

ALASKA HEART & VASCULAR INSTITUTE

Remote Care Deployment & Value Model

A three-lane strategy for heart failure and hypertension that optimizes FFS capture and ACO savings while setting the foundation for the FFS → VBC shift

\$8.07M

direct AHVI FFS net

\$834k

ACO TCoC savings

\$1.42M

Ambulatory Specialty Model upside

5,038 heart failure · 12,011 hypertension without HF

Modeled forecast — not a guarantee of reimbursement or clinical outcomes.

Prepared for AHVI leadership

CoachCare · September 2026

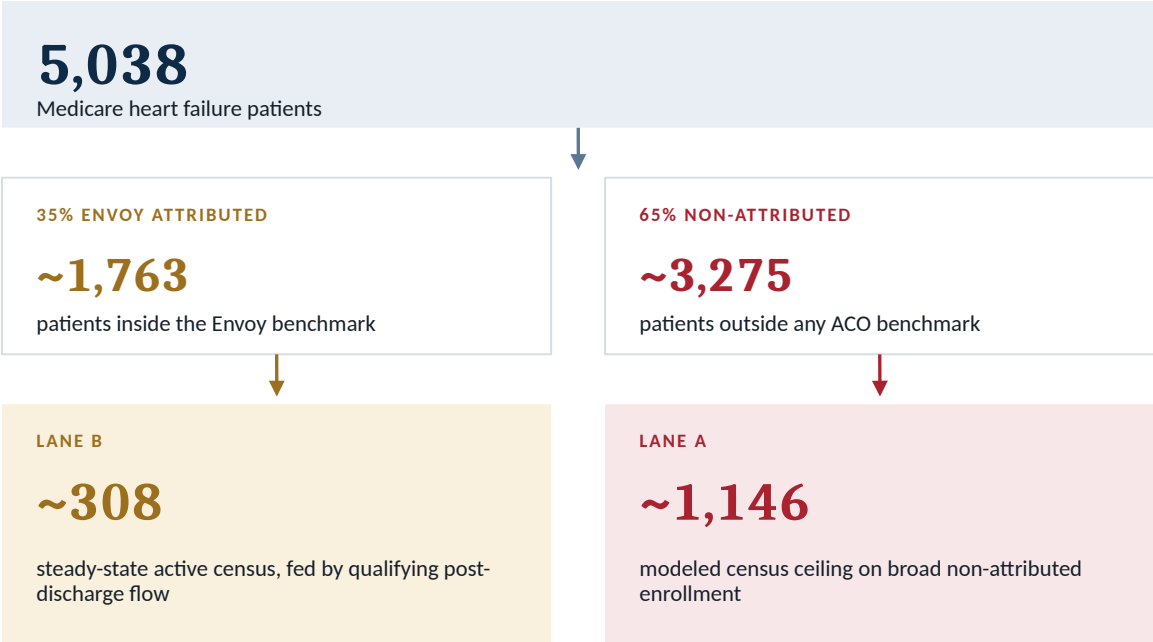
The optimal enrollment strategy changes materially depending on who bears the underlying economics

	LANE A Non-attributed HF	LANE B Attributed HF	LANE C Non-attributed HTN
Population	Non-attributed HF	Envoy-attributed HF	Non-attributed HTN without HF
Primary program	RPM + PCM	TCM + RPM + PCM	RPM + selective PCM
Enrollment trigger	Eligible HF patient	Qualifying acute discharge	Active HTN management need
Deployment posture	Broad	Selective	Broad
Primary beneficiary	AHVI	AHVI + Envoy	AHVI
Clinical objective	Longitudinal HF management	Reduce readmissions and ED utilization	Improve BP monitoring and longitudinal management
Key economic risk	Enrollment throughput / operating capacity	Care-management spend enters the ACO benchmark	Enrollment capacity + PCM eligibility and documentation

Broad enrollment makes sense where AHVI captures the economics directly; attributed beneficiaries require a higher clinical-value threshold.

