General and Brigham and Women's are the system's CABG sites. The other four participants are accountable for lower-extremity joint replacement, major bowel, surgical hip/femur fracture and spinal fusion episodes, and generate no CABG episodes at all.

Hospital	CCN	TEAM status	Performs CABG	Episode exposure
Massachusetts General Hospital	220071	Mandatory	**Yes**	CABG + other TEAM episodes
Brigham and Women's Hospital	220110	Mandatory	**Yes**	CABG + other TEAM episodes
Brigham and Women's Faulkner Hospital	220119	Mandatory	No	Non-CABG episodes only
Newton-Wellesley Hospital	220101	Mandatory	No	Non-CABG episodes only
Salem Hospital (listed by CMS as North Shore Medical Center)	220035	Mandatory	No	Non-CABG episodes only
Wentworth-Douglass Hospital, Dover NH	300018	Mandatory	No	Non-CABG episodes only

The community hospitals in the network perform diagnostic catheterization and, at several sites, percutaneous coronary intervention, and refer surgical patients inward to Boston. Salem Hospital states the arrangement plainly on its own site: cardiac surgery is now performed at Mass General, while all other aspects of a patient's heart care are provided at Salem. **That hub-and-spoke pattern is itself part of the opportunity.** Patients are operated on in Boston and recover at home in communities across Essex, Middlesex, Norfolk and southern New Hampshire — 25 to 100 miles from the operating surgeon. Post-discharge monitoring is the only practical way to keep eyes on that geography.

1.3 The only usable current volume basis

Massachusetts stopped publishing its hospital-level cardiac surgery report card after fiscal year 2014, and no later state report card exists. That leaves CMS claims as the only current, defensible volume source. The table below is drawn from the CMS Medicare Inpatient Hospitals — by Provider and Service file, data year 2024, queried by CCN.

Cohort (MS-DRGs)	Mass General	Brigham and Women's	Combined
CABG — the TEAM episode (231–236)	158	138	**296**
Cardiac valve and other major cardiothoracic (216–221)	336	184	**520**
Other cardiothoracic, incl. ECMO, VAD, transplant (001, 003, 215, 228, 229)	147	202	**349**
Heart failure and shock (291–293)	481	326	**807**
Percutaneous cardiovascular (246–251, 266, 267)	391	275	**666**
Total cardiac / cardiothoracic + heart failure	**1,513**	**1,125**	**2,638**

How to read these numbers

Medicare fee-for-service only. Medicare Advantage discharges do not appear in this file, and Suffolk County runs about 42 percent Medicare Advantage penetration.

Every cell is a floor, not a ceiling. CMS suppresses provider-DRG cells below 11 discharges, so true volumes are higher than shown.

Data year 2024. These are the most recent published figures as of July 29, 2026. All-payer cardiac surgery volumes at Mass General Brigham are not public and should be supplied in discovery.

1.4 Design principles for the service line

Principle	What it means operationally
Longitudinal by default	The relationship does not end at the 30-day mark. A surgical patient who converts to chronic cardiac management stays in the program under a different code, not a different team.
One scorecard across both campuses	A single divisional chief means a single set of metrics. Enrolled census, capture rate and episode cost are reported the same way at Massachusetts General and Brigham and Women's.
Hub-and-spoke aware	Patients are operated on in Boston and recover across four counties and southern New Hampshire. The pathway assumes distance rather than treating it as an exception.
One front door for the discharge	Enrollment is triggered by the cardiac surgery discharge itself, not by a downstream referral that depends on someone remembering to make it.
Digital as care, not as a channel	Readings land in Epic as discrete vitals and drive a defined escalation pathway. A reading nobody acts on is not monitoring.
Build once, reuse everywhere	The same enrollment, device, triage, documentation and billing engine serves the surgical episode, the heart failure cohort and any adjacent service line that follows.

2. Build Versus Partner

Most remote care proposals are written for organizations that have never run remote care. This one is not. Mass General Brigham has an in-house remote monitoring operation of real scale, a documented preference for building inside Epic rather than buying point solutions, and a hospital-at-home program that is among the largest in the country. **The question is not whether Mass General Brigham can run remote care. It demonstrably can. The question is whether the cardiac surgery discharge is covered by what it built.**

2.1 What Mass General Brigham has already built

	What exists	Vintage
Scale	The Accelerator for Clinical Transformation and the Remote Health team have managed 10,000 or more patients in remote programs, using both custom-built and vendor technology.	Published April 2023

	What exists	Vintage
Focus	Hypertension and cholesterol management at scale, plus a navigator- and pharmacist-led disease management program for roughly 1,000 patients with heart failure with reduced ejection fraction.	Program pages, undated
Devices	Cellular and Bluetooth blood pressure cuffs that transmit in real time without requiring a smartphone or app — a deliberate and well-judged access decision.	Program pages
Acute	Home Hospital lists “recovery after heart surgery” among supported conditions — while the patient is still classified as an inpatient under the CMS hospital-at-home waiver.	Current site
Rehab	A 2025 collaboration delivering the Benson-Henry Institute intensive cardiac rehabilitation program virtually and in person.	Announced Sept 2025

Current enrollment in these programs is not publicly verifiable. The most recent published figure is from April 2023. Nothing in this report assumes those programs are smaller, larger or differently scoped than they were then; the current state is a discovery question.

2.2 What the cardiac surgery discharge still needs

Gap	What our review did not find
A billable post-discharge service line	No outpatient, post-discharge remote monitoring program for cardiac surgery patients operating as a billable service line.
A hospital-to-home surgical pathway	No structured cardiac surgery pathway that begins once the inpatient waiver classification ends and the patient becomes an outpatient.
Transition billing	No TCM or RPM billing program attached to the cardiac surgery discharge. The codes that would fund the work are not being billed for this population.
Post-surgical scope in the rehab collaboration	The 2025 intensive cardiac rehabilitation collaboration does not cover remote monitoring, post-surgical or CABG populations.
A surgical-episode design	The existing chronic programs are designed around hypertension, lipids and heart failure — conditions, not a surgical episode with a 30-day clock and a target price attached to it.

This is stated structurally, not critically. Every one of these is the predictable consequence of building a chronic-disease remote care program first — which is the correct order to build in. Chronic programs are enrolled by condition and managed on a monthly cadence. A surgical episode is enrolled by an event, runs on a 30-day clock, and is reconciled against a target price. They are different operating models that happen to share a device.

2.3 The evidence base is already inside the institution

In August 2025 a prospective study led from Brigham and Women's reported results from fitting more than 100 patients recovering from open-heart surgery with a wearable ECG patch at discharge. Twenty-seven percent had atrial fibrillation detected after they went home. Nearly a quarter of those had no documented arrhythmia at any point during their hospital stay, and most episodes were under five minutes — short enough that a routine three-week follow-up visit would never see them.

That work remains classified as a research study. Our review found no evidence it has been operationalized into a standing clinical program, though absence of public evidence is not proof of absence and this should be confirmed in discovery. The point is not that something was missed. The point is that **the clinical case for monitoring this population after discharge was made by Mass General Brigham's own investigators, in Mass General Brigham's own patients**, and the operating layer that would act on it has not been built. The research and the service line sit in the same institution and are not connected to each other.

The build-inside-Epic posture is an argument for this proposal, not against it

Mass General Brigham's demonstrated reflex is to embed capability directly into Epic workflows rather than to buy standalone point solutions, and its digital leadership has described a strategy centered on working with existing platform partners. That posture is the right one. It is also why the integration described in Section 10.3 matters more here than it would anywhere else: enrollment flags inside the existing clinical workflow, readings landing as discrete vitals rather than PDFs, documentation in the record, and claim generation automated. **The requirement is not a portal. It is a workflow that already exists, extended to a population it does not currently cover.**

3. The Remote Care Service Line — The Spine

3.1 One continuous pathway from the discharge outward

The billing stack is not a collection of codes. It is a single continuous pathway that starts the day a cardiac surgery patient leaves the building and does not stop.

