COACHCARE | SERVICE LINE STRATEGY

Trinity Health

Livonia, Michigan. A Catholic health system with $25.4 billion of operating revenue, 133,000 colleagues and 8,900 employed physicians and clinicians, operating 58 hospitals with a Medicare provider number across 16 states and 15 regional health ministries, on a single Epic instance that completes this year

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

Trinity Health already has the proof, the payment programs and the platform. The proof is inside the system: six months of zero readmissions on the sickest heart-failure cohort at MercyOne Iowa Heart Center. The payment programs are four two-sided ACOs, an owned Medicare Advantage plan, a preliminary specialty-model exposure in three regions and a mandatory episode obligation at one hospital. The platform is one Epic instance finishing this year. What does not yet exist is one cardiovascular remote care service line that runs the same way in all fifteen regions. This document prices that service line.

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Trinity Health. It assembles the system's own CY2024 Medicare discharge record by provider number, its FY2026 heart-failure readmission ratios hospital by hospital, its verified position in four CMS payment programs, CoachCare's six-month evaluation at MercyOne Iowa Heart Center, the CY2026 payment environment at the Michigan locality, and a twenty-four-month financial forecast into one argument: the model that works in Des Moines can run in every region, on one Epic instance, at a margin, without a requisition.

Figures are drawn from CMS files pulled on 9 September 2026 and from Trinity Health's own statements; the numbered footnotes give the file, query and vintage for each.

Prepared by CoachCare for discussion with Trinity Health.

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Executive Summary

Trinity Health operates 58 hospitals with a Medicare provider number, 48 of them acute-care, across 16 states and 15 regional health ministries, with 8,900 employed physicians and clinicians and $25.4 billion of operating revenue.[1] In CY2024 those hospitals discharged 81,283 Medicare fee-for-service patients, 5,566 of them in the heart-failure diagnosis groups, MS-DRG 291 to 293. Heart-failure patients are the population this document prices.[2] In the FY2026 readmission program file, 42 Trinity hospitals report a heart-failure excess readmission ratio and 18 of them exceed 1.00.[3]

The central argument

The proof is already inside the system. In CoachCare's six-month evaluation at MercyOne Iowa Heart Center, 450 advanced heart-failure patients, NYHA class III and IV, stage C and D, recorded no 30-day or six-month readmissions against an 18% benchmark on the same panel, 4 heart-failure hospitalizations, 3 heart-failure emergency visits and 26 guideline-therapy gaps closed.

The payment programs are already in place. Four Trinity accountable care organizations are on the Enhanced track of the Medicare Shared Savings Program, which is two-sided risk on more than 223,000 beneficiaries. 27 heart-failure clinicians under three Trinity billing entities are named on the CMS preliminary participant list for the Ambulatory Specialty Model. One hospital carries a mandatory episode obligation. An owned Medicare Advantage plan operates in six states.

The platform is one Epic instance, expected to complete across the system by the end of 2026. One integration, built once, serves every region.

What does not exist is one cardiovascular remote care service line that runs the same way in every region. On fee-for-service economics alone, before any shared-savings settlement or specialty-model adjustment is counted, that service line returns $8,371,265 of net reimbursement over 24 months and Trinity Health keeps $3,546,981 of it, a 42.4% margin. Year 1 runs at 41.2% and Year 2 at 42.8%.

The readmission record is the place to start, and it starts with a compliment. MercyOne Des Moines, the hospital behind the Iowa Heart program, sits at 0.879 on 731 heart-failure discharges in the FY2026 file, well below expected. Eighteen other Trinity hospitals sit above 1.00, and the eight furthest above it run from Syracuse at 1.207 to Dubuque at 1.082. The question this document answers is how the other regions get to where Des Moines already is, and what that is worth on the way.

One market condition shapes every figure here. Discharge-weighted Medicare Advantage penetration across the hospital counties is 52.3%, ranging from 15.8% to 75.5%.[4] Plans must pay at least the Medicare rate for these code families, which is a floor; each contract sets its own terms above it. Because MediGold is Trinity's own plan in six states, part of that is a contracting decision Trinity controls, and on MediGold's own members an avoided admission is medical cost the system keeps.

The forecast covers heart-failure patients only, and they reach the service line two ways: at the cardiology office visit, where the referring cardiologists and CoachCare's on-site enrollment specialist flag eligible patients, and by post-discharge outreach after a heart-failure discharge, in the first days home. Heart-attack and arrhythmia patients are the next wave on the same engine and are not in the forecast.

[1] Trinity Health, Facts and Figures, fiscal year ended 30 June 2025, retrieved 9 September 2026: operating revenue $25.4 billion, 133,000 colleagues, 8,900 employed physicians and clinicians, 30,000 affiliated physicians, 2.3 million primary-care patients. Hospital, state and ministry counts from the CMS Hospital General Information file, provider-data dataset xubh-q36u, resolved by name, city and state for every Trinity-owned hospital.

[2] CMS Medicare Inpatient Hospitals by Provider and Service, CY2024, dataset 690ddc6c-2767-4618-b277-420ffb2bf27c, queried for all 58 Trinity provider numbers, retrieved 9 September 2026. Heart failure MS-DRG 291 to 293: 5,566; acute myocardial infarction 280 to 285: 2,184; cardiac arrhythmia 308 to 310: 2,198; all reported lines: 81,283. Cells under 11 discharges are suppressed, so every figure is a floor.

[3] CMS Hospital Readmissions Reduction Program, FY2026 hospital file, provider-data dataset 9n3s-kdb3, discharges 1 July 2021 to 30 June 2024, retrieved 9 September 2026. 42 Trinity provider numbers report a heart-failure excess readmission ratio; 18 exceed 1.00.

[4] CMS State/County Medicare Advantage penetration file, July 2026 release, retrieved 9 September 2026. Discharge-weighted across the Trinity hospital counties with a reported figure: 52.27%. Connecticut is absent from the July 2026 file and its hospitals inherit the weighted average. Range across hospital counties: Baker County, Oregon 15.8% to Muskegon County, Michigan 75.5%.

The forecast in one view

	Year 1	Year 2	24 months
Net reimbursement to Trinity Health	$2,084,384	$6,286,881	$8,371,265
CoachCare fees	$1,225,132	$3,599,151	$4,824,283
Retained by Trinity Health	$859,251	$2,687,730	$3,546,981
Retained margin	41.2%	42.8%	42.4%
Unique patients in active remote care	2,993 at month 12	3,953 at month 24	3,953 at month 24
Active program enrollments	3,634 at month 12	6,035 at month 24	6,035 at month 24
Hospitalizations avoided			352
Care-team hours delivered by CoachCare			75,135 (about 36 FTE-equivalent)

1. The Organization and the Panel

1.1 Fifty-eight provider numbers, fifteen regional ministries, one Epic instance

Trinity Health is a Catholic health system headquartered in Livonia, Michigan, with a fiscal year ending 30 June. Its own count is 91 acute-care hospitals, 133,000 colleagues, 8,900 employed physicians and clinicians, 30,000 affiliated physicians and 2.3 million primary-care patients.[5] Resolved against the CMS hospital file, 58 Trinity-owned hospitals carry their own Medicare provider number today: 48 acute-care and 10 critical access, across 16 states and 15 regional ministries. The two counts differ because Trinity's figure includes hospitals it manages under affiliation agreements, about twenty in Iowa alone, rehabilitation and behavioral campuses, and campuses that share a provider number; the 58 excludes one Iowa hospital that left the system in 2025, and it carries one Massachusetts hospital under a signed sale agreement whose discharges are left out of every sizing figure.[6] Every payment program in Section 6 is verified against those 58 provider numbers, one by one.

Regional ministry	States	Acute hospitals with a provider number	Cardiology
Trinity Health Michigan	MI	8 acute, 1 critical access	Michigan Heart, about 30 cardiologists; structural heart
MercyOne, including Genesis	IA, IL	9 acute, 7 critical access	Iowa Heart Center: 90+ providers, 20+ locations, advanced HF clinic, LVAD
Loyola Medicine and Saint Joseph Health System	IL, IN	5 acute	Academic advanced HF and transplant program
Mount Carmel Health System	OH	5 acute	Heart-failure clinics at three campuses; structural heart
Trinity Health Of New England	CT, MA	4 acute, one under a sale agreement	Community and tertiary cardiology

[5] See note 1. The 91-hospital figure is Trinity's own count on the same page.

[6] See note 1 for the CMS file. The 58 exclude MercyOne Siouxland, provider number 160153, which left the system on 1 September 2025. Mercy Medical Center Springfield, Massachusetts, provider number 220066, is on Care Compare as a Trinity hospital and is counted in the 58, but it is under a signed sale agreement of April 2026 and its discharges are excluded from every sizing and forecast figure in this report. Also excluded: hospitals MercyOne operates under management agreements, behavioral and psychiatric campuses, PACE sites and an unconsolidated Atlanta affiliate.