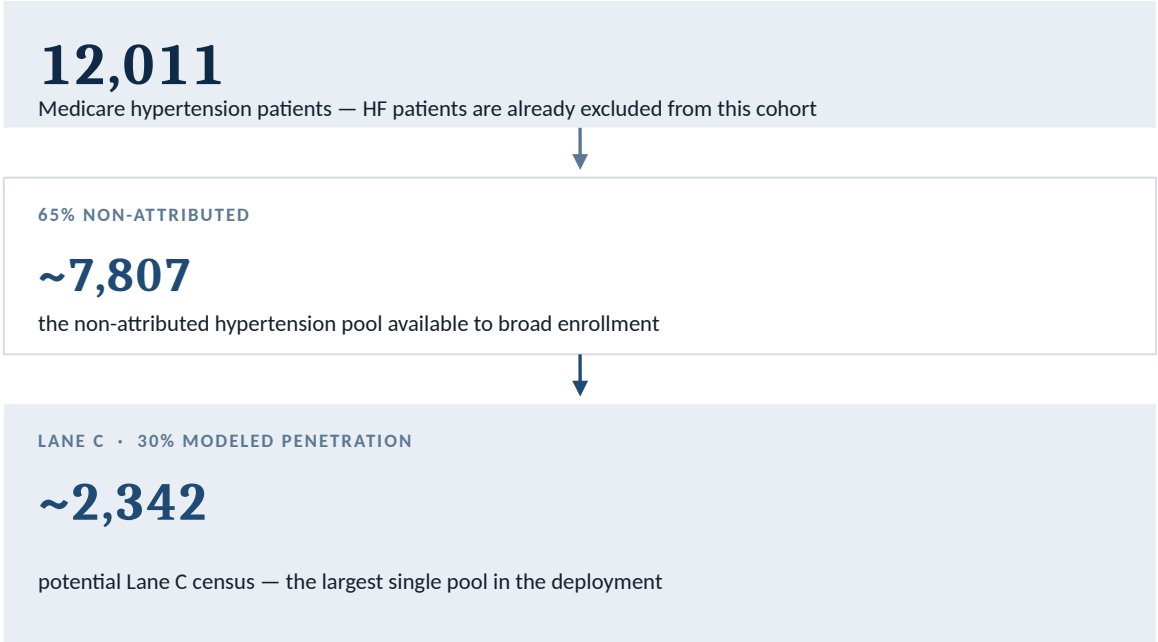
AHVI's addressable opportunity exceeds 17,000 HF and hypertension Medicare patients, but only selected cohorts should be enrolled

HEART FAILURE



Lane B is flow-based rather than panel-penetration based — the discharge is the enrollment gate.