Phase	Program	What happens	Codes
Days 0–30	Transitional Care Management	Contact within two business days of discharge, medication reconciliation, and a face-to-face visit within 7 or 14 days depending on complexity. The formal handoff — billable at discharge, in the exact window TEAM measures.	99495 / 99496
Days 0–90	Short-window remote monitoring	Weight, blood pressure and pulse from the first day home. Fluid overload and arrhythmia announce themselves in the data days before they announce themselves in an emergency department. CY2026's short-window codes make a two-week episode billable on its own terms.	99453, 99445, 99454, 99470, 99457, 99458

Phase	Program	What happens	Codes
Month 2 onward	Longitudinal RPM with PCM or CCM	The surgical patient becomes a chronic cardiac patient. Guideline-directed medical therapy titration, heart failure surveillance and comorbidity management continue as a managed process rather than an annual event.	99426 / 99427 (PCM); 99490 / 99439 (CCM); RPM continues

The one coordination rule

Care management codes do not stack with each other; RPM stacks with all of them. A patient carries one care-management wrapper in a given month — TCM through the transition, then PCM for a single dominant cardiac condition or CCM where two or more qualifying chronic conditions are present. Remote physiologic monitoring runs alongside whichever wrapper applies, with discrete time and documentation. Set the attribution policy before go-live: the cardiothoracic service line owns the discharge transition and the monitoring; where a patient is already under another Mass General Brigham care-management program, the shared care plan in Epic is the arbiter, not the billing system. Concurrency handling should be confirmed with billing compliance against the final CY2026 rules.

Why there is no primary-care arm in this proposal

A cardiothoracic surgery service line does not own a longitudinal primary-care panel, so Advanced Primary Care Management is deliberately out of scope here — there is no panel inside a surgical department to bill it against, and proposing one would be an accounting fiction. **TEAM's continuity-of-care expectation is met by connecting patients back to their existing primary care physicians with a shared care plan and structured data exchange**, not by standing up a parallel primary-care billing arm. The remote care service line makes that handoff better documented than it is today; it does not compete with it.

3.2 Standalone value: four layers, before any episode is reconciled

1. **Direct professional-fee revenue.** TCM is billed per discharge; RPM, PCM and CCM are billed per patient per month. Once a census is established the revenue is recurring and subscription-like, and it is generated at top-of-license staffing rather than by adding physician time. Section 9 models **$3,687,766** in 24-month net reimbursement on this basis — illustrative, modeled, and to be verified against service line data.
2. **Avoided cost and episode exposure.** Every emergency department visit, observation stay and readmission avoided inside the 30-day window lands directly against the TEAM target price for that episode. The model prices New England CABG episodes between $38,685 and $88,167 depending on MS-DRG, so a single avoided post-acute cascade is material against a single episode, and the Composite Quality Score adjusts the reconciliation on a readmission measure a post-discharge program directly moves.
3. **Throughput and capacity.** Mass General Brigham has publicly quantified an inpatient capacity constraint that new beds do not relieve until 2027 at the earliest. A monitored discharge is the mechanism by which a post-surgical day can be supported at home rather than held in a bed the system has said it does not have. Section 8 develops this, with its limits stated.
4. **Strategic and model readiness.** TEAM is running now, the Ambulatory Specialty Model begins January 1, 2027, and both Mass General Brigham ACOs sit in the MSSP Enhanced track. The same infrastructure is the readiness asset for all of them — and it defends a CABG quality position that is currently better than national and is easier to protect than to regain.

The CY2026 billing stack

Service / code	Type	CY2026 magnitude	Role in the cardiothoracic pathway
TCM 99495 / 99496	Per discharge	~$200 / ~$280	The post-cardiac-surgery handoff: contact within two business days, reconciliation, and the early follow-up visit inside the TEAM episode window.
RPM 99453	One-time setup	~$20	Device education and setup; requires at least two days of data.
RPM 99454 / 99445	Recurring monthly	~$52	Device supply and transmission. 99454 covers 16–30 days; 99445 is the CY2026 short-window code at 2–15 days — the one that makes a two-week post-surgical episode billable.
RPM 99457 / 99470	Recurring monthly	~$52 / ~$26	Treatment management time. 99457 covers a first 20 minutes; 99470 is the CY2026 first-10-minute code, sized for short post-discharge windows.
RPM 99458	Recurring monthly	~$41	Each additional 20 minutes of treatment management.
PCM 99426 / 99427	Recurring monthly	~$60 + ~$50	Single high-risk condition expected to last at least three months — the dominant cardiac diagnosis where a patient does not carry two qualifying chronic conditions.
CCM 99490 / 99439	Recurring monthly	~$60 + ~$47	Two or more chronic conditions expected to last at least 12 months — near-universal in the post-CABG population, where diabetes, chronic kidney disease and heart failure travel together.

Illustrative rates. The magnitudes above are national non-facility CY2026 order-of-magnitude figures shown for scale only. Actual payment is locality-adjusted and set by the regional MAC. The Value Analysis in Section 9 is computed at Massachusetts Medicare Physician Fee Schedule locality rates and should still be confirmed against the final CY2026 schedule for each billing site. Nothing here is a quote.

Why the revenue behaves like a subscription

A surgical service line's professional-fee revenue is episodic: it arrives when a case is booked and stops when the case is done. A remote care census behaves differently. Once a patient is enrolled and the device is transmitting, each month generates a claim without a new referral, a new authorization or a new appointment slot. Enrollment compounds against attrition, so the revenue line ramps and then holds — as Figure 3 shows, the modeled census reaches steady state around month 11 and the monthly contribution flattens at roughly $180,000 in net reimbursement. The service line's job after that is retention and capture rate, not acquisition.

