TRI-CITY CARDIOLOGY

Independent Physician-Owned Cardiology · Mesa, Arizona

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM, with CCM) as the operating spine

Purpose of this report

This report reads Tri-City Cardiology's public profile, its own published quality data, and its local market, and makes a single argument: a managed **Remote Care Service Line** is the highest-return, lowest-risk optimization move available to the group in 2026 — margin-positive as a standalone service line before any value-based dollar, and built on one shared infrastructure that also protects the group's patients after discharge, modernizes the device clinic, and supports procedural throughput.

Independent, model-free timing. Tri-City carries no mandatory CMS-model exposure today — this is pure-upside timing, and the same infrastructure leaves the group prepared if selection maps change.

Prepared by CoachCare · Remote Care Service Line Strategy · July 2026

Figures are illustrative and modeled — verify against practice data before contracting.

Table of Contents

Executive Summary

Tri-City Cardiology — legal and billing entity **Tri-City Cardiology Consultants, PC** — is one of the largest independent, physician-owned cardiology groups in Arizona: **29 physicians and roughly 10 advanced-practice providers across 13 East Valley locations**, including nine clinics, a dedicated vein and vascular center, and the group's own ambulatory surgery center. Founded in 1979 and led by Dr. Jaskamal Kahlon (President) and Gregg Florentin (CEO), the group runs an unusually procedural sub-specialty mix — **16 interventional cardiologists, 5 electrophysiologists and 8 general cardiovascular-disease physicians, and no advanced heart-failure sub-specialist**. It admits primarily to Banner Desert (34%), Banner Baywood (26%) and Banner Heart Hospital (13%), with additional affiliations at Dignity Health's Chandler Regional and Mercy Gilbert. The ambulatory EMR is NextGen.

Starting position. This is not a group that needs to be convinced remote care works — it has already bought remote care twice. Tri-City implants **CardioMEMS pulmonary-artery sensors in its own ASC** (among the first ambulatory surgery centers CMS approved to do so) and runs a **live virtual cardiac-rehabilitation partnership** with a third-party vendor. What it has none of is the **longitudinal, billable layer**: there is no RPM, no CCM and no PCM anywhere in the practice. Every dollar of chronic-care reimbursement across the panel is currently unbilled. The group has proven twice that it will adopt remote technology; what is missing is the reimbursed chronic-care service line that sits between the sensor and the rehab program.

The central argument

A managed Remote Care Service Line delivers value two ways at once.

1) Standalone value. Recurring, subscription-like professional-fee revenue at top-of-license staffing — margin-positive on its own P&L before any value-based upside, and delivered without adding practice headcount.

2) Connective tissue. One shared engine — enrollment, connected devices, 24/7 alerts and triage, nurse navigation, GDMT titration, billing capture, analytics — that simultaneously reduces avoidable readmissions at the hospitals taking the group's admissions, extends the electrophysiology device clinic, supports ASC and cath-lab throughput, and produces protocolized, time-logged documentation for every billed minute. Build once, reuse everywhere.

The readmission wedge. Tri-City's patients discharge into hospitals the group does not control clinically, and the CMS data on those hospitals is unflattering. The three Banner facilities taking roughly **73% of the group's admissions all carry a CMS Overall Hospital Star Rating of 2**, while the two Dignity Health hospitals the group also affiliates with are rated 4 and 5. CMS's FY2026 Hospital Readmissions Reduction Program data puts numbers on it: Banner Desert exceeds its risk-adjusted expected 30-day readmission rate on **four of five measures** — pneumonia (1.131), CABG (1.022), AMI (1.018) and COPD (1.018) — and Banner Heart Hospital exceeds expected on CABG (1.100). That is quantified post-discharge exposure sitting on the group's own patients, and today Tri-City has no program running in that window.

Their own quality data points at the same gap. In CMS PY2023 MIPS group reporting across 35 clinicians, Tri-City posted a final score of **82.0** — a group that performs well and clearly takes measurement seriously. Within that strong overall picture, one composite stands out: the ischemic-vascular-disease **all-or-none optimal-care measure came in at 43% across an 18,080-patient**

denominator. All-or-none composites fail on the components that depend on what happens *between* visits — blood-pressure control, statin and antiplatelet adherence, medication titration. That is precisely the work a longitudinal remote-care program industrializes, and it is the single clearest line from this service line to a measure the group already reports.