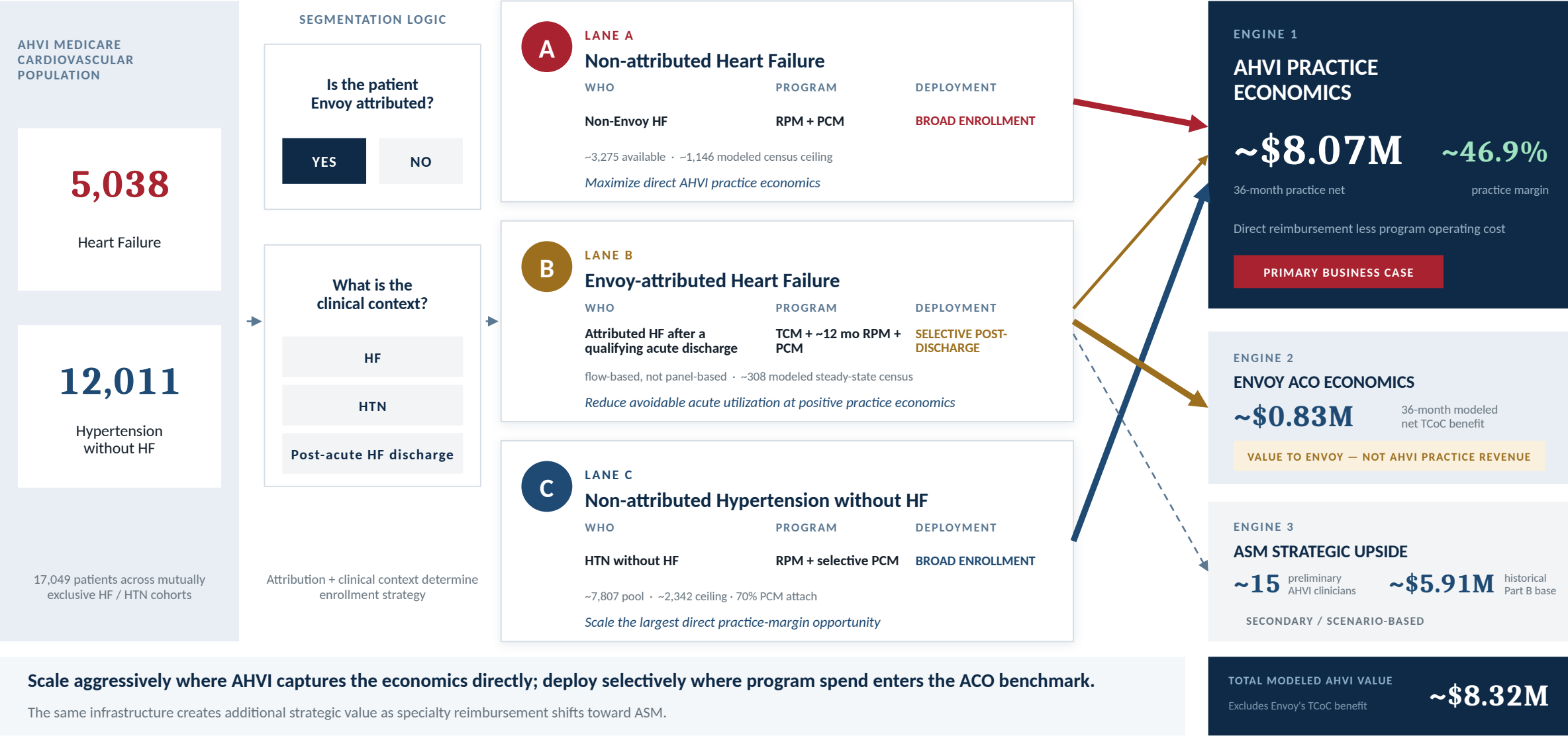
HYPERTENSION WITHOUT HEART FAILURE



70% PCM attach — applied only to the documented uncontrolled-hypertension slice, never the whole enrolled cohort.

AHVI has more addressable patient demand than the initial operating model can enroll within 36 months.

Three patient lanes connect AHVI's remote care deployment to three distinct value engines



A three-lane remote care strategy can create approximately \$8.32M of modeled AHVI value over 36 months

Patient segmentation allows AHVI to scale direct fee-for-service economics while selectively supporting value-based care performance



The deployment is self-funding from Month 1 while generating ~\$8.32M of AHVI value over 36 months

With implementation and integration waived, the model is purely variable-cost — expense scales alongside reimbursable events.

NO UPFRONT CAPITAL EXPOSURE

Implementation & setup	WAIVED
EHR integration setup	WAIVED
One-time cost to AHVI	\$0

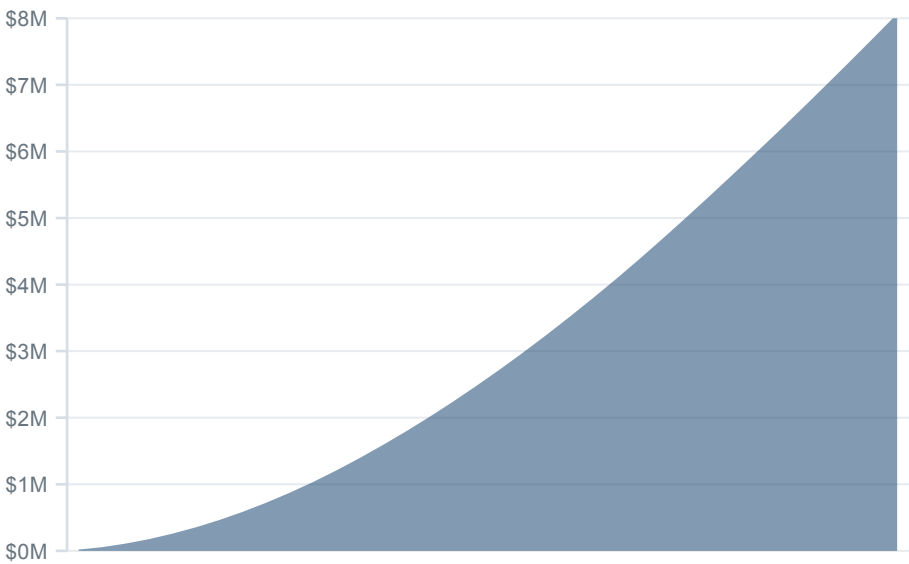
The only recurring platform charge outside the per-patient program fees is the \$150/month athenahealth EHR line, carried as operating expense.

ENROLLMENT INFRASTRUCTURE
2 dedicated enrollment specialists — CoachCare-funded

No dedicated enrollment-specialist salary is charged against modeled AHVI practice economics; internal AHVI operating burden may still exist.

MONTH 1	
Net reimbursement	~\$39K
Program cost	~\$20K
NET TO PRACTICE	+\$19K

CUMULATIVE PRACTICE CASH GENERATION



BREAK-EVEN: MONTH 1

M1	M12	M24	M36
+\$19K	~\$1.21M	~\$4.09M	~\$8.07M
~\$19K/mo	~\$174K/mo	~\$292K/mo	~\$356K/mo