3.3 Connective tissue: one infrastructure, every lever

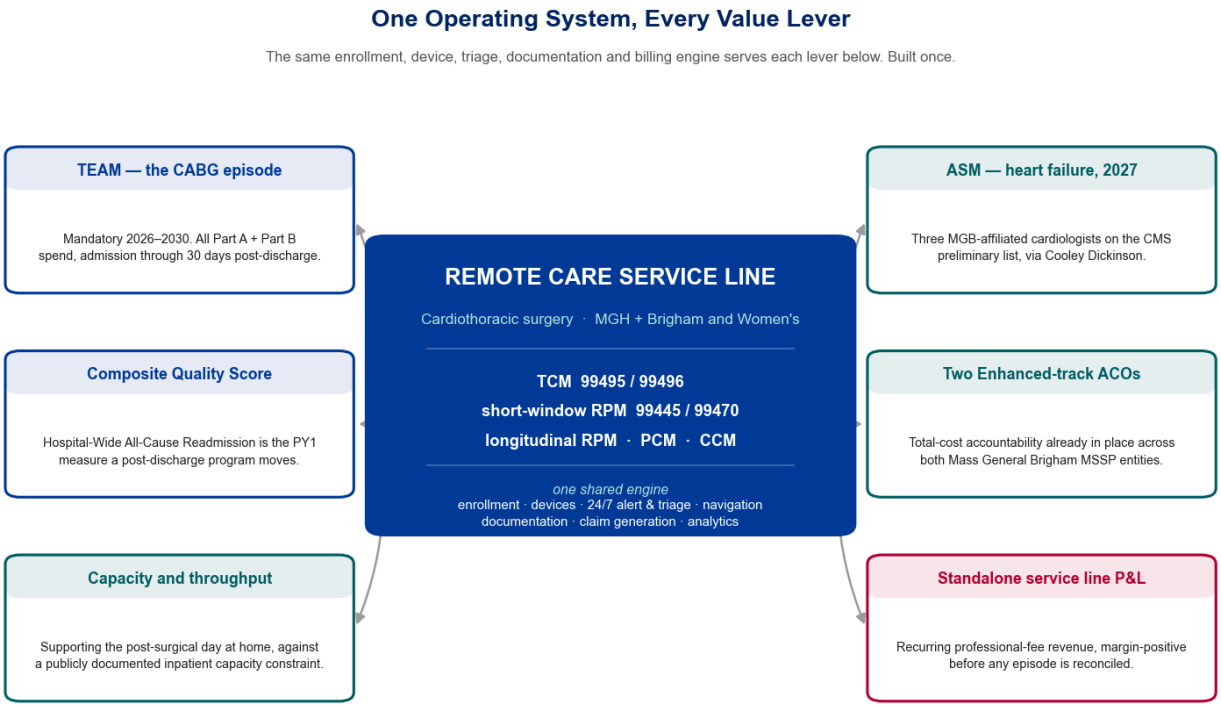

Figure 1. *One operating system, every value lever. The same enrollment, device, alert-and-triage, navigation, documentation and claim-generation engine serves each lever. Each spoke is individually verified in this report: TEAM and ASM against CMS participant files by CCN and NPI, the ACO tracks against the CMS Shared Savings Program file, and the capacity figures against Mass General Brigham's own published testimony.*

Lever	What the shared infrastructure supplies	Status at Mass General Brigham
TEAM — CABG episode	Continuous observation of the 30-day window; early detection of decompensation before it becomes an ED visit; documented post-acute coordination.	**Live now** — mandatory since Jan 1, 2026, at six CCNs
TEAM Composite Quality Score	Direct action on Hospital-Wide All-Cause Readmission, the one PY1 measure a post-discharge program moves; PSI 90 and the THA/TKA PRO-PM are not remote-care levers.	Weighted by episode volume in reconciliation
ASM — heart failure, 2027	Guideline-directed therapy titration as a production process, with weight and blood pressure trending between visits.	**Preliminary** — 3 clinicians via Cooley Dickinson; confirm against the final CMS list
Two Enhanced-track ACOs	Total-cost-of-care contribution from the same cohort, with the touch documented rather than inferred.	Both MGB ACOs in the MSSP ENHANCED track
Capacity and throughput	A monitored, documented post-surgical day at home, supporting discharge decisions that are currently constrained by what happens after the patient leaves.	Publicly quantified constraint; new beds from 2027

Lever	What the shared infrastructure supplies	Status at Mass General Brigham
Quality and reputation defense	Protection of a CABG readmission and mortality position already rated better than or no different from national at the two surgical campuses.	Five-star CMS overall rating at five MGB hospitals
Standalone service line P&L	Recurring professional-fee revenue at top-of-license staffing, independent of any value-based settlement.	**Modeled 41.8% 24-month margin** — illustrative; verify against service line data

4. The 2026 Policy and Payment Environment

4.1 TEAM: mandatory, CABG-inclusive, already running

The Transforming Episode Accountability Model is a five-year mandatory model established in the FY2025 IPPS final rule, running from January 1, 2026 to December 31, 2030. It holds participant hospitals financially accountable for episodes that begin with one of five procedure categories — coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment, and spinal fusion. Participation is by CCN and it is not an opt-in.

Both gates are verified for Mass General Brigham. Boston-Cambridge-Newton, MA-NH (CBSA 14460) is a selected mandatory CBSA, and six Mass General Brigham CCNs appear on the CMS TEAM participant list as **Mandatory** participants for the full model term: 220071, 220110, 220119, 220101, 220035 and 300018. The list rendition used here was published in June 2026 with hospital data as of April 15, 2026, and CMS updates it quarterly. Three Mass General Brigham hospitals are not participants — Cooley Dickinson, Nantucket Cottage, and Martha's Vineyard, the last of which is a Critical Access Hospital and therefore categorically outside a model that requires IPPS payment.

The episode economics

CMS publishes preliminary PY1 target prices by MS-DRG and census division, not by hospital. For New England (Census Division 1), with the CABG discount factor of 1.5 percent applied to a 2022–2024 baseline:

MS-DRG	Benchmark price	Trend factor	Discount	PY1 preliminary target price
231	$86,534	1.0344	1.5%	**$88,167**
232	$53,977	1.0296	1.5%	**$54,740**
233	$69,564	1.0374	1.5%	**$71,084**
234	$49,061	1.0396	1.5%	**$50,238**
235	$52,525	1.0281	1.5%	**$53,193**
236	$37,814	1.0386	1.5%	**$38,685**

The PY1 Composite Quality Score comprises three measures: **Hospital-Wide All-Cause Readmission** (claims-only in PY1), the CMS Patient Safety and Adverse Events Composite (PSI 90), and the hospital-level THA/TKA patient-reported outcome measure. The score adjusts reconciliation amounts and is weighted by the participant's TEAM episode volume. Of the three, only Hospital-Wide All-Cause Readmission is directly addressable by a post-discharge remote monitoring program — which is worth stating precisely, because it is also the one that does not benefit automatically from strong CABG-specific performance.

No prior bundled-payment experience — which is an argument for building it properly

CMS participant rosters confirm that no Mass General Brigham entity took part in BPCI-Advanced in any model year, or in the Comprehensive Care for Joint Replacement model; the 2017 cardiac episode payment models were cancelled before taking effect. TEAM is the system's first mandatory bundled-payment model. **There is no incumbent episode-management vendor, workflow or contract to unwind** — the operating layer is being designed for the first time, and can therefore be designed once, correctly, rather than retrofitted around something that already exists.

4.2 ASM: a second model in 2027, and it lands in western Massachusetts

The Ambulatory Specialty Model begins January 1, 2027, runs five performance years, applies two-sided risk with Part B payment adjustments of −9 to +9 percent in the first payment years, and covers two cohorts, one of which is heart failure. On the CMS preliminary CY2027 participant list, three Mass General Brigham-affiliated cardiologists appear in the **heart failure** cohort, billing under the Cooley Dickinson physician organization in Northampton, Greenfield and Springfield. The match was made by NPI against the NPPES registry rather than by name — an organization-name search of the CMS file for Mass General Brigham returns zero rows, because the entity is filed under a former legal name.

The geography explains both the hit and its limit. Amherst Town-Northampton (CBSA 11200) is a selected ASM mandatory geography; Boston-Cambridge-Newton (CBSA 14460) is not. **No Massachusetts General or Brigham and Women's cardiologist is eligible for ASM selection at all**, and because the geography list is fixed for the model, none can be added by the final list. This is a genuine but narrow exposure at a western Massachusetts community hospital that does not perform CABG, roughly 90 miles from Boston.

How to use this finding, and how not to

ASM is not the cardiothoracic surgery story. It is an outpatient specialist model for cardiologists managing heart failure; it does not attach to cardiac surgeons or to surgical episodes, and it does not touch Massachusetts General or Brigham and Women's. Its value in this conversation is narrower and still worth stating: mandatory specialty risk under two-sided arrangements has already reached inside Mass General Brigham's footprint, and the infrastructure proposed here for the surgical episode is the same infrastructure that cohort will need in eighteen months. It is a second, later-arriving reason the same build pays for itself — not a Boston-scale opportunity.

The ASM list is preliminary

The file used here is the CMS preliminary CY2027 participant list, built on 2024 data. CMS's final CY2027 list, built on 2025 data, had not published as of July 29, 2026. **The count of three can change, and this finding must be re-verified against the final CMS list before it is used in any planning document.** Re-verification must be run by NPI: the file's state and organization-name columns are both unreliable for this entity. The employment and contracting relationship between Mass General Brigham and these three clinicians is also a discovery question — all three carry other affiliations.