The billing tailwind. CY2026 widened the remote-care code set in the group's favour. New short-window RPM codes — 99445 for 2–15-day monitoring and 99470 for the first 10 minutes of management — make transitional and post-procedure monitoring billable alongside the established RPM, CCM and PCM codes. For a group running 16 interventionalists, a 5-electrophysiologist device program and an ASC that has passed 6,000 procedures, that is a direct fit.

What the model shows. Applied to a discovery-stage estimate of the group's Medicare panel, an RPM + CCM + PCM service line is modeled to generate **$8,611,485 in net reimbursement over 24 months** and **$3,664,567 in practice net after CoachCare's fees**, while avoiding approximately **279 hospitalizations** (about $4.18M in system-level cost at $15,000 per admission) and putting **4,470 unique patients** into active remote care by Month 24. These are illustrative, modeled figures — verify against practice data — but the direction is unambiguous: each program stands on its own, margin-positive, from Year 1.

2026–2027 Priority Recommendations

1. **Stand up the Remote Care Service Line as a standalone P&L.** Launch RPM + CCM + PCM on the existing Medicare panel with CoachCare-funded enrollment, device logistics and monitoring staff, so the service line adds margin without adding practice headcount.
2. **Lead with heart failure — and fill a real local void.** The group has no advanced heart-failure sub-specialist, and Banner Heart Hospital has no LVAD, mechanical circulatory support or transplant program; Banner's advanced-HF program sits at Banner–University Medical Center Phoenix. An East Valley heart-failure patient leaves the East Valley. Longitudinal remote HF management fills a genuine gap rather than duplicating an existing service.
3. **Deploy on the native NextGen integration.** Enroll and bill inside the existing EHR workflow — bidirectional enrollment by service, discrete vitals written back into the chart, and automated claim generation — so patients begin services quickly and documentation lives where the chart already is.
4. **Extend the device clinic rather than starting a new concept.** With five electrophysiologists — two recruited in December 2025 — remote-transmission workflows are already routine here. RPM is an extension of a familiar operating model, not a new one, which materially shortens adoption time.
5. **Make the IVD optimal-care composite a named service-line KPI.** Put the 43% all-or-none measure on the service-line scorecard from month one, with BP control, statin and antiplatelet adherence tracked as between-visit workflows rather than visit-day reminders.
6. **Treat recurring revenue as independence infrastructure.** In a metro where private-equity-backed and health-system buyers have absorbed several cardiology groups, a margin-positive, non-procedural, recurring service line diversifies the revenue base that physician ownership rests on.

1. Footprint & Operating Model

Tri-City Cardiology is a physician-owned, single-specialty cardiology group serving the East Valley of the Phoenix–Mesa–Chandler metro, spanning both Maricopa and Pinal counties. The profile below is drawn from public sources, live CMS provider data and the account research dossier; items that could not be independently confirmed are flagged for discovery.

Attribute	Profile (verify in discovery where flagged)
Organization	Tri-City Cardiology — legal and billing entity Tri-City Cardiology Consultants, PC. Independent and physician-owned; founded 1979. No private-equity, MSO, or health-system parent found in any public source
Leadership	Dr. Jaskamal Kahlon, MD, FACC (President); Gregg Florentin (CEO); Angela Szczublewski (COO); Michelle Holmes (CFO); Janice Batts (Revenue Cycle Management); Bruce Stec (ASC Administrator). No published CMO and no named heart-failure program lead
Scale	29 physicians and ~10 advanced-practice providers in the CMS group roster (the practice's careers page cites 42+ providers); ~244 employees
Locations	13 sites — nine clinics (Mesa, Chandler, Gilbert, Sun Lakes, Gold Canyon, San Tan Valley, Casa Grande) plus the vein & vascular center, the ASC and the administrative office. A Prescott office is in recruitment; a San Tan Valley campus opens in 2026
Sub-specialty mix	16 Interventional Cardiology · 5 Cardiac Electrophysiology · 8 Cardiovascular Disease. No advanced heart-failure / transplant sub-specialist — heart failure sits with the general and interventional cardiologists
Owned facilities	Tri-City Surgical Centers (ASC): 15,745 sq ft, four procedure rooms and two cath labs; passed 6,000 procedures in December 2025. Accredited vascular lab; in-office echo, nuclear, stress and telemetry
Hospital affiliations	Banner Desert (34% of admissions), Banner Baywood (26%), Banner Heart Hospital (13%) — all three rated 2 stars by CMS — plus Dignity Health's Chandler Regional (4 stars) and Mercy Gilbert (5 stars). Privileges, non-exclusive across two competing systems
Payer & VBC posture	Fee-for-service. Reports MIPS at group level (PY2023 final score 82.0) and participates in the ACC PINNACLE registry, so quality-measure plumbing already exists. No public ACO/MSSP participation found — confirm at TIN level in discovery
Remote-care footprint	CardioMEMS implanted in the group's own ASC; a live virtual cardiac-rehabilitation partnership with a third-party vendor; an EP-run implantable-device