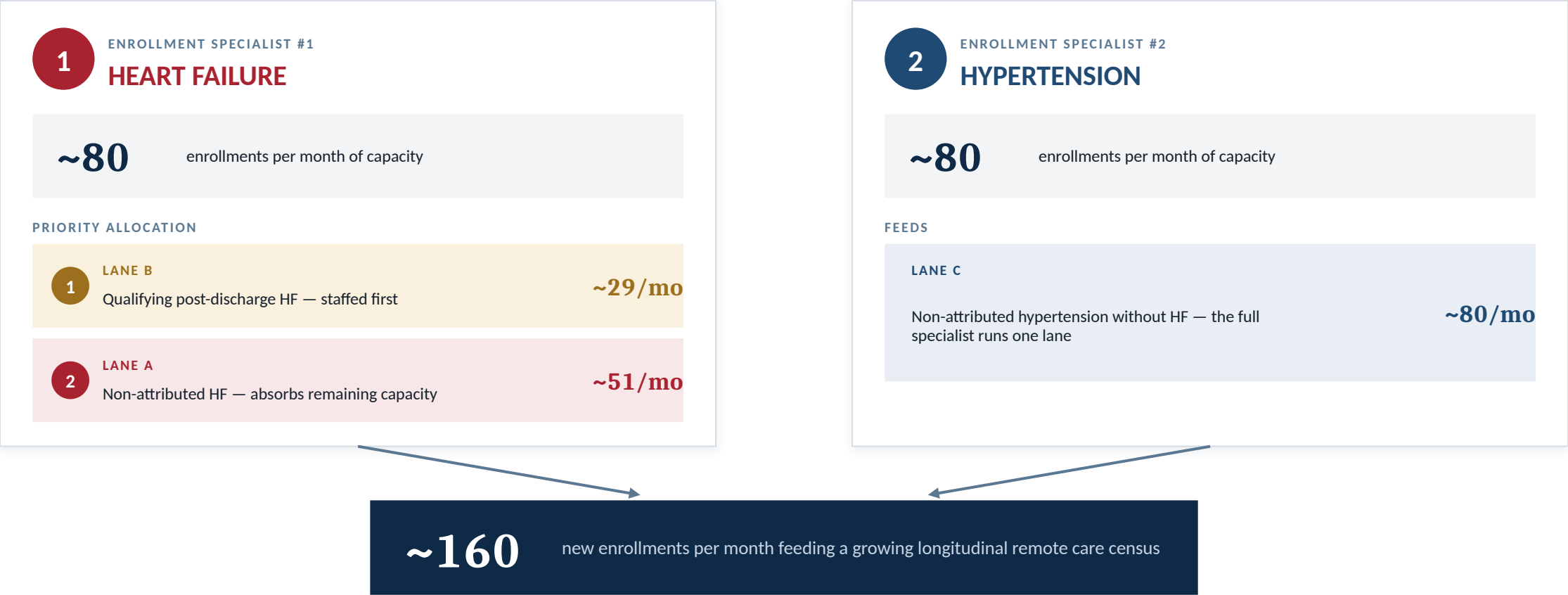
36-MONTH ECONOMIC OUTCOME

Net reimbursement	~\$17.20M
less modeled remote-care program expense	-\$9.13M
DIRECT PRACTICE NET	~\$8.07M
Practice margin ~46.9%	
+ ASM cash received in the 36-month window	~\$240K
+ Envoy participant distributions to AHVI	~\$9K
TOTAL MODELED AHVI VALUE	~\$8.32M
ENTERPRISE VALUE, NOT AHVI CASH	
Modeled Envoy net TCoC benefit — relevant to the enterprise relationship, not treated as AHVI practice revenue.	~\$0.83M

UPFRONT SETUP	BREAK-EVEN	36-MO PRACTICE NET	TOTAL AHVI VALUE
\$0	Month 1	~\$8.07M	~\$8.32M

The decision is less about financing a long payback period than about validating enrollment throughput, clinical eligibility, reimbursement realization and operational execution.

Two dedicated enrollment engines create capacity for approximately 160 new patients per month