Regional ministry	States	Acute hospitals with a provider number	Cardiology
St. Peter's Health Partners; St. Joseph's Health	NY	4 acute	Inpatient cardiology expanding in 2026
Trinity Health Mid-Atlantic	PA, DE	4 acute	Community cardiology
Holy Cross Health	MD, FL	3 acute	Community cardiology
Saint Alphonsus Health System	ID, OR	3 acute, 1 critical access	Heart Institute, about 33 physicians; advanced HF
Saint Agnes Medical Center	CA	1 acute	Community cardiology
St. Mary's Health Care System	GA	2 acute, 1 critical access	Community cardiology

The record system is the fact that makes a system-wide design possible. Trinity is finishing a single-instance Epic build, TogetherCare, in twelve regional waves: the Illinois region went live in February 2026, Iowa was scheduled for May 2026, and completion across the system is expected by the end of 2026.[7] Section 5 treats that as the integration calendar. Whether the Iowa wave completed on schedule is not confirmed from a post-go-live source, and it is an item in Section 12.

1.2 The cardiology bench, region by region

Cardiology at Trinity is organized regionally, and no single executive owns the cardiovascular service line across the system.[8] That is a recommendation in this document, not a criticism: a service line that runs the same way in fifteen regions needs one owner, and Section 11 says so. The regional benches differ in depth, and the differences decide the rollout order in Section 9.

Region	What is there	What it means for the service line
MercyOne Iowa Heart Center	More than 90 providers across more than 20 locations and 35 outreach communities; an advanced heart-failure clinic; an accredited LVAD program; a cardiovascular research center; a heart-failure population of more than 9,000 patients	The reference site. The advanced-HF cohort runs on CoachCare today; the expansion is the rest of the heart-failure population and the heart-failure discharges of the Iowa hospitals.
Trinity Health Michigan Heart	A single cardiology division of about 30 cardiologists headquartered on the Ann Arbor campus; structural heart including TAVR, mitral repair and left atrial appendage closure; more than 1,000 ablations and 1,600 device implants a year; left-sided ablation added at Livonia	The largest heart-failure discharge volume in the system, 1,221 across nine hospitals, and the headquarters locality the forecast is priced at.
Loyola Medicine	Academic advanced heart-failure and transplant program, more than 500 heart transplants to date, with an accredited advanced-HF fellowship	The highest-acuity cohort outside Iowa; the post-transplant and pre-transplant panels are a natural principal-care-management population.
Mount Carmel	Heart-failure clinics at three campuses run by advanced practice providers under a cardiologist; a structural heart and valve program with a new hybrid operating room	Clinic-based HF management already exists; the service line adds the device layer and the discharge loop to it.
Saint Alphonsus Heart Institute	About 33 physicians in Boise; an advanced heart-failure program with LVAD and transplant evaluation	One of the three regions whose clinicians are on the preliminary specialty-model list.

[7] Becker's Health IT reporting on the TogetherCare single-instance Epic program, an approximately $800 million build in twelve regional waves; Loyola live February 2026, Iowa scheduled May 2026, system completion expected by end of 2026. Trinity Health second-quarter FY2026 management discussion names optimizing the TogetherCare platform as a priority.

[8] Trinity Health executive leadership page and regional cardiology service pages, retrieved 9 September 2026. No system-level cardiovascular service-line executive is listed; cardiology leadership is regional.

Region	What is there	What it means for the service line
St. Peter's Health Partners; Trinity Health Of New England	Inpatient cardiology expanding at Troy in 2026; the Hartford and Albany employed groups carry the other two preliminary specialty-model listings	The two largest specialty-model exposures in the system, 17 and 8 clinicians.

1.3 The position a new service line has to fit

Trinity closed FY2025 at roughly break-even on $25.4 billion of operating revenue. Through the first nine months of FY2026 the operating result was $200 million of income, a 1.0% margin, with a net gain of $1.1 billion and premium and capitation revenue up 31%.[9] The stated strategy is to move community, outpatient and virtual care from 62% to more than 75% of revenue within three to five years, to invest asset-light, and to get the most out of the Epic platform it has already paid for.[10] A service line that adds no headcount and no capital, bills on the fee schedule from its first month, and runs at a 42.4% margin fits that strategy without an exception being made for it. That is the implication this document works from.

1.4 Sizing the panel from the system's own discharges

The in-scope population is derived from CMS discharge counts by provider number for CY2024, not from a claims-dollar proxy. Across the 48 hospitals with a reported line, 5,566 Medicare fee-for-service discharges fall in the heart-failure diagnosis groups; all Medicare fee-for-service discharges total 81,283.[11] Heart failure is the whole of the in-scope population. Heart attack and arrhythmia, 4,382 further discharges between them, are the next wave on the same engine and are not in the forecast.

Cohort (MS-DRG groups)	CY2024 Medicare FFS discharges	Role in this report
Heart failure (291 to 293)	5,566	The in-scope population, before the Medicare Advantage gross-up; the cohort the readmission program and the specialty model both score
Acute myocardial infarction (280 to 285)	2,184	Next wave, not in scope
Cardiac arrhythmia (308 to 310)	2,198	Next wave, not in scope
COPD (190 to 192)	1,343	Second arm; no revenue in this forecast
Renal failure and chronic kidney disease (682 to 684, 698 to 700)	4,070	Second arm; no revenue in this forecast
Diabetes and endocrine (637 to 645)	3,184	Second arm; no revenue in this forecast
All Medicare fee-for-service discharges	81,283	The total-panel basis

[9] Trinity Health audited financial statements for the fiscal year ended 30 June 2025 and Becker's Hospital Review reporting of results through 31 March 2026, dated 22 May 2026: nine-month operating income $200 million on $20.0 billion of revenue, a 1.0% margin; net gain $1.1 billion; premium and capitation revenue up 31%.

[10] Trinity Health second-quarter FY2026 management discussion and analysis, and reporting in Becker's Hospital Review and Modern Healthcare of the chief executive's stated goal of moving community, outpatient and virtual care from 62% to more than 75% of revenue within three to five years through asset-light investment.

[11] See note 2. COPD MS-DRG 190 to 192: 1,343; renal failure and chronic kidney disease 682 to 684 and 698 to 700: 4,070; diabetes and endocrine 637 to 645: 3,184. The 10 critical access hospitals and the new, surgical and rehabilitation campuses carry no reported DRG line.

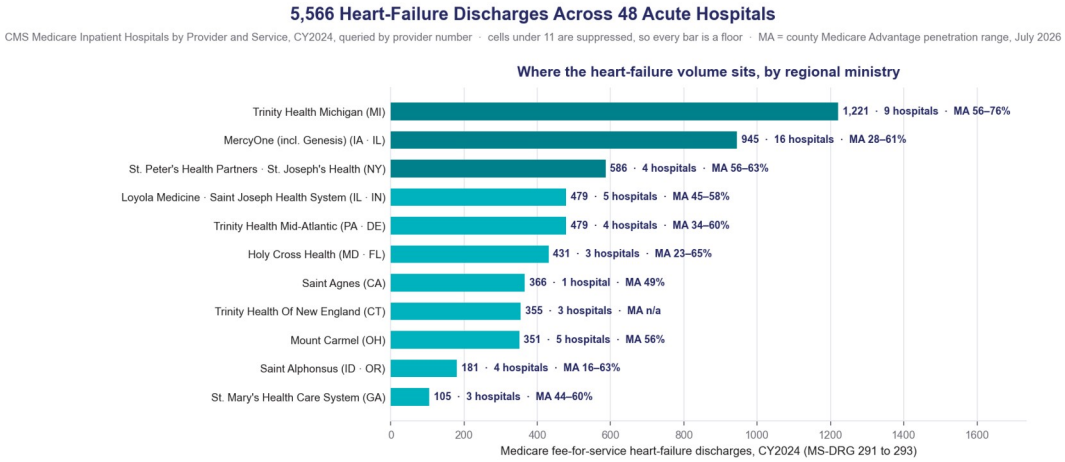

Figure 1. CY2024 Medicare fee-for-service heart-failure discharges by regional ministry, from the CMS inpatient file queried by provider number. Cells under eleven are suppressed, so every bar is a floor.

Grossing those counts for the 52.3% discharge-weighted Medicare Advantage share gives the two panel figures the model runs on: 5,566 ÷ (1 − 0.5227) ≈ 11,661 heart-failure patients in scope in Year 1, and 81,283 ÷ (1 − 0.5227) ≈ 170,400 total Medicare. The credible range on the in-scope figure is 9,000 to 15,000 and the model's 11,661 sits inside it. Discharges are encounters rather than unique patients, which pulls the figure down; a heart-failure patient admitted three times is three lines. Three things pull it up: CMS suppresses any provider-and-diagnosis cell under eleven discharges, so every count above is a floor; the roughly twenty managed affiliate hospitals carry no line at all; and the Iowa Heart Center's own heart-failure population of more than 9,000 patients, most of whom never admit, is by itself about 77% of the modeled in-scope figure. Counting the cohort against chart data, region by region, is the first item in Section 12.