Attribute	Profile (verify in discovery where flagged)
	clinic. No RPM, no CCM, no PCM — the longitudinal billable layer is entirely open
EMR	NextGen — independently corroborated: the practice's patient-portal tenant resolves on NextGen's own PxP portal domain. Exact NextGen Enterprise version and hosting model to be confirmed in contracting
Market	CBSA 38060 (Phoenix–Mesa–Chandler), Maricopa and Pinal counties. Medicare Advantage covers roughly half of Medicare in Maricopa (~51%, close to the national average); Pinal County — where the Casa Grande and San Tan Valley offices sit — runs higher, around 57%

What the operating model implies. Three features shape the entire strategy. **First, it is procedurally weighted without a longitudinal layer**: 16 interventionalists, five electrophysiologists, two cath labs of its own and 6,000+ ASC procedures produce a continuous stream of patients who need structured follow-up in the 2–30-day window — the window CY2026's short-window RPM codes were written for — and nothing bills for that work today. **Second, it is independent and fee-for-service**: no hospital parent captures the professional fees and no downside-risk contract complicates attribution, so recurring care-management revenue lands directly on the group's own P&L. **Third, its post-discharge exposure sits in someone else's building**: roughly three-quarters of admissions land at three 2-star hospitals with measured excess readmissions, which makes the between-visit window both the group's largest clinical risk and its clearest opportunity to become indispensable to its hospital partners.

Design principles for the service line

Principle	What it means for Tri-City
Longitudinal by default	Chronic cardiac patients are enrolled in continuous monitoring at the point of care — the practice owns the between-visit relationship rather than handing it out
One shared scorecard	Enrolled census, billable-capture rate and revenue per patient per month sit on the same dashboard as clinical outcomes and reported quality measures
Top-of-license staffing	CoachCare-funded coaches and nurses run enrollment, device logistics and monitoring; the group's physicians and APPs practice at the top of their license
One front door	A single enrollment and triage pathway for RPM, CCM and PCM across all 13 sites — patients experience one program, not three
Documented by construction	Every billed minute carries a protocolized care plan, a time log and device-data provenance, generated by the workflow, not reconstructed later
Digital-as-care	Connected devices and 24/7 alerting are clinical infrastructure, not IT — data drives titration and escalation, and feeds the existing device clinic

2. The Remote Care Service Line — The Spine

This section is the center of the report. A Remote Care Service Line is not a point solution bolted onto the practice; it is a managed operating line with its own P&L, its own staffing model and its own scorecard. For an independent cardiology group it runs as a single specialty arm — the transitional and longitudinal codes a cardiology practice can bill on the patients it already manages.

2.1 What it is: the specialty-arm stack

The service line sequences four billing motions across the cardiac patient journey — from the transition out of the hospital, through short post-procedure windows, into longitudinal chronic management:

Motion	Codes	Clinical role
TCM	99495 / 99496	Transitional Care Management: structured contact within two business days of discharge and a face-to-face visit within 7–14 days — the hand-off from Banner or Dignity back to the practice, and the first place post-discharge risk becomes manageable
RPM	99453 · 99454 · 99445 · 99457 · 99470 · 99458	Remote Physiologic Monitoring: connected BP, weight and pulse-oximetry devices with monitoring time. The new 99445 / 99470 short-window codes fit 2–15-day post-PCI, post-ablation and post-device follow-up
PCM	99426 / 99427	Principal Care Management: a single high-risk condition — heart failure above all — managed longitudinally for three months or more. The specialist's chronic-care wrapper, and the natural home for GDMT titration
CCM	99490 / 99439	Chronic Care Management: the multimorbid majority (two or more chronic conditions for 12 months or more) — the broadest cohort in an ageing East Valley panel

One coordination rule to set on day one

RPM stacks; CCM and PCM do not. RPM may be billed alongside either CCM or PCM, with discrete time and documentation. CCM and PCM cannot both be billed for the same patient in the same calendar month — one longitudinal wrapper per patient. TCM covers the 30-day post-discharge window, then transitions the patient into RPM plus CCM or PCM.