4.3 Why these are one program, not two

TEAM measures a surgical episode; ASM measures ambulatory heart failure management. They arrive a year apart, in different geographies, and are owned by different clinicians. But the operational requirement underneath them is identical: continuous physiologic data from patients at home, a 24/7 alert-and-triage layer with defined thresholds and owners, documented intervention, medication titration between visits, and a shared care plan visible to everyone involved. Add the two MSSP Enhanced-track ACOs — the maximum two-sided risk arrangement, already carrying total-cost-of-care accountability across the system — and there are three separate reasons to build the same thing.

Building it three times is the failure mode. A single remote care service line, with one enrollment engine, one device logistics chain, one escalation policy and one billing pathway, satisfies all three and is amortized

across all three. That is the connective-tissue argument in Figure 1, and it is the reason the standalone economics in Section 9 understate the total value rather than overstate it.

5. An Operating System for Service Line Performance

5.1 The balanced scorecard

Domain	Measure	Why it matters here
Clinical	30-day readmission after cardiac surgery discharge	The measure you already win on. The objective is protection, not improvement.
	ED presentations and observation stays within 30 days	Where the TEAM variance actually lives, and invisible to the readmission measure.
	Post-acute utilization within the episode window	SNF and home-health days are Part A spend inside the reconciliation window.
	Time from arrhythmia detection to clinical contact	The metric the institution's own post-discharge AFib study implies but does not yet track.
Operational	Time to first billable enrollment	The single best early indicator that the pathway is real rather than designed.
	Enrollment capture rate against eligible discharges	Capture rate, not eligible population, is what determines revenue.
	Device connectivity and reading adherence	16 days of readings is the billing threshold for 99454; 2 days for 99445.
	Alert closure time and escalation completion	An alert that is not closed is a documentation liability, not a safety net.
Financial	Net reimbursement per patient per month	The unit economics of the service line, tracked by program.
	Claims capture rate against eligible patient-months	The gap between clinically delivered and billed is where programs quietly lose money.
	Service line margin and margin percentage	Modeled at 41.8 percent over 24 months; verify against actuals monthly.
	Episode cost against the TEAM target price	The reconciliation-facing number, by MS-DRG.
Model	Composite Quality Score component tracking	HWR, PSI 90 and THA/TKA PRO-PM tracked continuously, not at reconciliation.
	CMS list re-verification currency	TEAM quarterly by CCN; ASM by NPI when the final CY2027 list publishes.

5.2 TEAM readiness checklist

Readiness item	What good looks like
Episode identification	CABG episodes flagged at admission, not discovered at reconciliation. MS-DRG-level visibility into which of 231–236 an episode will price against.
30-day cost visibility	A view of Part A and Part B spend across the window, including ED, observation and post-acute, refreshed faster than the CMS reconciliation cycle.
Discharge pathway ownership	A named owner for the cardiac surgery discharge at each campus, with the same pathway and the same thresholds at both.
TCM billing operational	Two-business-day contact documented, reconciliation performed, and the 7- or 14-day visit scheduled before the patient leaves.
Enrollment at discharge	Monitoring enrollment triggered by the discharge event itself, with device in hand or shipped before the patient is home.
Continuity of care to primary care	Every patient reconnected to their existing primary care physician with a shared care plan and structured data exchange — the model's continuity expectation, met without a parallel primary-care billing arm.
Post-acute coordination	Preferred post-acute relationships and a documented rationale for each placement, because those days price into the episode.
Quality score tracking	Hospital-Wide All-Cause Readmission monitored as an operating metric, not as an annual result.
Reconciliation review cadence	A standing review that compares episode cost to target price by MS-DRG and feeds the findings back into the pathway.

5.3 Clinical governance: what makes it safe

The economics prove the service line pays. Governance is what proves it is safe to point at a post-surgical population. A monitoring program that generates alerts without disciplined escalation creates work, not safety. Every reading routes through one shared escalation engine with defined thresholds, defined owners and documented outcomes.

- **One engine, every reading.** Critical values escalate regardless of whether the patient reports symptoms. Out-of-range but non-critical readings trigger a retake and a symptom check first, so a cuff error does not become a phone call to a surgeon.
- **Trend is defined, not inferred.** A trend means three readings at least an hour apart for blood pressure, or three within seven days for heart rate. The definition is objective, so escalation is consistent between coaches and across shifts.
- **Unreachable is still escalated.** No answer means voicemail plus a scheduled callback — and if the value is critical or the trend is established, escalation proceeds anyway. Silence is never read as stability.
- **Three-way routing.** Emergency routes to 911. Non-critical but actionable routes to a defined member of the practice team. Stable and resolved is documented as an FYI in the record. The service line sees what needs a clinician and is not buried in what does not.
- **Everything is documented.** Every escalation records the vital, the findings, the contact method, who was reached, the outcome and the follow-up. Continuity governance re-escalates unreachable patients on a fixed cadence, and the practice is notified at every decision point.

The emergent pathway is not configurable

Chest pain, new shortness of breath, stroke signs, syncope, worst-ever headache or sudden swelling trigger a 911 call with the patient still on the line. If the patient refuses, the care team routes to the clinic; if contact is lost and the presentation is emergent, CoachCare activates 911 directly. **CoachCare's urgent and emergent policy supersedes any client-specific escalation preference.** That is deliberately not a configuration option, and it is the reason the program can be trusted with a post-surgical population.

The post-discharge three-touch cadence

Any hospitalization or emergency department visit in the previous 60 days triggers a structured outreach cadence: **days 1–2, days 5–8, and days 12–14**. That cadence maps precisely onto the first two weeks of the TEAM episode window, where readmission risk concentrates — and it is the operational mechanism behind the modeled hospitalizations avoided in Section 9.3.

6. Performance Snapshot: A Position of Strength to Protect

6.1 Quality and recognition

Measure	Massachusetts General (220071)	Brigham and Women's (220110)
CMS Hospital Overall Rating	5 of 5	5 of 5
30-day CABG mortality (MORT_30_CABG)	**1.0 — Better Than National**	1.9 — No Different than National
30-day CABG readmission (READM_30_CABG)	**8.3 — Better Than National**	10.2 — No Different than National
30-day heart failure mortality	6.6 — Better Than National	7.0 — Better Than National
30-day heart failure readmission	17.9 — Better Than National	17.2 — Better Than National
30-day excess days in acute care, heart failure	**10.4 — More Days Than Average**	1.5 — Average
PSI 90 (a TEAM quality measure)	0.87 — No Different	0.88 — No Different
FY2026 HRRP payment adjustment	**1.0000 — no penalty**	0.9948 — 0.52% penalty

Beyond the CMS measures: five Mass General Brigham hospitals — Massachusetts General, Brigham and Women's, Brigham and Women's Faulkner, Newton-Wellesley and Salem — each carry a five-star CMS Hospital Overall Rating. Massachusetts General is ranked #8 nationally for cardiology and heart and vascular surgery in the 2025–2026 US News rankings, confirmed on Mass General Brigham's own site. Brigham and Women's is reported at #12 in the same specialty; that figure came from a search summary rather than a retrieved page and ***should be verified before it is used externally***.