1.5 The market: 52.3% Medicare Advantage, and an owned plan

County (hospital)	Region	Medicare eligibles	MA enrolled	MA penetration
Wayne, MI (Livonia)	Trinity Health Michigan	352,947	229,884	65.1%
Kent, MI (Grand Rapids)	Trinity Health Michigan	124,841	93,100	74.6%
Muskegon, MI	Trinity Health Michigan	43,545	32,881	75.5%
Polk, IA (Des Moines)	MercyOne	91,038	40,551	44.5%
Cook, IL (Loyola)	Loyola Medicine	893,755	401,101	44.9%
Franklin, OH (Columbus)	Mount Carmel	209,921	118,367	56.4%
Albany, NY	St. Peter's Health Partners	67,630	38,141	56.4%
Onondaga, NY (Syracuse)	St. Joseph's Health	105,214	66,136	62.9%
Broward, FL (Fort Lauderdale)	Holy Cross Health	380,527	247,107	64.9%
Fresno, CA	Saint Agnes	162,444	79,248	48.8%
Montgomery, MD (Silver Spring)	Holy Cross Health	198,254	44,742	22.6%
Discharge-weighted across the hospital counties				52.3%

Just under half of the Medicare beneficiaries in Trinity's hospital counties are in traditional fee-for-service, and the share swings from 15.8% in eastern Oregon to 75.5% in Muskegon.[12] Connecticut is absent from the July 2026 CMS file, so the Hartford and Waterbury hospitals inherit the weighted average. That number does two things to this analysis. It sets the panel arithmetic in Section 1.4, because the discharge counts are fee-for-service only and have to be grossed to reach a total Medicare population. And it makes plan treatment of the care-management code families a contracting question: the statutory floor is the Medicare rate, each contract sets its own terms above it, and the model prices the whole in-scope panel at the fee schedule at each region's own locality. MediGold, Trinity's own plan in Connecticut, Idaho, Iowa, Michigan, New York and Ohio, turns part of that question into a decision Trinity makes for itself.[13]

2. The Proof Inside the System

2.1 Six months at MercyOne Iowa Heart Center

MercyOne Iowa Heart Center carries a heart-failure population of more than 9,000 patients. In 2026 it identified 450 of its most complex cases, NYHA functional class III and IV, ACC/AHA stage C and D, as the first enrollment cohort for a remote patient monitoring program delivered by CoachCare alongside routine advanced heart-failure care. Before enrollment, the 30-day readmission rate for that group was 18%. That was the benchmark.[14]

Measure, six months, 450 patients	Result
30-day and six-month readmissions	None, against an 18% benchmark on the same panel
Heart-failure hospitalizations	4
Heart-failure emergency department visits	3 patients
Guideline-directed medical therapy gaps identified and closed	26
Daily transmitted vitals	Blood pressure, heart rate and weight through connected devices; app questionnaires
Contact cadence	Real-time alerts to clinicians; at least one phone interaction a month with every patient

Read against the readmission arithmetic in the case study, zero readmissions on 450 patients against an 18% benchmark is roughly 81 readmissions that did not happen in six months, on the sickest tenth of one region's heart-failure population. That is the spine of this document. The rest of it is about scale.

[12] See note 4. County figures: Wayne 352,947 eligibles and 229,884 enrolled; Kent 124,841 and 93,100; Muskegon 43,545 and 32,881; Polk 91,038 and 40,551; Cook 893,755 and 401,101; Franklin 209,921 and 118,367; Ada 106,645 and 59,426; Albany 67,630 and 38,141; Onondaga 105,214 and 66,136; Broward 380,527 and 247,107; Fresno 162,444 and 79,248; Montgomery 198,254 and 44,742.

[13] Trinity Health Plan of Michigan and MediGold plan pages, retrieved 9 September 2026: MediGold operates in Connecticut, Idaho, Iowa, Michigan, New York and Ohio; the Michigan HMO launched for 2026 in 25 counties. Membership is not published.

[14] CoachCare, six-month evaluation at MercyOne Iowa Heart Center, 2026: 450 advanced heart-failure patients, NYHA class III and IV, ACC/AHA stage C and D, enrolled in remote patient monitoring alongside standard advanced heart-failure care; 0% 30-day and six-month readmissions against an 18% benchmark on the same panel; 4 heart-failure hospitalizations; 3 heart-failure emergency visits; 26 guideline-directed medical therapy gaps identified and closed. The evaluation has not yet been released beyond CoachCare and MercyOne; the partnership was announced on 31 March 2026.

What the evaluation established

Daily physiologic data plus a triage protocol plus a monthly clinical contact, on top of standard advanced heart-failure management, held a stage C and D cohort out of the hospital for six months. That is the operating recipe, and it is the same recipe the Care Management SOP in Section 4.4 runs everywhere.

The care team saw early decompensation before it became an admission. Four heart-failure hospitalizations across 450 patients in six months is the number that carries into the shared-savings benchmark in Section 6.1 and the readmission ratios in Section 3.

Twenty-six therapy gaps closed is the result the CY2027 specialty model will score as quality. Iowa Heart is outside that model, and the three regions inside it are the ones that need the same result.

2.2 What the evaluation was, and what it was not

It was a six-month evaluation on a single, deliberately selected cohort: adults with stage C or D heart failure, consented, active on the program for the full period, with a monthly contact and daily readings. It was not a randomized trial, it was not a system-wide population, and it has not yet been released beyond CoachCare and MercyOne. The benchmark was the same panel's own prior readmission rate rather than a national rate, which is the stricter comparison for this purpose: it removes case mix from the argument.

It also did not run under the Ambulatory Specialty Model, and it could not have. Des Moines is not a selected area and no MercyOne or Iowa Heart entity appears on the preliminary participant file. The Iowa Heart story is readmission and shared-savings economics; MercyOne ACO III, an Enhanced-track organization, is where its avoided admissions land. The specialty-model story belongs to Albany, Hartford and Boise, and Section 6.3 keeps the two apart.

2.3 What runs today, and what does not

Program	What it is	Where it sits
Iowa Heart Center advanced heart-failure monitoring	The CoachCare program evaluated above, announced in March 2026, on top of an earlier cellular-device heart-failure monitoring program that reached North Iowa in 2023	Ambulatory cardiology, one region. This is the program the service line extends.
Trinity Health At Home post-acute monitoring	Tablet and wireless vitals with a virtual nurse, delivered through the national home-health ministry with a home-health technology partner	Post-acute home health, not ambulatory cardiology. It is not displaced by this service line and its patients are not in the forecast.
TogetherTeam Virtual Connected Care	Inpatient virtual nursing: a bedside nurse, a bedside aide and an on-campus virtual nurse through an in-room camera, on 27 hospitals and 82 nursing units	Inside the building. It proves Trinity will run virtual care at system scale, and it ends at discharge.
Digital-health ordering layer inside Epic	An ordering and monitoring layer inside the Epic workflow in which Trinity is one of the health-system investors	Infrastructure, not a program. It is the kind of workflow this service line runs through rather than around.

No system-level ambulatory cardiology remote-monitoring program is named in Trinity's public materials.[15] The only ambulatory cardiology monitoring program that is named is the Iowa Heart program, and it is CoachCare's. The inpatient layer is built, the post-acute home-health layer is built, and the ambulatory cardiology layer exists in one region. That is the gap this document prices, and it is a completion argument rather than a replacement one.

[15] Trinity Health, MercyOne, Trinity Health At Home and Mount Carmel program pages and press releases, retrieved 9 September 2026; Trinity Health second-quarter FY2026 management discussion for the TogetherTeam footprint of 27 hospitals and 82 nursing units; Trinity Health press release on its investment in a digital-health ordering platform. No ambulatory cardiology remote-monitoring program is named at system level.

3. The System's Readmission Record

3.1 The compliment first: Des Moines at 0.879

The FY2026 Hospital Readmissions Reduction Program file, which covers discharges from July 2021 through June 2024, assigns each hospital a heart-failure excess readmission ratio against a peer group; a ratio above 1.00 reduces every Medicare inpatient payment the hospital receives for the year, and the size of the ratio is what sets the size of the reduction.[16] MercyOne Des Moines, the hospital behind the Iowa Heart program, sits at 0.879 on 731 heart-failure discharges in the measurement window. Only Muskegon, at 0.836, is lower in the system; Waterloo at 0.885 and Hartford at 0.889 are close behind. The care inside those buildings, and the thirty days after it, already hold.

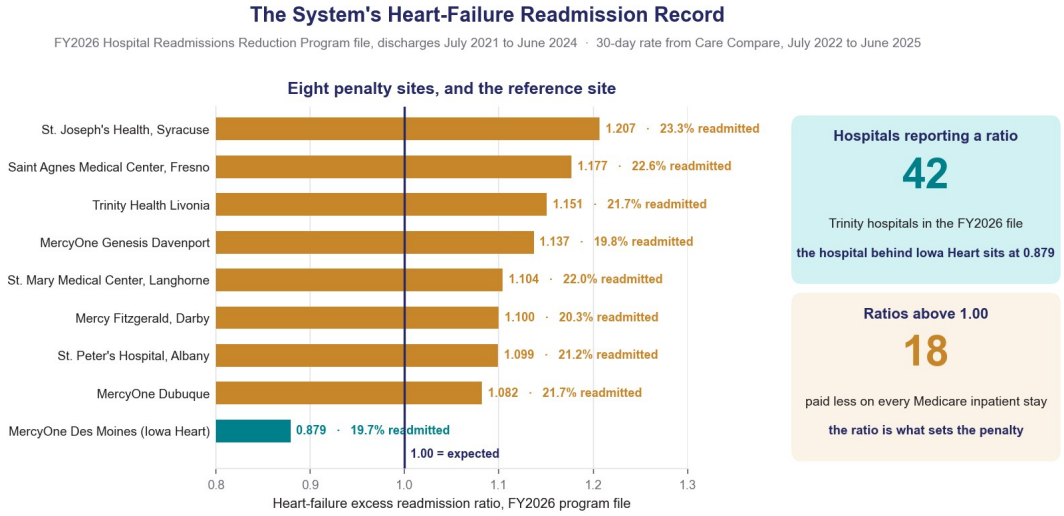

Figure 2. FY2026 heart-failure excess readmission ratios for the eight Trinity hospitals furthest above 1.00, and for the hospital behind the Iowa Heart program. The 30-day readmission rate is the Care Compare unplanned-visit measure for July 2022 through June 2025.