LANE C BECOMES CAPACITY CONSTRAINED BEFORE IT BECOMES POPULATION CONSTRAINED

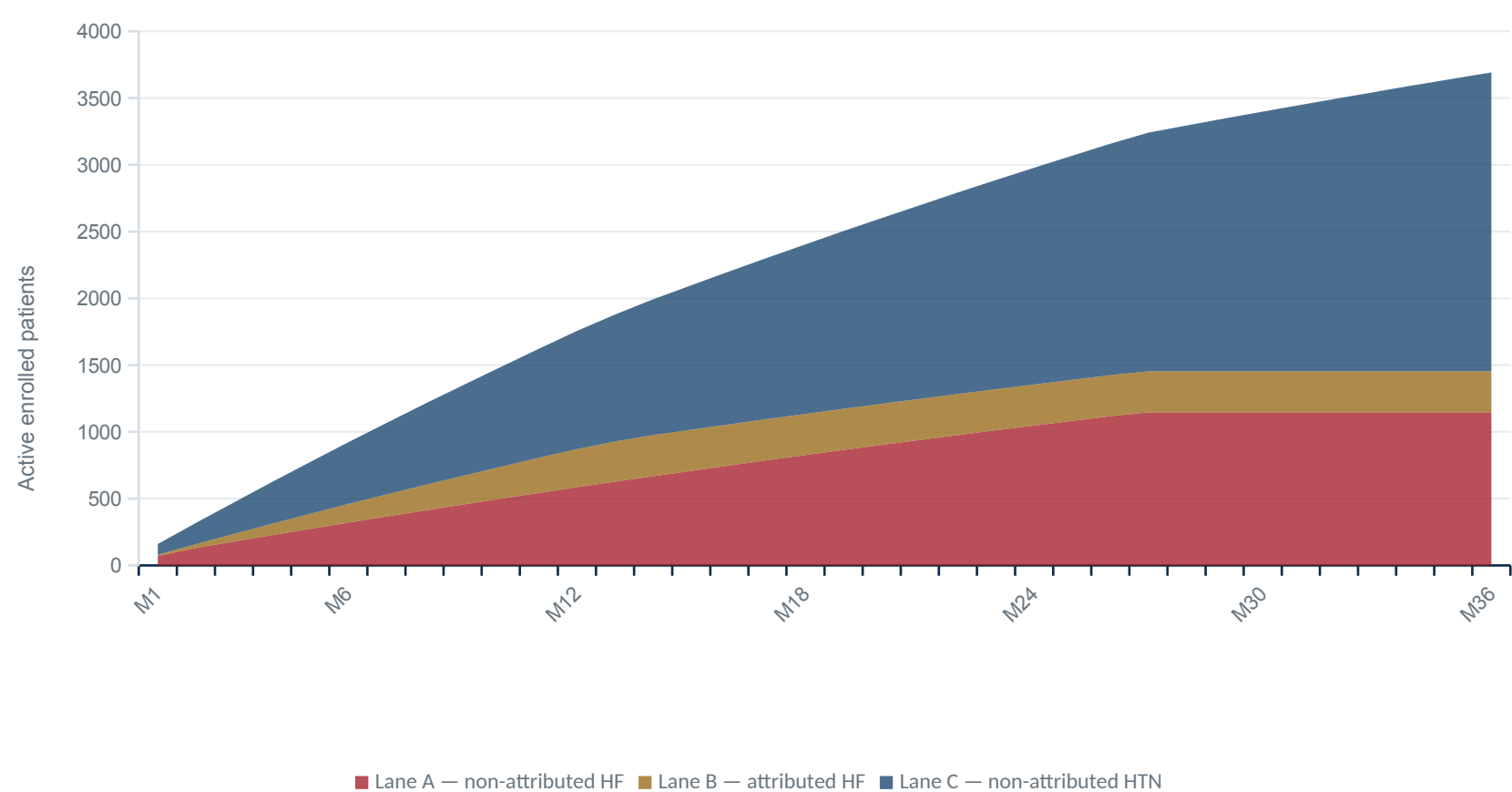
Additional enrollment capacity is a future scale lever once the economics and clinical performance validate — the population is not the binding constraint.

~2,342
potential Lane C ceiling

vs

~80/mo
current ES throughput

The modeled census grows predictably over 36 months, with hypertension becoming the largest deployment lane



HF ENROLLMENT

Balances high-value post-discharge capture against broader non-attributed enrollment. Lane A ramps toward its ~1,146 ceiling; Lane B steadies at ~308.

HTN ENROLLMENT

Remains throughput constrained. Lane C grows every month of the horizon and never exhausts its addressable pool.