6.2 Readmission performance against peers

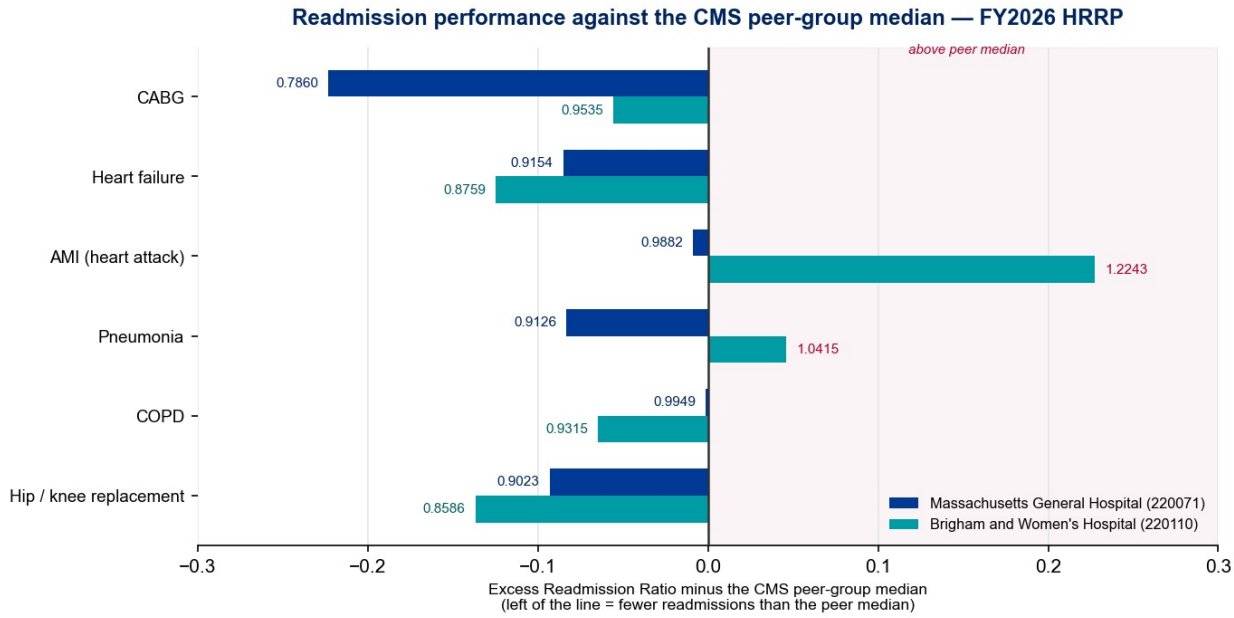

Figure 2. *Excess readmission ratio minus the CMS peer-group median, FY2026 HRRP, performance period July 1, 2021 to June 30, 2024. Bars to the left of the line indicate fewer readmissions than the peer median — lower is better. Both hospitals sit below the median on CABG, and neither is penalized on the CABG measure. Directional snapshot; refresh against the current HRRP file before external use.*

The chart is included to make one point clearly and one point honestly. The clear point is that on CABG — the measure that maps to the TEAM episode this service line exists to operate — Massachusetts General is a strong favorable outlier at 0.7860 against a peer median of 1.0091, and Brigham and Women's is comfortably below the median at 0.9535. Neither triggers a CABG penalty. And on CMS Care Compare, of the eight CABG-performing hospitals inside the Boston TEAM CBSA, Massachusetts General posts both the lowest 30-day CABG readmission rate (8.3) and the lowest 30-day CABG mortality rate (1.0).

The honest point is Brigham and Women's 0.52 percent FY2026 payment adjustment, which is driven entirely by acute myocardial infarction (1.2243) and pneumonia (1.0415). Neither is a cardiac surgery measure, neither is what this report is about, and neither is offered here as a criticism of a hospital whose CABG excess readmission ratio sits below the CMS peer-group median and carries no CABG penalty. It is included because a performance snapshot that showed only the favorable measures would not be worth reading.

6.3 Where the remaining variance actually sits

The structural point

Not CABG readmissions. Both hospitals sit below the peer median and neither is penalized. That performance is an asset to protect, not a deficit to fix.

But TEAM does not pay on the readmission rate. It reconciles against all Medicare Part A and Part B spend in the 30-day window.

So the variance lives in emergency department presentations, observation stays and unplanned post-acute utilization that never become readmissions and never appear in the readmission measure.

Signal Massachusetts General's 30-day excess days in acute care for heart failure is 10.4, rated More Days Than Average, while its heart failure readmission rate is better than national. Excess days worse and readmission rate better is the ED-and-observation pattern, in an adjacent cohort, in the same building.

Quality The Composite Quality Score uses Hospital-Wide All-Cause Readmission, not the CABG-specific measure — so strong CABG performance does not by itself carry the quality score.

Stated plainly: Mass General Brigham is accountable for 30 days it currently observes in fragments — a discharge summary, a phone call, and a follow-up visit somewhere around week three. Remote care makes that window continuous and documented. That is the whole argument, and it does not require anything to be wrong today.

Data vintage. *HRRP figures are from the FY2026 files published September 2025, performance period July 1, 2021 to June 30, 2024. Care Compare figures cover the same period, with PSI 90 covering July 1, 2022 to June 30, 2024. Confirm the current values on CMS Care Compare before external use.*

7. Powering TEAM: The CABG Episode

7.1 What changes operationally

Before TEAM, a cardiac surgery discharge was an endpoint. The operation succeeded, the patient went home, and the service line's accountability effectively ended at the door with a follow-up appointment as the only scheduled touch. Under TEAM the discharge is the midpoint of an episode that is still being priced for another 30 days, and every Part A and Part B dollar spent in those 30 days — wherever it is spent, by whoever spends it — counts against a target price fixed in advance.

Three things have to change, and none of them are clinical.

1. **The discharge acquires an owner.** Someone is accountable for the patient's trajectory for 30 days, with a defined cadence, not an open invitation to call if something feels wrong.
2. **The window becomes observable.** Weight, blood pressure and pulse from day one home turn a 30-day blind spot into a data series. Fluid overload and new arrhythmia are visible in the trend before they are visible in an emergency department.
3. **The work becomes billable.** TCM and short-window RPM fund the coordination the model requires, so episode management pays for itself instead of being absorbed as overhead against a reconciliation that arrives much later.

7.2 The episode bundle

Episode day	Action	Billing	Episode purpose
Day 0 — discharge	Enrollment triggered by the discharge event; device issued or shipped; patient and caregiver educated.	99453	Starts the data series while the patient is still in the building.
Days 1–2	First structured contact. Medication reconciliation. Symptom and wound review.	99495 / 99496 (TCM initiated)	The two-business-day contact TCM requires, in the highest-risk 48 hours.
Days 2–15	Daily readings, trended and escalated against defined thresholds. Second structured contact at days 5–8.	99445 + 99470	The CY2026 short-window codes make the two weeks that matter most billable in their own right.
Days 7–14	Face-to-face follow-up visit — 7 days for high complexity, 14 for moderate.	TCM visit component	Completes the TCM service and puts eyes on the patient inside the window.

Episode day	Action	Billing	Episode purpose
Days 12–14	Third structured contact. Reassessment of trajectory and post-acute needs.	99457 / 99458 as applicable	The last touch inside the two weeks where readmission risk concentrates.
Days 16–30	Continued monitoring at full-month cadence for patients still at risk.	99454 + 99457	Carries the remainder of the episode window.
Day 31 onward	Conversion to longitudinal management for patients with ongoing chronic cardiac disease; reconnection to primary care with a shared care plan for those who do not.	PCM or CCM + RPM	Turns an episode into a census — and satisfies the continuity-of-care expectation.

7.3 Build once, reuse everywhere

The same pathway, with different thresholds and a different enrollment trigger, serves the heart failure population sitting behind the surgical one — 807 Medicare fee-for-service heart failure and shock discharges at the two campuses in data year 2024, on top of 1,165 cardiac surgical discharges. It serves the total-cost-of-care accountability both Mass General Brigham ACOs already carry in the MSSP Enhanced track. From January 1, 2027 it serves the ASM heart failure cohort in western Massachusetts. And it does all of that on one enrollment engine, one device logistics chain, one escalation policy and one billing pathway.