3.2 Eighteen ratios above 1.00

Hospital	Provider number	HF excess readmission ratio	HF 30-day readmission rate
St. Joseph's Health, Syracuse	330140	1.207	23.3%
Saint Agnes Medical Center, Fresno	050093	1.177	22.6%
Trinity Health Livonia	230002	1.151	21.7%
MercyOne Genesis Davenport	160033	1.137	19.8%
St. Mary Medical Center, Langhorne	390258	1.104	22.0%
Mercy Fitzgerald, Darby	390156	1.100	20.3%
St. Peter's Hospital, Albany	330057	1.099	21.2%
MercyOne Dubuque	160069	1.082	21.7%

[16] See note 3. MercyOne Des Moines, provider number 160083: heart-failure excess readmission ratio 0.8793 on 731 eligible discharges. Trinity Health Muskegon 0.8356; MercyOne Waterloo 0.8853; Saint Francis Hartford 0.8887.

Hospital	Provider number	HF excess readmission ratio	HF 30-day readmission rate
MercyOne Des Moines (Iowa Heart)	160083	0.879	19.7%

Eighteen of the 42 Trinity hospitals that report the measure sit above 1.00, and ten more sit between 1.00 and 1.07 behind the eight in the table.[17] The pattern is not regional. Syracuse, Fresno, Livonia, Davenport, Langhorne, Darby, Albany and Dubuque are eight hospitals in seven regions and six states, and the highest-volume heart-failure hospitals in the system, Ann Arbor at 1,113 discharges and Fresno at 916, sit on either side of the line. The penalty percentages that attach to each ratio are in the FY2026 supplemental file, which this pass did not pull; the ratio is what sets them, and a ratio that moves under 1.00 removes them.

Why the ratio is the right target

The measurement window for the next program year is running now, and it runs on three years of discharges. A change made in the first quarter of a service line shows up in the ratio for three consecutive program years.

At the eight hospitals in the table the reduction applies to every Medicare inpatient payment, not to heart-failure payments alone. The lever is narrow; what it moves is wide.

Three of the eight, Albany, Davenport and Dubuque, are also the hospitals where a specialty-model listing, an Enhanced-track ACO or a mandatory episode obligation already prices the same thirty days a second time.

4. The Service Line

4.1 Transitional care, then remote monitoring, then principal care

The service line is one operating engine with two clinical arms, and the heart-failure arm is the one this document prices. It follows the patient in the order the codes do: a transitional care contact at discharge, remote physiologic monitoring from the first week, and principal care management for the single dominant condition once the patient is stable enough to manage rather than watch. Patients enter two ways: at the cardiology office visit, where the referring cardiologists and CoachCare's on-site enrollment specialist flag eligible patients, and by post-discharge outreach after a heart-failure discharge.

Step	Program	Population	What it is for
At discharge	Transitional care management, 99495 and 99496	Every qualifying cardiac discharge from the 48 acute hospitals	The contact inside two business days and the visit inside seven or fourteen that opens the thirty-day window. Described and priced in Section 7; not in the forecast.
From the first week	Remote physiologic monitoring: 99453 at setup, 99454 or 99445 for the device, 99457, 99458 or 99470 for management	The heart-failure cohort in Section 1.4: post-discharge outreach after a heart-failure discharge, plus the ambulatory heart-failure panels that never admit, referred at the office visit	Daily weight, blood pressure and heart rate with a triage protocol behind them. This is the Iowa Heart recipe, and it is the larger of the two forecast programs.

[17] See note 3. The ten hospitals between 1.00 and 1.07 are Holy Cross Germantown 1.0687, MacNeal 1.0609, Saint Joseph Mishawaka 1.0549, St. Mary's Sacred Heart 1.0536, Loyola Gottlieb 1.0499, St. Mary's Athens 1.0329, Saint Alphonsus Ontario 1.0146, Johnson Memorial 1.0106 and Saint Mary's Waterbury 1.0029, plus the Springfield hospital under sale agreement at 1.0250. Heart-failure volume in the window: Ann Arbor 1,113, Fresno 916, Hartford 839, Albany 803. The 30-day rate is Care Compare READM_30_HF, Unplanned Hospital Visits, 1 July 2022 to 30 June 2025. Readmission-program penalty percentages are in the FY2026 supplemental file, not pulled this pass.

Step	Program	Population	What it is for
Once stable	Principal care management, 99426 and 99427	Patients with heart failure as the single dominant condition, managed for three months or more	The monthly clinical contact, medication reconciliation and care-plan work that closes guideline-therapy gaps. The second forecast program; it reaches its ceiling at month 19.

Transitional care management is the clinical entry point and the hinge into the longitudinal programs. It is priced in Section 7 so the reader can see what a cardiac discharge is worth at the Michigan locality, and it sits outside the financial model in Section 8, which forecasts remote physiologic monitoring and principal care management only. Chronic care management is off in the model. Advanced primary care management is off, and carries no revenue anywhere in this report.

4.2 The engine, and the post-discharge cadence

The engine is enrollment, connected devices, twenty-four-hour alert triage, a documented monthly clinical contact, the documentation each code requires, and claim capture. Enrollment runs on two channels at once: office-based referral at the cardiology visit, worked by the referring cardiologists and the on-site enrollment specialist, and post-discharge outreach from the heart-failure discharge list. It is built once and amortized across every region and, later, every service line. That is the economic case for running it centrally rather than staffing it fifteen times, and it is why the Epic calendar in Section 5 matters more than any regional preference.

Any hospitalization or emergency department visit in the previous sixty days triggers a fixed three-touch cadence: a contact on days 1 to 2, a second on days 5 to 8 and a third on days 12 to 14. Each one carries medication reconciliation, a structured symptom check, confirmation of the follow-up appointment and a device reading taken inside a window that bills, and each one documents and escalates clinical alerts under the same protocol.[18] That cadence is the operating mechanism behind the 352 avoided hospitalizations in the forecast, and it is aimed at the ratios in Section 3 rather than at a general engagement target.

The short-window codes are what make the first month work. A thirty-day transitional window rarely produces the sixteen device-days the standard supply code requires. Under the older codes alone that month was unbillable. Codes 99445 and 99470, new for CY2026, pay for two to fifteen device-days and for ten to twenty minutes of management, which is exactly the pattern a post-discharge patient produces.

[18] CoachCare Care Management Programs Standard Operating Procedures, version March 2026, process map 06, Post-Discharge Follow-Up Sequence, section 7.6.1.

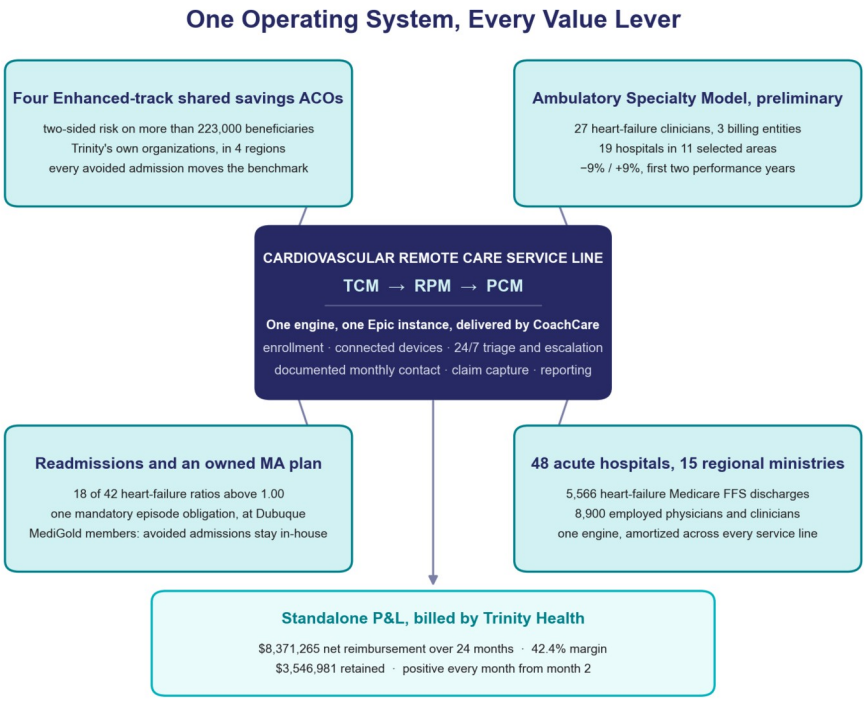

Figure 3. The same enrollment, device, triage, documentation and billing engine carries the standalone service-line P&L and each of the verified payment programs in Section 6.