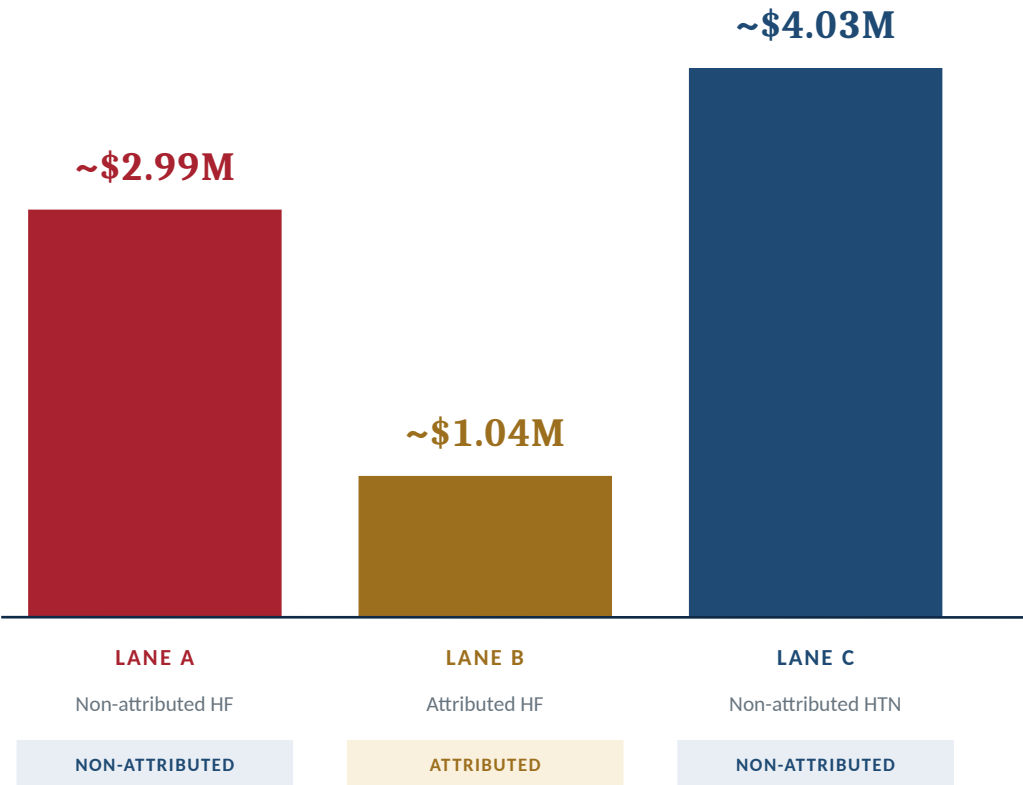
FUTURE SCALE

Add enrollment capacity only after validating actual economics and clinical performance.

Lane C is still climbing at Month 36 — it reaches ~2,238 of its ~2,342 modeled ceiling, so the lane ends the horizon capacity-limited rather than population-limited.

Non-attributed populations generate the overwhelming majority of AHVI's direct economic value

Cumulative 36-month practice net by lane

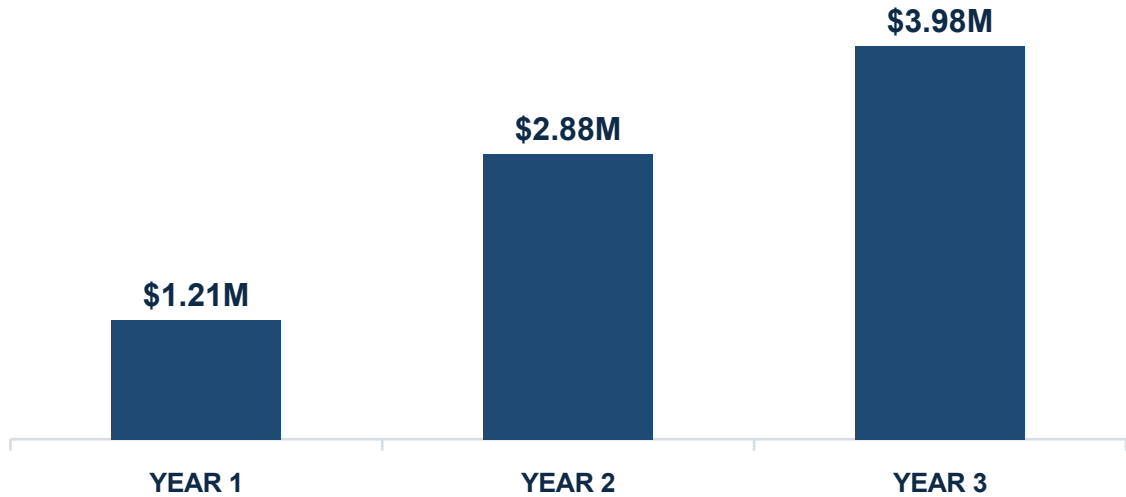


Approximately 87% of modeled practice net originates from the two non-attributed lanes.

Lane C is the largest direct margin engine, followed by broad non-attributed HF deployment.