That is why the recommendation in Section 10 is to prove the pathway on one cardiac surgery service first and then extend it — rather than to design four programs and sequence them. The second deployment costs a fraction of the first because the infrastructure is already standing.

8. Capacity and the Post-Surgical Day

Mass General Brigham has been unusually specific in public about its capacity position, which makes this the rare value lever that does not require a vendor to estimate anything. The figures below are the system's own, drawn from its chief executive's pre-filed testimony to the Massachusetts Health Policy Commission and from Massachusetts General's own reporting.

Mass General Brigham's published capacity position (FY2024 unless noted)	Value
Massachusetts General and Brigham and Women's in a state of “capacity disaster”	95% of the time
Average emergency department boarders per day across the two academic medical centers	102, up 20% year over year
Inpatient transfers from community hospitals declined for capacity reasons	1,836
Average wait for a medical/surgical inpatient bed	19 hours
Risk-adjusted length of stay against the national average	About 10% higher
Average acute length of stay, FY2025 (audited)	5.92 days, down 1.5%
New inpatient beds at Massachusetts General with the Ragon Building	+94, phasing in from 2027

A capacity disaster is formally triggered at Mass General Brigham when more than 45 inpatients are boarding in the emergency department. The system cannot build its way out of this before 2027 at the earliest. In its FY2025 management discussion it explicitly ties throughput work to revenue growth amidst what it describes as an unrelenting capacity crisis.

The relevance to a cardiothoracic service line is direct. Post-surgical length of stay decisions are made, in part, on what can be observed after the patient leaves. When the answer is a phone number and a follow-up appointment in three weeks, the safe decision is to keep the patient. When the answer is daily weight, blood pressure and pulse flowing into Epic as discrete vitals, reviewed against defined thresholds by a team that escalates on a documented policy, the conversation changes. **Remote care does not shorten length of stay by itself. It removes one of the reasons length of stay is long.**

What this section does not claim

No length-of-stay reduction is modeled anywhere in this report, and none is included in the Section 9 economics. Length of stay at an academic medical center is driven by case mix, post-acute placement availability, and social complexity as much as by clinical readiness — Mass General Brigham's own Performance Improvement Plan reported missing its skilled-nursing utilization target specifically because system-wide capacity limited strategic placements. The claim here is narrower and defensible: a monitored, documented post-discharge pathway removes an argument for keeping a stable post-surgical patient another night. Quantifying that is a discovery exercise against Mass General Brigham's own length-of-stay and readmission data, not a modeling exercise.

9. Value Analysis: Illustrative Service Line Economics

This section presents a computed forecast for a remote care service line operated on the cardiothoracic surgical and heart failure populations at Massachusetts General and Brigham and Women's. It is built at Massachusetts Medicare Physician Fee Schedule locality rates, with CoachCare pricing held at list. ***Every figure in this section is illustrative and modeled, and must be verified against Mass General Brigham's own service line data before it is used for any purpose.***

9.1 How the population was sized

Step	Basis	Figure
Cardiac surgical throughput (Medicare FFS)	CMS Medicare Inpatient Hospitals — by Provider and Service, data year 2024: CABG 296, valve and other major cardiothoracic 520, other cardiothoracic including ECMO/VAD/transplant 349.	**1,165**
Heart failure (Medicare FFS)	Heart failure and shock, MS-DRGs 291–293, same file.	**807**
Medicare Advantage gross-up	CMS county-level Medicare Advantage penetration across the Suffolk, Middlesex, Norfolk and Essex catchment, weighted at approximately 35 percent. FFS claims exclude MA discharges entirely.	—
Year-one in-scope population	The grossed-up cardiac surgical and heart failure cohorts combined.	**3,052**

Step	Basis	Figure
Total Medicare population modeled	The broader Medicare denominator the service line draws from over the modeled horizon.	**4,082**
Referring providers assumed	An assumption, not a count. Mass General Brigham's actual referring-provider count for this service line is not public.	**45**

Two figures that are estimates, and are labeled as such

The year-one in-scope population of 3,052 is an estimate built from CMS fee-for-service claims and a Medicare Advantage gross-up. CMS suppresses provider-DRG cells below 11 discharges, so the underlying claims counts are floors. This number must be validated against Mass General Brigham's own chart counts in discovery, and the model re-run on the validated figure.

The 45 referring providers is an assumption, not a finding. It should be replaced with the service line's actual number before any figure in this section is relied upon.

9.2 Financial summary

Measure	Year 1	Year 2	24 months
Net reimbursement	$1,525,829	$2,161,937	**$3,687,766**
CoachCare fees	$898,025	$1,248,218	**$2,146,243**
Service line margin	$627,804	$913,719	**$1,541,523**
Margin %	41.1%	42.3%	**41.8%**

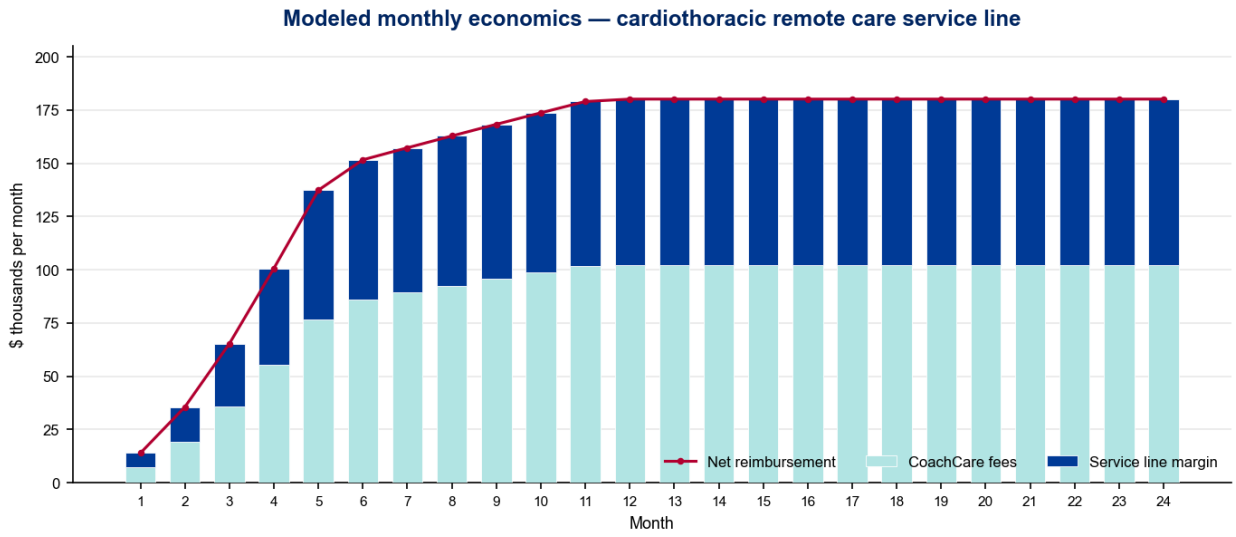

Figure 3. *Modeled monthly economics over 24 months. The stacked bars sum to net reimbursement; the blue segment is service line margin. Census reaches steady state around month 11 and the monthly contribution flattens at roughly $180,000 in net reimbursement. Illustrative, modeled — verify against service line data.*