4.3 The second arm: employed primary care, COPD and kidney disease

The second arm is named here and carries no revenue in this forecast. Trinity's employed primary-care network manages 2.3 million patients, and four of its accountable care organizations are on a two-sided track, which is the participation that makes advanced primary care management billable. Chronic care management and advanced primary care management on that panel are the primary-care arm of the same engine. The nearer wave sits inside cardiology itself: the 4,382 heart-attack and arrhythmia discharges in Section 1.4 run on the same two programs, the same devices and the same discharge outreach, and they are explicitly outside this forecast. The COPD, kidney disease and endocrine discharge cohorts in Section 1.4, together about 8,600 fee-for-service discharges a year before the Medicare Advantage gross-up, run on remote monitoring and principal care management exactly as the heart-failure cohort does, and they are the scale path once the heart-failure line is running.

One coordination rule the two arms share

Principal care management and chronic care management are mutually exclusive for the same patient in the same calendar month, and advanced primary care management cannot be billed with any of them. Remote physiologic monitoring stacks with all of them.

The attribution policy is set once. Primary care owns the longitudinal wrapper through chronic or advanced primary care management; cardiology owns the transitional contact at discharge and the device layer; one shared care plan sits in the Epic record. A patient handed between the two arms keeps the same care manager, the same thresholds and the same escalation contact.

4.4 Clinical governance and escalation

The economics prove the service line pays. Governance is what proves it is safe to run in fifteen regions at once. Every reading a patient takes routes through one escalation engine, and only signal reaches the clinical team.[19]

Tier	Trigger	What happens
Emergency	Active emergent symptoms reported during outreach: chest pain, new shortness of breath, stroke signs, syncope	CoachCare calls 911 with the patient still on the line. If the patient refuses, the case routes to the clinic. If the patient cannot be reached, 911 is activated anyway. CoachCare's urgent and emergent policy supersedes any client-specific preference.
Critical values	A critical reading, with or without symptoms	Escalates regardless of symptoms. If the patient is unreachable, CoachCare leaves a voicemail, sets a callback and escalates anyway.
Non-critical	An out-of-range reading	The reading is retaken with a symptom check first. A confirmed trend, three readings at least an hour apart for blood pressure or glucose, or three inside seven days for heart rate, routes to the practice team member named for that cohort.
Stable and resolved	In-range readings and resolved trends	Documented in the record as information. No page, no call, no interruption. The clinician sees the trend at the next visit.

What Trinity Health sets, and what CoachCare runs

Trinity Health sets: the alert thresholds by cohort, the escalation pathway and on-call routing in each region, the enrollment criteria, and the clinical protocols the care team works to. The responsible clinician makes every clinical decision.

CoachCare runs: enrollment and consent, device fulfillment and logistics, twenty-four-hour monitoring and triage, the documented monthly clinical contact, the documentation that supports each claim, the discharge decision flow, and the reporting back to each region.

Discharge is governed too. Unreachable patients follow a program-specific escalation timeline, the clinic is notified in every case, and a recommended discharge is re-escalated every thirty days before it proceeds.

5. The Epic Integration

Trinity is finishing one Epic instance for the whole system, and the program runs inside it rather than beside it. Clinicians in fifteen regions do not learn a second system, the revenue cycle does not gain a manual step, and the integration is built once. Enrollment flags and trigger orders sit in the existing workflow, readings land in the chart as discrete vitals, and the claim is generated automatically.

Integration pillar	What it does in the record
Integrated enrollment	Enrollment flags and trigger ordering sit inside the clinical workflow. CoachCare enrols qualified Medicare patients on Trinity's behalf, and enrollment status is visible in Epic in real time rather than in a report someone has to request.
Exchange of health history	Bi-directional at intake, so the care team starts from what is already in the chart instead of from a phone call.
Integrated discrete vitals	**Device readings land in the chart as discrete vitals, not as scanned documents and not in a separate portal. That is the difference between a weight series a cardiologist can trend and an attachment nobody opens.**

[19] Same source as note 18: process map 04, Clinical Alert and Escalation Decision Logic, sections 4.7 to 4.10; process map 05, Emergent and Urgent Communication Protocol, section 5; process map 07, Patient Discharge Decision Flow, section 11.

Integration pillar	What it does in the record
Compliance documentation and integrated care summary	The care summary and time documentation each code requires are written into the record as the work happens, which is what makes the claim defensible on audit.
Automated claim generation	**CoachCare is the only care-management application integrated with Epic that creates claims automatically. That removes one manual step per patient per month. At 3,953 patients it is the difference between a program that bills and one that leaks.**

Two consequences carry into the ramp in Section 8. Patients begin receiving monitoring and care-management services in under five days from the enrollment flag, which is why the census climbs as steeply as it does through the first year. And because claim construction is automatic, the 153,809 claims in Section 8.5 never reach a billing desk as manual work. One sequencing fact decides the rollout: a region joins the service line when its Epic wave is live, and the last waves are expected to complete by the end of 2026. Iowa and Michigan are live or scheduled first, which is one of three reasons they open the rollout in Section 9.

6. The Payment Programs

6.1 Four Enhanced-track shared savings organizations

Four Trinity accountable care organizations participate in the Medicare Shared Savings Program on the ENHANCED track in performance year 2026, verified in the live CMS organizations file.[20] Enhanced is the highest-risk track in the program: two-sided, with shared losses as well as shared savings on the attributed population. Trinity's own statement puts the beneficiaries across its shared savings organizations at more than 223,000.[21]

ACO	Service area	Track	Agreement
Trinity Health Integrated Care (A3454)	DE, ID, IL, IN, MI, NY, OH, PA	ENHANCED, high revenue	Third period; current agreement from 1 January 2025
Trinity Health Of New England CIN (A5419)	CT, MA	ENHANCED, high revenue	Third period; agreement from 1 January 2024
MercyOne ACO III (A3380)	IA	ENHANCED, high revenue	Third period; current agreement from 1 January 2025
Genesis ACO (A4799)	IA, IL, WI	ENHANCED, high revenue	Third period; current agreement from 1 January 2022

This is the strongest economic layer in the document, and it is the one the Iowa Heart evaluation speaks to directly. Every avoided admission, observation stay and emergency return on an attributed patient lands on the benchmark of one of these four organizations, and all four are Trinity's own, so the economic buyer for the shared-savings argument and the operational owner of the service line sit inside the same system. The assigned beneficiary count for each organization is not in the CMS organizations file and is

[20] CMS Medicare Shared Savings Program PY2026 organizations file, dataset 9767cb68-8ea9-4f0b-8179-9431abc89f11, retrieved 9 September 2026. A3454 Trinity Health Integrated Care; A5419 Trinity Health Of New England CIN LLC; A3380 MercyOne ACO III; A4799 Genesis Accountable Care Organization LLC. All four ENHANCED track, high revenue, third agreement period. Assigned beneficiaries are not carried in this file.

[21] Trinity Health press release on its Medicare ACO results, eighth year of savings: more than 223,000 beneficiaries across its shared savings organizations; 17 clinically integrated networks accountable for about 2 million lives in alternative payment models.

an item in Section 12. For context, Trinity is absent from the performance year 2026 ACO REACH participant list, and that model ends on 31 December 2026 regardless.[22]

6.2 What an avoided heart-failure admission is worth under shared savings

The Shared Savings Program reconciles total cost of care for each organization's assigned beneficiaries against a benchmark once a year. Heart failure is the largest single driver of avoidable inpatient spend in a Medicare population, and the cost sits in the thirty days after a discharge: the readmission, the observation stay, the emergency visit. A heart-failure admission that does not happen is fee-for-service margin for the service line and, for an assigned beneficiary, a dollar that stays under the organization's benchmark. The same program writes to both ledgers. On the Enhanced track the organization keeps up to 75% of savings under benchmark, and carries losses when admissions go the other way.[23]

Figure	Value	What it is
Hospitalizations avoided in the forecast	352	Over 24 months on the enrolled heart-failure cohort, at the model's generic 20% annual admission rate.
Acute-care spend that does not occur	$5,281,249	352 avoided admissions at $15,000 each, before any shared-savings split.
Avoided admissions at a 40% annual admission rate	704	Twice the forecast count. A post-discharge heart-failure cohort runs closer to this rate; the Iowa Heart panel readmitted 18% inside 30 days before the program.
Enhanced-track share of savings under benchmark	Up to 75%	The share the organization keeps, and the share of losses it carries.

No shared-savings dollars are claimed in this document, and none are in the Value Analysis in Section 8, which is priced on the fee-for-service codes alone. Two numbers decide what the layer is worth and neither is public: the share of enrolled heart-failure patients who are assigned beneficiaries of one of the four organizations, and where each organization sits against its benchmark. Those are the first two figures to put beside the forecast in the working session, and both are in Section 12. On MediGold's own members the arithmetic is simpler still: an avoided admission is medical cost the system keeps outright, with no benchmark and no split.

6.3 The Ambulatory Specialty Model, preliminary, in three regions

The Ambulatory Specialty Model applies to selected specialists in selected geographies and adjusts their Medicare physician fee schedule payment on measured heart-failure quality and cost. Nineteen Trinity hospitals sit in eleven selected areas.[24] With the geography open, the verdict turns on the live CMS participant file. In the heart-failure cohort, 27 clinicians under three Trinity billing entities are named on the CMS preliminary participant list for the Ambulatory Specialty Model.[25]

[22] CMS ACO REACH performance year 2026 participant list, 74 organizations, retrieved 9 September 2026. No Trinity, MercyOne, Loyola, Mount Carmel, Saint Alphonsus, Holy Cross or St. Peter's entity appears. The model ends 31 December 2026.