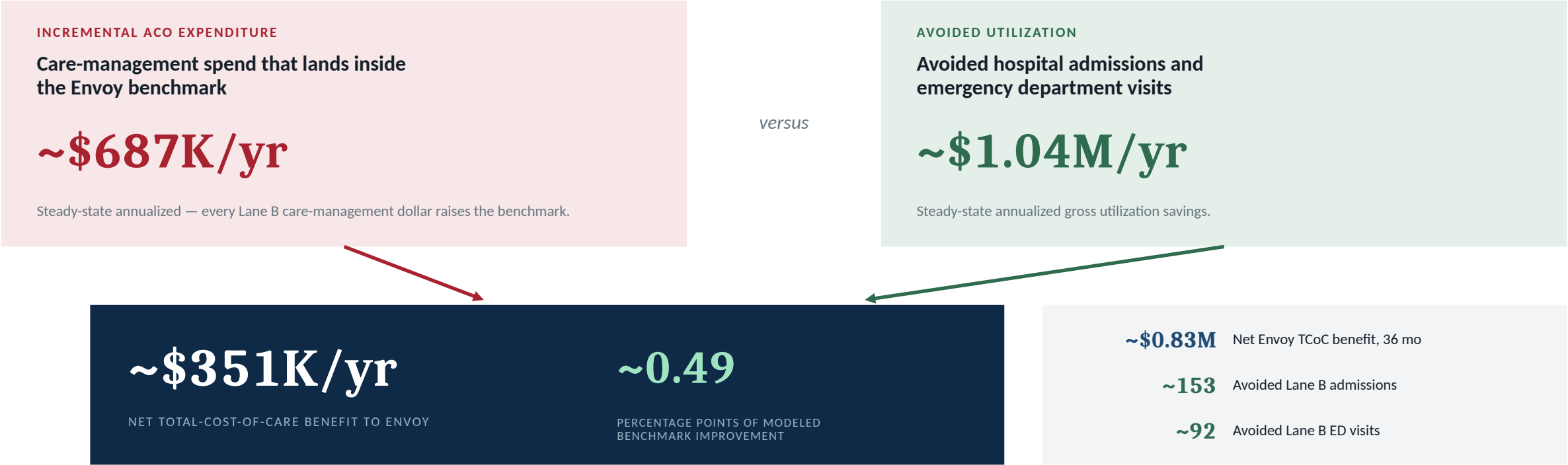


ANNUAL RAMP



Positive practice contribution begins in Month 1 — every lane's cost is variable and scales with its own census.

Selective post-discharge enrollment lets Lane B utilization savings outweigh the incremental ACO program spend



PRINCIPAL CARE MANAGEMENT ATTACH	0%	25%	50%	70% • MODELED	100%
Benchmark drag	0.61 pts	0.73 pts	0.86 pts	0.95 pts	1.10 pts
Net TCoC benefit to Envoy	+\$599K/yr	+\$511K/yr	+\$422K/yr	+\$351K/yr	+\$244K/yr
Avoided admissions needed / 100 to break even	8.9 of 20	10.7 of 20	12.5 of 20	13.9 of 20	16.1 of 20
AHVI Lane B net	\$246K/yr	\$303K/yr	\$359K/yr	\$405K/yr	\$472K/yr

Every point of attach moves both directions at once: it raises what Envoy absorbs and raises the avoided admissions the lane must deliver to pay for itself. The modeled cohort delivers 20 per 100 enrollee-years, so the lane clears at every attach shown — with 1.44× cushion at 70% and 1.24× if it were billed on the whole census.

Envoy can capture meaningful enterprise value, but MSR and quality thresholds decide how much becomes distributable shared savings



The AHVI participant distribution is deliberately drawn small — the enterprise value sits in total cost of care, not in the distribution check.

RISK — MINIMUM SAVINGS RATE

~3.53% **~7.54 pts** **POTENTIAL PAYOUT CLIFF**

MSR to clear modeled Year-3 cushion

If total ACO savings fail to clear the MSR, distributable shared savings may fall to zero — regardless of how well Lane B performs.

RISK — QUALITY PERFORMANCE

73.85 **~39.2%** **~27.8%**

modeled quality threshold at or above threshold at reference score 71.03

Quality materially changes the monetization of savings — the same avoided utilization is worth roughly a third less below the threshold.

ACO economics strengthen the enterprise case for Lane B, but remain secondary to AHVI's direct fee-for-service investment case.

ASM creates secondary strategic upside and raises the value of building HF management infrastructure before reimbursement risk increases

PERFORMANCE YEAR TO PAYMENT YEAR — RISING TWO-SIDED EXPOSURE



Two-sided adjustment on covered professional Part B reimbursement, widening from ±9% to ±12% across the ladder.

AHVI EXPOSURE BASE

~15 preliminary AHVI clinicians identified

~\$5.91M historical Part B allowed charges

ASM adjustments affect covered professional Part B reimbursement broadly — not simply remote care claims.

CLINICAL-ECONOMIC BRIDGE

Remote monitoring · post-discharge intervention · longitudinal HF management · risk documentation