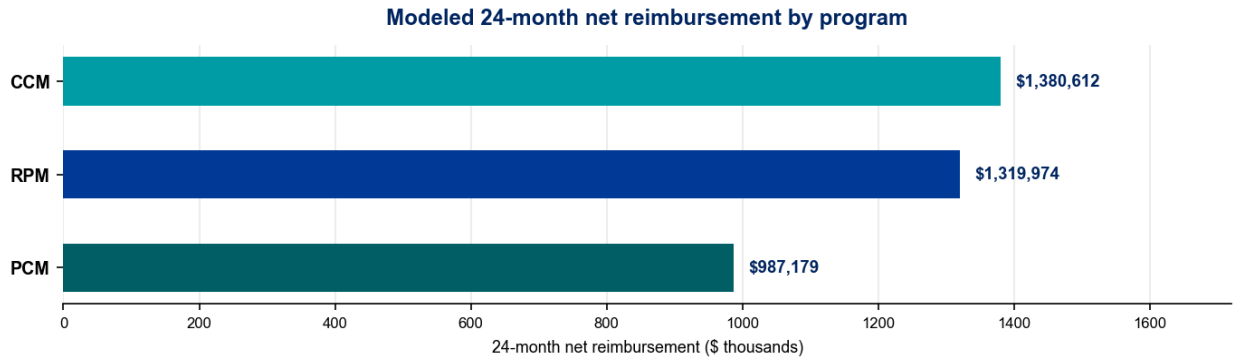

Figure 4. *Modeled 24-month net reimbursement by program: CCM $1,380,612, RPM $1,319,974, PCM $987,179. RPM covers 99453, 99445, 99454, 99470, 99457 and 99458; CCM covers 99490 and 99439; PCM covers 99426 and 99427. TCM is billed per discharge and is not a monthly census program. Illustrative, modeled — verify against service line 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 Mass General Brigham funds.** This is also why the model carries no negative-margin month: the enrollment engine is funded before the census exists, so there is no capital at risk during the ramp.

9.3 Enrollment, clinical and operational outcomes

Measure at month 24	Modeled value	What it means
Active program enrollments	**1,617**	RPM 549, CCM 534, PCM 534. A patient may carry more than one program.
Unique patients in active remote care	**1,068**	Deduped across programs on the model's dual-enrollment assumption. This is the patient count; 1,617 is the service count.
Hospitalizations avoided (24 months)	**79**	Modeled from RPM patient-months at a published-literature rate. A modeled outcome, not a guarantee. This is also the figure that moves the TEAM episode.
Physiologic readings captured	**124,485**	Landing in Epic as discrete vitals over 24 months — trendable and reportable, not PDFs.
Billable claims and units generated	**60,458**	Generated automatically rather than assembled per patient per month by staff.
Care team hours returned	**30,357**	Approximately 14.6 full-time equivalents of clinical and administrative time over 24 months.

9.4 Assumptions and what must be validated

- **Reimbursement.** Calculated at Massachusetts Medicare Physician Fee Schedule locality 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.

- **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. RPM conversion is modeled at 30 percent and CCM/PCM 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.
- **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 ACO shared-savings contribution, no length-of-stay reduction and no ASM payment adjustment appears anywhere in these figures. The margin stands on professional-fee revenue alone.

Illustrative, modeled — verify against service line data. Every financial and operational figure in Section 9 depends on population size, enrollment conversion, clinical eligibility and locality reimbursement. None of it is a quote, a commitment, or a guarantee of outcome.

10. Implementation Playbook

10.1 Scope and target populations

Start narrow enough to prove the pathway and wide enough for the economics to be visible. The recommended year-one scope is the cardiac surgical discharge at one campus, extended to the second campus once the pathway is running, with the heart failure cohort added behind it.

Cohort	Enrollment trigger	Pathway
CABG discharges	The discharge event itself, flagged in Epic	TCM + short-window RPM through day 30, then conversion review
Valve and other major cardiothoracic discharges	Same trigger, same pathway	Same as CABG; not a TEAM episode, but the same clinical risk window
Other cardiothoracic, including ECMO, VAD and transplant	Case-by-case, on the surgical team's judgment	Longer monitoring horizon; individualized thresholds
Heart failure discharges	Discharge with a heart failure or shock DRG	TCM + RPM, converting to PCM or CCM as a longitudinal census
Post-surgical patients converting to chronic management	Assessment at day 30 against chronic-condition criteria	PCM for a single dominant cardiac condition; CCM where two or more qualify

10.2 Staffing and the enrollment engine

The service line is staffed at top of license and, critically, the enrollment labor is not Mass General Brigham's to fund. A CoachCare-funded on-site enrollment specialist embeds with the service line and enrolls qualified Medicare patients on its behalf, with enrollment status visible in Epic in real time. CoachCare health coaches carry the monitoring and outreach cadence; the service line supplies clinical escalation ownership and the billing provider relationship.

- **Mass General Brigham supplies:** the billing provider, a named clinical escalation owner per campus, the discharge workflow integration point, and a service line executive sponsor.

- **CoachCare supplies:** the on-site enrollment specialist at its own expense, connected cellular devices and logistics, 24/7 alert triage and health coaching, documentation, and automated claim generation.

10.3 Technology, data and billing architecture

Mass General Brigham runs Epic across the enterprise, historically branded Partners eCare, with Patient Gateway as its MyChart instance. The system's demonstrated preference is to embed capability inside Epic rather than to add a parallel application. The integration is built for exactly that.

Pillar	What it does
01 Integrated enrollment	Enrollment flags and trigger ordering sit inside the clinical workflow. The CoachCare team enrolls qualified Medicare patients on the service line's behalf, and enrollment status is visible in Epic in real time.
02 Exchange of health history	Bi-directional at intake, so the monitoring program starts with the chart rather than re-collecting it.
03 Integrated discrete vitals	Device readings land in the chart as discrete vitals — trendable, reportable, and usable in clinical decision support. Not PDFs.
04 Compliance documentation	Time, touchpoints and interventions documented to an audit-ready standard inside the record.
05 Automated claim generation	CoachCare is the only care-management application integrated with Epic that provides automated claims creation, removing the manual per-patient, per-month claim step entirely.
Speed to service	Patients begin receiving remote care services in fewer than five days from the enrollment flag.

> *"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."*

10.4 Clinical workflow

1. **Flag at discharge.** The cardiac surgery discharge order triggers the enrollment flag. No downstream referral step is required.
2. **Enroll and equip.** The on-site specialist enrolls the patient before or at discharge; the connected device is issued or shipped so the data series starts on day one at home.
3. **Monitor and triage.** Daily readings route through the shared escalation engine. Critical values escalate immediately; out-of-range non-critical values trigger retake and symptom check.
4. **Structured outreach.** The three-touch post-discharge cadence — days 1–2, 5–8 and 12–14 — runs against every recently discharged patient.
5. **Close the TCM loop.** Two-business-day contact documented, medication reconciliation completed, face-to-face visit inside 7 or 14 days.
6. **Convert or hand back.** At day 30, patients with ongoing chronic cardiac disease convert to longitudinal PCM or CCM with RPM; the rest are reconnected to their primary care physician with a shared care plan and structured data exchange.
7. **Bill automatically.** Claims generate from the documented activity rather than being assembled by staff per patient per month.

10.5 KPI dashboard

Category	Metric	Why it is on the dashboard
Clinical	30-day readmission; ED and observation encounters in the window; arrhythmia detection-to-contact interval; device adherence	The clinical case for the program, and the inputs to the episode result.
Operational	Time to first billable enrollment; enrollment capture rate against eligible discharges; alert closure time; escalation completion rate	Early indicators. Capture rate is the number that most often decides whether a program hits its model.
Financial	Net reimbursement per patient per month; claims capture rate; service line margin and margin percentage; enrolled census by program	The standalone P&L, reported monthly against the Section 9 model.
Model	Episode cost against TEAM target price by MS-DRG; Hospital-Wide All-Cause Readmission trend	The reconciliation-facing view, tracked continuously rather than annually.