[23] CMS Ambulatory Specialty Model mandatory geographic areas file, 235 selected areas on OMB 2023 codes, retrieved 9 September 2026. Selected areas holding a Trinity hospital: Warren-Troy-Farmington Hills division, Waterloo-Cedar Falls, Davenport-Moline-Rock Island, Boise City, Fresno, Albany-Schenectady-Troy, Syracuse, Hartford, Wilmington division, Fort Lauderdale division, Athens-Clarke County. Des Moines-West Des Moines, Ann Arbor, Detroit-Dearborn-Livonia division, Grand Rapids, Chicago division, Columbus and Dubuque are not selected.

[24] CMS Ambulatory Specialty Model participants dataset 175d576d-0568-4ac2-aec5-d77f3ee02205, file CY27_Prelim_ASMParticipants_Public.csv, posted January 2026, retrieved 9 September 2026: 6,637 rows, of which 2,610 are the Heart Failure cohort. Matched on organization legal name across all states. St. Peter's Health Partners Medical Associates, P.C. 17; Trinity Health Of New England Provider Network Organization Inc 8; Saint Alphonsus Regional Medical Center Inc 2. No MercyOne, Iowa Heart, Trinity Health Michigan, Genesis, Saint Agnes, Holy Cross or Mid-Atlantic entity appears in the cohort.

[25] CMS Transforming Episode Accountability Model participant list, as of 15 April 2026, retrieved 9 September 2026: 720 hospitals, 710 mandatory and 10 voluntary, across 189 distinct core-based statistical areas. MercyOne Dubuque Medical Center, provider number 160069, CBSA 20220, mandatory, 1 January 2026 to 31 December 2030. No other Trinity provider number appears. A similarly named Ohio hospital on the list belongs to a different health system.

Billing entity on the CMS file	Heart-failure clinicians	Region
St. Peter's Health Partners Medical Associates, P.C.	17	St. Peter's Health Partners, Albany
Trinity Health Of New England Provider Network Organization Inc	8	Trinity Health Of New England, Hartford
Saint Alphonsus Regional Medical Center Inc	2	Saint Alphonsus, Boise
Total named on the preliminary list	27	Three regions

What is verified	Detail
Cohort	Heart failure
Payment adjustment	−9% to +9% for the first two performance years, widening to −12% to +12%
Timing	Performance year 1 is CY2027, paid in payment year 2029
List status	Preliminary. CMS will publish a final CY2027 list, and every verdict here re-runs against it
Outside the model	MercyOne Iowa Heart Center. Des Moines is not a selected area and no MercyOne entity is on the file

The dollar exposure on 27 clinicians does not carry a system this size, and it is not the argument. What the listing tells you is what CMS has decided to measure and when: consented longitudinal management, documented monthly contact and continuous physiologic data on a heart-failure population, from 1 January 2027, with the first adjustment landing in 2029. The quality and cost measures the model scores are the outputs of the program in Section 4. Albany, Hartford and Boise are also three of the regions with a ratio above 1.00 in Section 3 or a hospital in a selected area, which is why the second rollout wave in Section 9 is theirs.

6.4 One mandatory episode obligation, at Dubuque

MercyOne Dubuque Medical Center, provider number 160069, is a mandatory participant in the Transforming Episode Accountability Model from 1 January 2026 through 31 December 2030. No other Trinity hospital appears on the participant list; the ten critical access hospitals are outside the model by category, and the two Maryland hospitals are excluded under that state's all-payer arrangement.[26] Heart failure is not an episode in that model. Coronary artery bypass grafting is. At Dubuque, the post-discharge cadence in Section 4.2 sits inside a thirty-day episode that CMS reconciles against a target price, so the same three touches that move the heart-failure ratio also move a bypass episode's cost. That is the whole of the episode story in this document; no system-wide episode economics appear anywhere in it.

6.5 An owned Medicare Advantage plan

MediGold is Trinity's own Medicare Advantage plan, operating in Connecticut, Idaho, Iowa, Michigan, New York and Ohio, with the Michigan product launched for 2026.[27] On the plan's own members, an avoided admission is not a fee-schedule question at all: it is medical cost the system keeps. Premium and capitation revenue is the fastest-growing line in Trinity's results, and a service line that lowers admissions on the plan's own heart-failure members improves that line directly. It also changes the Medicare Advantage contracting question in Section 1.5, because for six states part of the counterparty is Trinity itself. Hospital-at-home participation could not be confirmed from public sources and is listed in Section 12 as not confirmed.

[26] See note 13.

[27] CMS Medicare Physician Fee Schedule, CY2026, non-facility amounts for MAC locality 08202-01, Wisconsin Physicians Service J8, Michigan locality 01, resolved from ZIP 48152 through the CY2026 ZIP-to-locality crosswalk; conversion factor $33.4009. Transitional care and physician principal-care rates computed from the CY2026 RVU file at the same locality.

7. The CY2026 Billing Stack at the Michigan Locality

Every rate below is the CY2026 non-facility physician fee schedule amount at Trinity's headquarters Medicare Administrative Contractor locality, 08202-01, Michigan locality 01, resolved from ZIP 48152.[28] The forecast is priced there. Each region bills at its own locality, so the actual rate in Fresno, Hartford or Boise differs from the figure below by that locality's geographic adjustment; the rollout table in Section 9 carries each region's Medicare Advantage range, and the per-region rate spread sits in the companion Disclosures document.

Code	What it pays for	CY2026 rate	Where it fires
99495	Transitional care management, moderate complexity	$220.23	Once per discharge. Described in Section 4; not in the forecast.
99496	Transitional care management, high complexity	$298.36	Once per discharge. Not in the forecast.
99453	Remote monitoring setup and patient education	$21.43	Once, at enrollment
99454	Device supply and transmission, 16 to 30 days	$50.52	Monthly, at steady state
99445	Device supply and transmission, 2 to 15 days	$50.52	New for CY2026. The post-discharge month, and any month a patient steps down.
99457	Treatment management, first 20 minutes	$51.64	Monthly
99458	Treatment management, each additional 20 minutes	$41.64	Monthly, higher-touch patients
99470	Treatment management, 10 to 20 minutes	$25.98	New for CY2026. Shorter months, and step-down patients.
99426	Principal care management, clinical staff, first 30 minutes	$68.29	Monthly, single dominant condition
99427	Principal care management, clinical staff, each additional 30 minutes	$54.25	Monthly
99424	Principal care management, physician, first 30 minutes	$88.79	Where the cardiologist delivers the service directly
99425	Principal care management, physician, each additional 30 minutes	$62.16	As above

Three rules that decide what this stack actually earns

Principal care management and chronic care management are mutually exclusive for the same patient in the same calendar month. The forecast models principal care management on the heart-failure cohort, where heart failure is the single dominant condition, so it does not collide with a primary-care chronic care management panel.

Advanced primary care management is the primary-care arm's code family, billable where a two-sided ACO participation exists, which Trinity has in four regions. It carries no revenue in this forecast and appears in no financial figure here.

Medicare Advantage sets a floor. At 52.3% discharge-weighted penetration, about half of the panel's reimbursement is contract-dependent. Plans must pay at least the Medicare rate for these code families; each contract sets its own terms above it, and for the six MediGold states part of that counterparty is Trinity.

[28] CMS-1848-P, CY2027 Physician Fee Schedule proposed rule, Federal Register, with the proposed RVU and conversion-factor files, repriced at MAC locality 08202-01 against the forecast's own code frequencies. Comment period closes 14 September 2026.

8. The Value Analysis

8.1 Model inputs

The forecast models remote physiologic monitoring and principal care management on heart-failure patients only, sized from the heart-failure discharges of the 48 acute hospitals and billed by Trinity Health at the Michigan locality. Patients enter through office-based referral at the cardiology visit and through post-discharge outreach after a heart-failure discharge. Chronic care management is off in the model. Advanced primary care management is off and carries no revenue anywhere in this report. Transitional care management is described and priced but not forecast.

Input	Value	Basis
Year-1 in-scope Medicare heart-failure patients	11,661	5,566 heart-failure discharges, MS-DRG 291 to 293, in CY2024, grossed for the 52.3% Medicare Advantage share. The credible range is 9,000 to 15,000 and the model sits inside it.
Total Medicare panel	170,400	81,283 Medicare fee-for-service discharges, grossed the same way.
Referring cardiologists	295	Cardiologists across the regional groups in Section 1.2 who refer into the service line at the office visit. The second enrollment channel, post-discharge outreach after a heart-failure discharge, runs from the hospital discharge list.
Programs modeled	Remote physiologic monitoring and principal care management	Chronic care management off. Advanced primary care management off.
Eligibility and acceptance	Eligibility: remote monitoring 75% · principal care management 85%. Acceptance: 35% and 30% of eligible patients.	Eligibility is applied to the in-scope population rather than to the whole panel: 8,746 eligible for remote monitoring, 9,912 for principal care management.
Enrollment support	One on-site enrollment specialist	Recruited, employed and paid by CoachCare; works the cardiology clinics alongside the referring cardiologists.
Program ceilings	Remote monitoring 3,061 · principal care management 2,974	The maximum enrolled census each program reaches against this panel. Both are reached inside the window: month 13 and month 19.
Locality, payer mix and record system	MAC locality 08202-01 · 52.3% Medicare Advantage · Epic	Michigan locality 01, resolved from ZIP 48152. Each region bills at its own locality. Epic single instance completing in 2026.