Fewer inpatient and ED events · improved expected-cost capture

Potential improvement in ASM economic performance

Directional modeled O/E **1.034 → 0.980** — not a predicted CMS score

SELECTED MODELED SCENARIO

~+\$240K

2029 cash adjustment — the only ASM payment falling inside the 36-month window

~+\$1.42M

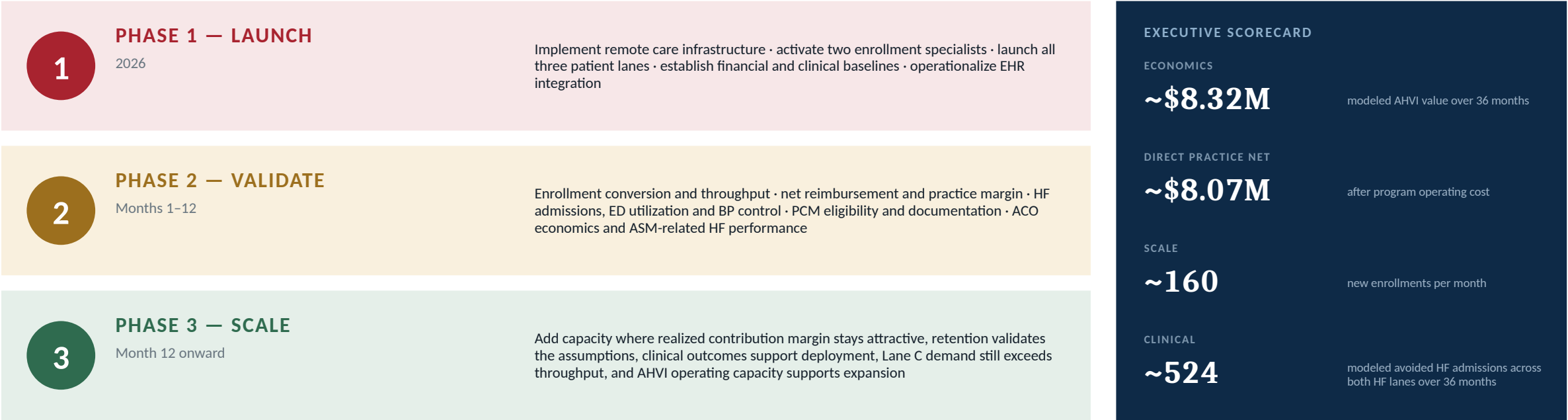
five-year selected scenario, 2029–2033

SCENARIO ANALYSIS — NOT A GUARANTEED FORECAST

The direct fee-for-service business case stands on its own; ASM raises the strategic value of the same clinical infrastructure.

EXECUTIVE RECOMMENDATION

Launch a controlled-scale three-lane model in 2026, validate real-world performance, then expand the highest-return lanes



RECOMMENDATION

Proceed with a three-lane deployment: maximize direct practice economics in non-attributed populations, selectively manage attributed HF patients where acute-utilization savings justify the ACO spend, and use the resulting infrastructure to strengthen AHVI's position as specialty reimbursement moves further toward value.

Launch → measure → validate → expand.

POPULATION Validate actual Envoy attribution overlap	OPERATIONS Validate real enrollment conversion and staffing capacity	CLINICAL Validate utilization and hypertension management outcomes	VALUE-BASED CARE Confirm ASM participation; monitor Envoy MSR and quality
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WHAT WE NEED FROM YOU

Every figure in this deck rests on an input — eleven of them are placeholders AHVI can replace with an exact number

Where your data was unavailable we used a documented placeholder rather than a flattering guess. Each one below names what it drives and where the real number lives.

TIER ONE — MOVES THE FORECAST MOST		TIER TWO — SHIFTS THE ACO AND ASM LAYERS		TIER THREE — FINE-TUNES THE REVENUE MODEL	
Share of HF patients attributed to Envoy	35%	Medicare cost per acute admission, Alaska	\$16K	Denial rate and coinsurance collection	2.5% / 75%
Envoy's attribution feed — or a query of your HF patients against the six Envoy primary care TINs by referring physician.		Envoy's claims data — actual Medicare paid amounts on HF admissions for attributed patients.		Revenue cycle reporting. Sets the 92.6% gross-to-collected conversion, which moves every figure proportionally.	
Annual hospitalization rate, HF cohort	40%	12-month readmission rate, post-discharge	50%	Envoy savings rate and distribution terms	10.58%
athenaOne joined to hospital discharge records; Envoy's claims feed for the attributed share.		Hospital readmission reporting or your own follow-up data. The break-even test is most sensitive to this.		Envoy directly — its 2025 performance results and the participation agreement's terms across 14 practices.	
Share of discharges the program captures	50%	HF episode cost — observed / expected	\$30K / \$29K	ASK FOR ONE DOCUMENT FIRST The CMS episode-based cost measure feedback report Available through the QPP portal. It replaces four separate placeholders in the Ambulatory Specialty Model layer at once, and it is the highest-value single document for that half of the analysis.	
Your HF clinic's current 7–14 day post-discharge follow-up rate. Clinical director and APP leadership.		Your CMS episode-based cost measure feedback report, via the QPP portal.			
PCM attach — attributed post-discharge	70%	Share of census managed by ASM clinicians	60%		
Your documentation practice. The largest single line in both AHVI's Lane B margin and Envoy's drag — see the attach curve.		The same CMS feedback report, or your own general-versus-procedural clinician split.			
PCM attach — uncontrolled hypertension	70%				
A chart review of the hypertension panel: how many are uncontrolled, mid-titration, or recently changed.					

Two figures here are ours to defend, not yours to supply: the 40% admission reduction — applied identically in every lane, so the model cannot claim a larger effect in one room than another — and the code completion profile. Both come from CoachCare's book across 40+ cardiology customers, and both we will show you rather than assert.

Replacing an assumption is one cell, not a rebuilt analysis — bring the numbers and we recalculate together.