10.6 Twelve-month roadmap

Window	Milestone
Days 0–30	Validate the population against Mass General Brigham's own chart counts. Agree the year-one cohort. Name the executive sponsor and the clinical champion at each campus. Re-verify the current CMS TEAM participant list by CCN.
Days 30–60	Design the pathway around the existing cardiac surgery discharge process, with specific attention to days 0–14. Set escalation thresholds with the surgical and heart failure teams. Complete billing compliance review of the code stack and concurrency handling.
Days 60–90	Build the Epic integration: enrollment flags, discrete vitals, documentation and automated claim generation. Onboard the CoachCare-funded on-site enrollment specialist. Dry-run the escalation pathway.
Months 3–4	Go live at campus one. First billable enrollments. Weekly operating review on capture rate and time-to-first-billable-enrollment.
Months 4–6	Reach steady state at campus one. Begin reporting ED, observation and post-acute utilization inside the 30-day window against the TEAM target prices.
Months 6–9	Extend to campus two on the same pathway. Add the heart failure discharge cohort. First review of episode cost against target price by MS-DRG.
Months 9–12	Full run rate across both campuses. Reconciliation-ready reporting. Evaluate extension to the western Massachusetts heart failure cohort ahead of the January 1, 2027 ASM start, on the final CMS participant list.

Expected impact

Within twelve months, on the modeled assumptions, the service line reaches steady-state census, generates roughly $180,000 per month in net reimbursement at a margin above 40 percent, and — more importantly for the model exposure — converts the 30 days after a cardiac surgery discharge from a period Mass General Brigham observes in fragments into one it observes continuously and documents completely. **The financial figures are illustrative and modeled and must be verified against service line data. The operational change is not a forecast: it is what the pathway does.**

About CoachCare

500,000+ patients managed across more than 400 managed conditions · 10,000+ providers · 1,000+ successful implementations · 5M+ claims generated through care plan coding and billing · 100M+ vitals recorded · 4M+ care actions enabled.

Companion materials: the Mass General Brigham Cardiothoracic Remote Care Strategy microsite, which carries a live scenario explorer reproducing the Section 9 model, and the Mass General Brigham CoachCare Value Analysis 2026 workbook.

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. Six Mass General Brigham CCNs verified individually as Mandatory participants, 01/01/2026–12/31/2030. CMS updates this list quarterly.
- FY2025 IPPS/LTCH PPS final rule, 89 FR 68986 (August 28, 2024) — TEAM model parameters, five-year term, five episode categories including coronary artery bypass graft, 188 selected CBSAs.
- 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. Regional, not hospital-specific.
- CMS TEAM Quality Scoring fact sheet, September 2025 — PY1 Composite Quality Score measures: Hospital-Wide All-Cause Readmission, CMS PSI 90, THA/TKA PRO-PM.
- CMS Ambulatory Specialty Model Participants dataset (data.cms.gov dataset 175d576d-0568-4ac2-aec5-d77f3ee02205), file CY27_Prelim_ASMParticipants_Public.csv, catalog modified February 4, 2026 — heart failure cohort only, matched by National Provider Identifier against NPPES. Preliminary list.
- CMS ASM mandatory geographic areas file — CBSA 11200 Amherst Town-Northampton selected; CBSA 14460 Boston-Cambridge-Newton not selected.
- CMS Medicare Shared Savings Program Accountable Care Organizations PUF, file vintage January 2, 2026 — Mass General Brigham ACO, LLC (A4641) and Mass General Brigham ACO 2, LLC (A5932), both ENHANCED track.
- CMS BPCI-Advanced participant rosters for model years 3, 5, 6, 7 and 8, and the CJR hospital list (updated July 1, 2024) — no Mass General Brigham entity appears in any; no Massachusetts hospital appears in CJR.

Volumes, quality and readmissions

- CMS Medicare Inpatient Hospitals — by Provider and Service, data year 2024 (dataset 690ddc6c-2767-4618-b277-420ffb2bf27c), queried by CCN 220071 and 220110. Medicare fee-for-service only; CMS suppresses provider-DRG cells below 11 discharges, so all figures are floors.
- CMS FY2026 Hospital Readmissions Reduction Program payment adjustment factors (IPPS Table 15) and FY2026 HRRP Supplemental Data File, performance period July 1, 2021 to June 30, 2024.
- CMS Care Compare — Complications and Deaths (ynj2-r877) and Unplanned Hospital Visits (632h-zaca) datasets; Hospital General Information dataset (xubh-q36u) for CCN, hospital type and overall star rating.

- CMS Medicare Advantage State/County Penetration file, July 2026 — Suffolk 42.09 percent, Middlesex 34.21 percent, Norfolk 32.09 percent, Essex 35.48 percent.
- Massachusetts Department of Public Health, Cardiac Surgery Hospital Report FY2014 (published November 2016) — the most recent state cardiac surgery report card. Massachusetts hospital-level cardiac surgery public reporting has not published since.
- US News Best Hospitals 2025–2026 — Massachusetts General #8 nationally for cardiology and heart and vascular surgery, confirmed on Mass General Brigham's own site.

Mass General Brigham published sources

- Mass General Brigham Heart and Vascular Institute program pages; Division of Cardiac Surgery and Division of Thoracic Surgery leadership pages at Massachusetts General and Brigham and Women's; Mass General Brigham press release announcing the inaugural Heart and Vascular Institute executive director.
- Mass General Brigham Accelerator for Clinical Transformation and Remote Health program pages; Mass General Brigham newsroom article on remote blood pressure monitoring (published April 2023) for the 10,000+ patient figure.
- Mass General Brigham Healthcare at Home / Home Hospital program pages, including the supported conditions list.
- Mass General Brigham and Recora collaboration announcement, September 16, 2025 — intensive cardiac rehabilitation delivered virtually and in person.
- Prospective wearable-ECG study of post-cardiac-surgery atrial fibrillation led from Brigham and Women's (investigator Jakob Wollborn, MD, MPH), reported August 21, 2025 — 100+ open-heart surgery patients monitored at discharge; 27 percent with post-discharge atrial fibrillation, nearly 25 percent of those with no documented arrhythmia during the hospital stay.
- Mass General Brigham pre-filed testimony to the Massachusetts Health Policy Commission and Massachusetts General reporting on capacity, published January 31, 2025 (FY2024 figures); Mass General Brigham Summary Audited Consolidated Financial Statements for the period ended September 30, 2025, filed to MSRB/EMMA December 19, 2025.
- Massachusetts Health Policy Commission, Mass General Brigham Performance Improvement Plan Final Evaluation, December 12, 2024 — including the skilled-nursing utilization shortfall attributed to system-wide capacity.

What is not verified, and must be treated as such

- Mass General Brigham's all-payer cardiac surgery volumes, current cardiothoracic surgical staffing, and the true referring-provider count for this service line. The model uses 45 referring providers as an assumption.
- Current enrollment in Mass General Brigham's existing remote monitoring programs. The most recent published figure is from April 2023; 2026 enrollment is not publicly verifiable.
- Whether any post-discharge cardiac surgery monitoring capability has been stood up since the August 2025 research publication. Our review found no evidence of one; absence of public evidence is not proof of absence, and this is a discovery question rather than an assertion.
- The employment and contracting relationship between Mass General Brigham and the three cardiologists on the preliminary ASM list, who bill under the Cooley Dickinson physician organization and carry other affiliations. The ASM list itself is preliminary and must be re-verified by NPI against the final CMS publication.
- Mass General Brigham's self-reported cardiac procedure volumes — the Heart and Vascular Institute page and the cardiac surgery page give figures that are not reconciled, and both are undated. Neither is used in this report.
- Brigham and Women's US News rank of #12 in cardiology and heart and vascular surgery, which came from a search summary rather than a retrieved page.
- 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 Mass General Brigham'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 Ambulatory Specialty Model participant list is preliminary and subject to change before the model begins on January 1, 2027, and the TEAM participant list is updated quarterly. Medicare Physician Fee Schedule amounts are locality-specific and subject to annual rulemaking. This document is confidential, prepared solely for Mass General Brigham, and is not for distribution.