8.2 The twenty-four-month forecast

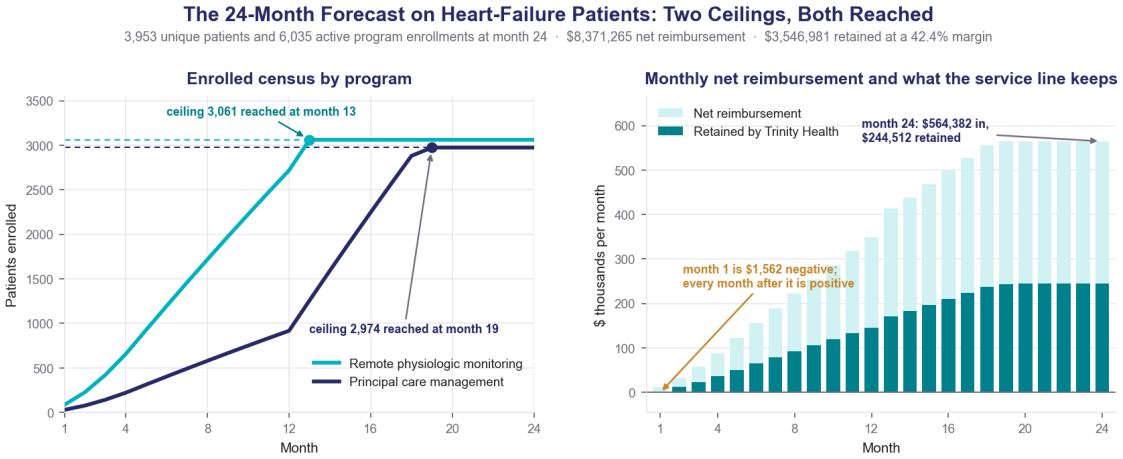

Figure 4. Enrolled census against program ceilings, and monthly net reimbursement against the share Trinity Health keeps. Month 1 is $1,562 negative as implementation and Epic integration setup post against a still-ramping census; every month after it is positive.

Modeled result	Year 1	Year 2	24 months
Net reimbursement to Trinity Health	$2,084,384	$6,286,881	$8,371,265
CoachCare fees	$1,225,132	$3,599,151	$4,824,283
Retained by Trinity Health	$859,251	$2,687,730	$3,546,981
Retained margin	41.2%	42.8%	42.4%
Unique patients in active remote care	2,993 at month 12	3,953 at month 24	3,953 at month 24
Active program enrollments	3,634 at month 12	6,035 at month 24	6,035 at month 24
Hospitalizations avoided			352
Claims generated			153,809
Device readings received			554,531
Care-team hours delivered			75,135

The margin, and how it is defined

Retained margin is 24-month service-line net divided by 24-month net reimbursement: $3,546,981 ÷ $8,371,265 = 42.4%. Year 1 runs at 41.2% because implementation and Epic integration setup post in the first month. Year 2 runs at 42.8%.

Month 1 is $1,562 negative. Implementation and integration setup post against a census that is still ramping, so the first month does not clear. Every month from month 2 forward is positive, and by month 24 the service line takes in $564,382 and keeps $244,512 of it.

The on-site enrollment specialist, the care managers, the devices and the logistics are CoachCare's expense. They sit on CoachCare's side of the model, embedded in the fee, and are never deducted from the margin shown.

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month retained
Remote physiologic monitoring	$1,588,574	$3,514,406	$5,102,980	$2,922,379	$2,180,601
Principal care management	$495,809	$2,772,475	$3,268,284	$1,723,789	$1,544,495
Shared program infrastructure				$178,115	−$178,115
Total	$2,084,384	$6,286,881	$8,371,265	$4,824,283	$3,546,981

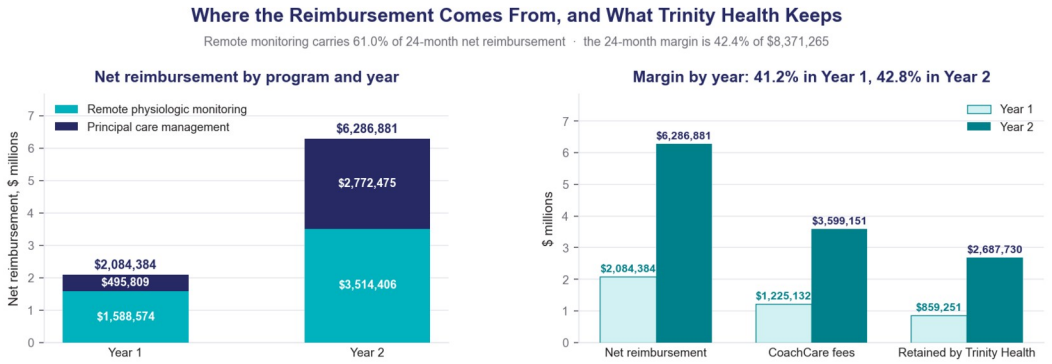

Figure 5. Net reimbursement by program and by year, and the year-by-year margin. Remote monitoring carries 61.0% of the 24-month total.

8.3 Two ceilings, both reached inside the window

Both programs are ceiling-limited. Remote physiologic monitoring fills to 3,061 enrolled patients by month 13 and holds. Principal care management fills to 2,974 by month 19 and holds, standing at 2,974 at month 24. From those months the binding constraint on the forecast is the size of the heart-failure cohort, not the pace of onboarding, and the only lever that moves the 24-month figure is the in-scope population.

That is why counting the cohort against chart data region by region is the first item in Section 12: the credible range of 9,000 to 15,000 is wide, the model sits inside it, and every patient the chart count adds raises both ceilings together. Enrollment capacity matters in Year 1, while the census is still building, and a second on-site enrollment specialist cannot raise either ceiling but reaches both sooner, and the extra patient-months in between are real revenue. The heart-attack and arrhythmia discharges in Section 1.4 are the next wave on the same engine and are outside this forecast.

The unique-patient count and the enrollment count are different numbers and both are true. At month 24 there are 6,035 active program enrollments across 3,953 unique patients, because a patient carrying both remote monitoring and principal care management in the same month counts once as a person and twice as an enrollment. The ramp to that point runs about 1,316 unique patients at month 6, 2,993 at month 12 and about 3,925 at month 18.

8.4 Capacity as a staffing plan

The ramp is built to what a care team can onboard responsibly rather than to what the panel would allow. Net-new enrollment peaks at about 281 remote-monitoring and 95 principal-care enrollments a month in Year 1, and at about 384 and 354 a month in Year 2 once the second wave of regions is live. That is what holds the month-12 unique census at 2,993 and keeps enrollment quality ahead of enrollment volume. By months 13 and 19 the ceilings, not the pace, are what hold the census.

Read as a staffing plan, at the documented caseload of 165 patients per care manager the enrolled population needs roughly 18 care managers at the end of Year 1 and roughly 24 at the end of Year 2,

spread across the regions in proportion to their census. Every one of those posts is CoachCare's to fill, and none of them is a Trinity requisition. The service line is delivered, not licensed.

8.5 Clinical and operational output

Output over 24 months	Volume	What it represents
Hospitalizations avoided	352	Admissions prevented across the enrolled cohort. This is the line that carries into the four shared-savings benchmarks, the readmission ratios and MediGold's medical cost.
Device readings received and reviewed	554,531	About 140 readings for every unique patient enrolled, each one a chance to intervene before an admission.
Claims generated	153,809	Produced, documented and submitted automatically under each region's own billing identifiers.
Care-team hours delivered	75,135, about 36 FTE-equivalent	Clinical labor delivered rather than recruited. At the documented 165-patient caseload the steady-state program is staffed entirely by CoachCare.
Care-management tasks and patient conversations	307,618 tasks · 46,143 conversations	Documented care-plan work, of which 76,904 are chart updates written back into Epic, plus 2,563 hours of call time carrying the monthly contact each code requires and the post-discharge cadence in Section 4.2.

The 75,135 hours is the figure worth dwelling on. It is about 36 full-time equivalents of clinical work delivered into a system whose stated strategy is asset-light growth, without a single requisition.

9. The Rollout

Fifteen regions do not start at once, and the order is decided by three facts that are already known: where the program is running, where a payment program prices the same thirty days a second time, and where the readmission ratio is highest. The Epic wave calendar in Section 5 is the gate on each.

Wave	Regions	Why these, and why now	County MA range
1. Extend the proof	MercyOne Iowa, including Genesis; Trinity Health Michigan	Iowa Heart is live on CoachCare; the expansion is its remaining heart-failure population and the heart-failure discharges of the Iowa hospitals, with Davenport at 1.137 and Dubuque at 1.082 among them. Michigan is the headquarters locality, the largest heart-failure volume in the system at 1,221 discharges, and holds Livonia at 1.151.	28% to 61%; 56% to 76%
2. The specialty-model regions	St. Peter's Health Partners; Trinity Health Of New England; Saint Alphonsus	The three billing entities named on the preliminary specialty-model list, with performance year 1 opening on 1 January 2027. Albany carries a 1.099 ratio; Hartford at 0.889 is the model for the other two.	56% to 63%; not reported; 16% to 63%
3. The penalty sites	St. Joseph's Health, Syracuse; Saint Agnes, Fresno; Trinity Health Mid-Atlantic	The three highest ratios outside waves 1 and 2: Syracuse 1.207, Fresno 1.177, Langhorne 1.104 and Darby 1.100. The measurement window for the next program year is open now.	63%; 49%; 34% to 60%
4. The rest of the system	Loyola Medicine and Saint Joseph Health System; Mount Carmel; Holy Cross Health; St. Mary's Health Care System	The remaining 15 acute hospitals join the same engine as their Epic waves complete. Loyola's transplant panel and Mount Carmel's clinic-based heart-failure program are the two largest clinical opportunities in this wave.	45% to 58%; 56%; 23% to 65%; 44% to 60%

Wave	Regions	Why these, and why now	County MA range
5. The next waves	Heart-attack and arrhythmia discharges in every region; then the employed primary-care network and the COPD and kidney-disease cohorts	Heart attack and arrhythmia first, 4,382 discharges a year on the same two programs and the same discharge outreach. Then chronic and advanced primary care management on the primary-care panel, and remote monitoring with principal care management on the pulmonary and renal cohorts, on the engine the heart-failure line has already built. No revenue in this forecast from any of them.	As above

Heart failure is the right first cohort in every wave, on three independent grounds. It is the largest cardiovascular medical diagnosis group at almost every hospital in the system. It is the measure the readmission program scores and the one on which eighteen Trinity hospitals sit above 1.00. And it is the cohort the CY2027 specialty model scores in three regions. The Iowa Heart evaluation was run on exactly that cohort.

10. The CY2027 Proposed Rule

The CY2027 physician fee schedule proposed rule, CMS-1848-P, would change the payment for the remote monitoring device-supply codes. Repriced at the Michigan locality, the effect cascades in three steps: the device-supply codes 99454 and 99445 fall by 20.5%; because device supply is 31.6% of the remote-monitoring arm, that arm falls by 9.0%; and because remote monitoring is 61.0% of the service line, the service line's net reimbursement falls by 5.8% with the census unchanged. Principal care management is essentially untouched, moving by less than one percent.[29]

Code	CY2026 rate, locality 08202-01	CY2027 proposed, same locality
99453	$21.43	$19.57
99454	$50.52	$40.17
99445	$50.52	$40.17
99457	$51.64	$49.74
99458	$41.64	$40.87
99470	$25.98	$20.80
99426	$68.29	$67.22
99427	$54.25	$54.61

The conversion factor moves from $33.4009 to $32.8409 in the same rule. None of this is final. Comments on CMS-1848-P close on 14 September 2026, the final rule publishes in early November 2026, and it takes effect on 1 January 2027. The forecast in Section 8 is priced at CY2026 rates throughout; the CY2027 consequence for the margin is worked through in the companion Disclosures document, and the operating conclusion does not change: the management codes, the setup code and principal care management, which together carry most of the line, are not the codes the rule reprices.

[29] Medicare Shared Savings Program, 42 CFR 425.610: ENHANCED track final sharing rate up to 75 percent of savings below the updated benchmark, with shared losses. Avoided admissions are the Value Analysis figure at the model's 20% annual admission rate; the 40% figure is the same model run at twice that rate; $15,000 per admission is the planning value used on the companion microsite. No shared-savings amount is claimed or modeled anywhere in this report.

11. Implementation and Contracting

Phase	Weeks	Milestones
Design	Weeks 0 to 4	Name the service-line owner. Count the heart-failure cohort against chart data in the wave-1 regions. Agree cohort thresholds, the escalation pathway and on-call routing with each region's clinical leadership, and the billing identifiers and claim-review cadence with revenue cycle.
Build	Weeks 2 to 8	Epic integration on the single instance: enrollment flags, trigger ordering, discrete-vitals write-back, documentation templates, automated claim generation. On-site enrollment specialist recruited and placed in Iowa.
Launch	Weeks 6 to 12	Extend the Iowa Heart program to its remaining heart-failure population and to the heart-failure discharges of the Iowa hospitals; open Michigan on the same protocols. Office-based referral and post-discharge outreach start together. First claims out inside the first month of live operation.
Extend	Months 4 to 24	Waves 2 through 4 join as their Epic waves complete. Reporting shifts to the heart-failure ratio, the shared-savings benchmark and MediGold medical cost on the enrolled cohort against its own pre-enrollment baseline.

Three contracting facts are worth settling in the first working session. Fifteen regional ministries bill under their own identifiers and at their own Medicare localities, so one system agreement carries fifteen billing schedules rather than one, and the claims in this forecast go out under each region's own numbers. The clinicians with the preliminary specialty-model listing sit under three separate billing entities, so any design touching cardiology in Albany, Hartford or Boise has to work for each. And the Medicare Advantage treatment of remote monitoring and principal care management is a contract question in every region and a MediGold decision in six of them.

The timing is favorable. Trinity's fiscal year ends 30 June, so a program that generates its first claims inside the first month of live operation contributes revenue to FY2027 from the quarter it starts in, which is a different conversation from a capital request. The single Epic instance is expected to complete by the end of 2026. Performance year 1 of the specialty model opens on 1 January 2027. And the readmission measurement window for the next program year is running now. CoachCare's ask is a working session with the cardiovascular, population-health and revenue-cycle leads of the wave-1 regions to settle the items in Section 12 and agree the design.

12. Open Items for the First Call

Nine questions would sharpen the design. Each is a working-session item rather than something public data can settle.

Question	Why it matters
What is the chart count of the heart-failure cohort in each region, and how much of the Iowa Heart Center's heart-failure population is already enrolled?	The model uses 11,661 in scope against a credible range of 9,000 to 15,000, derived from suppressed CMS discharge cells, and both programs are ceiling-limited, so this is the single input that scales the whole forecast.
What share of the enrolled heart-failure patients are assigned beneficiaries of the four Enhanced-track organizations, how many beneficiaries does each carry, and where does each sit against its benchmark?	The CMS organizations file carries none of it; Trinity's own statement gives more than 223,000 beneficiaries across the four. The assigned share and the benchmark position are the first two numbers to put beside the forecast, and they size the layer in Section 6.2 region by region.
When CMS posts the final CY2027 specialty-model list, which of the 27 clinicians remain, and do the two other legal names on the preliminary file belong to Trinity employed groups?	The listing is preliminary. Two further legal names on the file were not counted because they could not be matched to Trinity entities from public records; confirming them by NPI would change the count and possibly the wave-2 regions.

Question	Why it matters
Did the Iowa Epic wave complete in May 2026, and what are the final-wave dates?	Every region joins the service line when its wave is live. Iowa opens the rollout, so its go-live status decides the launch date.
How do the Medicare Advantage contracts, and MediGold's own benefit design, treat remote monitoring, principal care management and transitional care management?	52.3% discharge-weighted penetration across the hospital counties, from 15.8% to 75.5%. Plans must pay at least the Medicare rate; each contract sets its own terms above it, and in six states Trinity is on both sides of the table.
What is the current Medicare Advantage penetration for the Connecticut hospitals?	Connecticut is absent from the July 2026 CMS file, so Hartford and Waterbury inherit the weighted average. The Hartford entity carries eight of the 27 specialty-model clinicians.
Does any Trinity hospital participate in the acute hospital care at home program?	Not confirmed from public sources. Absence from a retrievable file is not evidence of non-participation, and a hospital-at-home program would add a scoring surface the same enrolled population already serves.
What are the FY2026 readmission penalty percentages at the eighteen hospitals above 1.00?	The supplemental file that carries the percentage was not pulled this pass. The ratio is what sets it, and the ratio is in Section 3; the percentage converts it to dollars.
Who owns the cardiovascular service line across the system?	No system-level cardiovascular service-line executive is identified in public materials, and cardiology is organized regionally. Naming one owner shortens every decision that follows.

References & Data Sources

Every figure in this report traces to a CMS file, to a document Trinity Health has itself issued, or to CoachCare's own evaluation at MercyOne Iowa Heart Center; the numbered footnotes give the file, query and vintage for each. A companion Disclosures document holds the modeling assumptions and the per-region rate spread behind Section 8.

Source	Vintage
CMS Medicare Inpatient Hospitals by Provider and Service, queried by provider number	CY2024
CMS Hospital General Information; Hospital Readmissions Reduction Program hospital file; Care Compare Unplanned Hospital Visits	Retrieved 9 September 2026; FY2026, discharges 07/2021 to 06/2024; 07/2022 to 06/2025
CMS Ambulatory Specialty Model geography file and CY2027 preliminary participant list	OMB 2023 codes; posted January 2026
CMS Transforming Episode Accountability Model participant list; Medicare Shared Savings Program organizations file; ACO REACH participant list	As of 15 April 2026; PY2026
CMS State/County Medicare Advantage penetration; CMS Medicare Physician Fee Schedule, MAC locality 08202-01; CMS-1848-P proposed rule	July 2026; CY2026; CY2027 proposed
Trinity Health facts page, audited statements, quarterly management discussion, press releases and service pages	FY2025; FY2026 through 31 March 2026; 2023 to 2026
CoachCare six-month evaluation at MercyOne Iowa Heart Center; CoachCare Care Management SOP process maps	2026; version March 2026