Attribution with the referring PCP. Because CCM can only be billed by one practice per patient per month, agree a simple attribution policy with each patient's primary-care physician up front: the cardiology group owns TCM at discharge, RPM, and PCM for the cardiac condition; where it bills CCM, it confirms the PCP is not billing it the same month. A single shared care plan in NextGen, with data exchanged back to the referring practice, keeps the relationship collaborative rather than competitive — an important consideration for a group whose volume depends on primary-care referrals.

2.2 Standalone value: three value layers

Before any connective-tissue benefit, the service line earns its place on the P&L. Value accrues in three layers, led — for an independent, fee-for-service group — by the standalone economics:

1. **Direct professional-fee revenue —** Recurring, subscription-like monthly reimbursement (RPM, CCM, PCM) on patients the group already sees, across a panel of this size. Delivered at top-of-license staffing with CoachCare-funded coaches and nurses, it adds margin without adding practice headcount. **This is the lead layer** and the reason the service line stands on its own, independent of any downstream benefit.
2. **Avoided cost & referral-relationship defense —** Fewer avoidable heart-failure and post-procedure readmissions at Banner Desert, Banner Baywood, Banner Heart Hospital and the Dignity facilities. Tri-City does not pay a readmission penalty directly, but the hospitals it admits to do — and CMS data shows several of them already exceeding expected rates. A group that measurably reduces those readmissions stops being simply a source of volume and becomes a partner in the hospital's quality performance. That is the most durable form of referral defense available to an independent practice sitting between two competing systems.
3. **Device-clinic, EP and procedural throughput —** Structured post-PCI, post-ablation and post-implant monitoring keeps the cath-lab and ASC pipeline continuous and safe, supports same- and next-day discharge, and gives the five-electrophysiologist device clinic a longitudinal data layer alongside the transmission data it already reviews. Growth built on the same shared engine, with no second build.

CY2026 billing stack (illustrative — Arizona locality)

The stack below shows the CY2026 remote-care codes and their approximate Arizona-locality magnitudes, drawn from the value-analysis model (AZ carrier/locality 03102-00) with national magnitudes where noted. Actual payment is locality-adjusted and set by the regional MAC; confirm current-year Physician Fee Schedule values in contracting.

Service / code	Type	Approx. rate	Notes
TCM 99495 / 99496	Per discharge	~$200 / ~$280	National magnitude; two-business-day contact plus face-to-face within 14 / 7 days
RPM 99453	One-time setup	~$21	Requires at least two days of device data

Service / code	Type	Approx. rate	Notes
RPM 99454 / 99445	Monthly (device)	~$50	99454 = 16–30 days; 99445 = new 2–15-day short-window code (2026)
RPM 99457 / 99470	Monthly (mgmt)	~$51 / ~$25	First 20 minutes / new first-10-minute code (2026)
RPM 99458	Monthly (add'l)	~$41	Each additional 20 minutes
PCM 99426 / 99427	Monthly (specialty)	~$66 / ~$53	Single high-risk condition (e.g. heart failure) for three months or more
CCM 99490 / 99439	Monthly (chronic)	~$65 / ~$49	Two or more chronic conditions for 12 months or more — the multimorbid majority

Recurring-revenue mechanics

Each enrolled patient generates a predictable monthly professional fee for as long as they remain clinically appropriate and engaged — the economics behave like a subscription book that compounds as the enrolled census ramps. A patient enrolled in RPM plus a longitudinal wrapper (CCM or PCM) contributes multiple recurring lines per month; across the modeled panel, 4,470 unique patients generate 7,016 active program enrollments by Month 24. The Year-1-to-Year-2 step-up shown in Section 3 is precisely this compounding: the census built in Year 1 bills for all of Year 2.

2.3 Connective tissue: one engine, every lever

The reason to build this as a service line rather than a billing tactic is that one shared infrastructure powers every lever at once. The same enrollment engine, connected devices, 24/7 alert-and-triage desk, nurse navigation, titration protocols, billing capture and analytics that produce the standalone revenue also drive readmission avoidance, procedural throughput, device-clinic modernization and quality-measure performance. Build it once; reuse it everywhere.

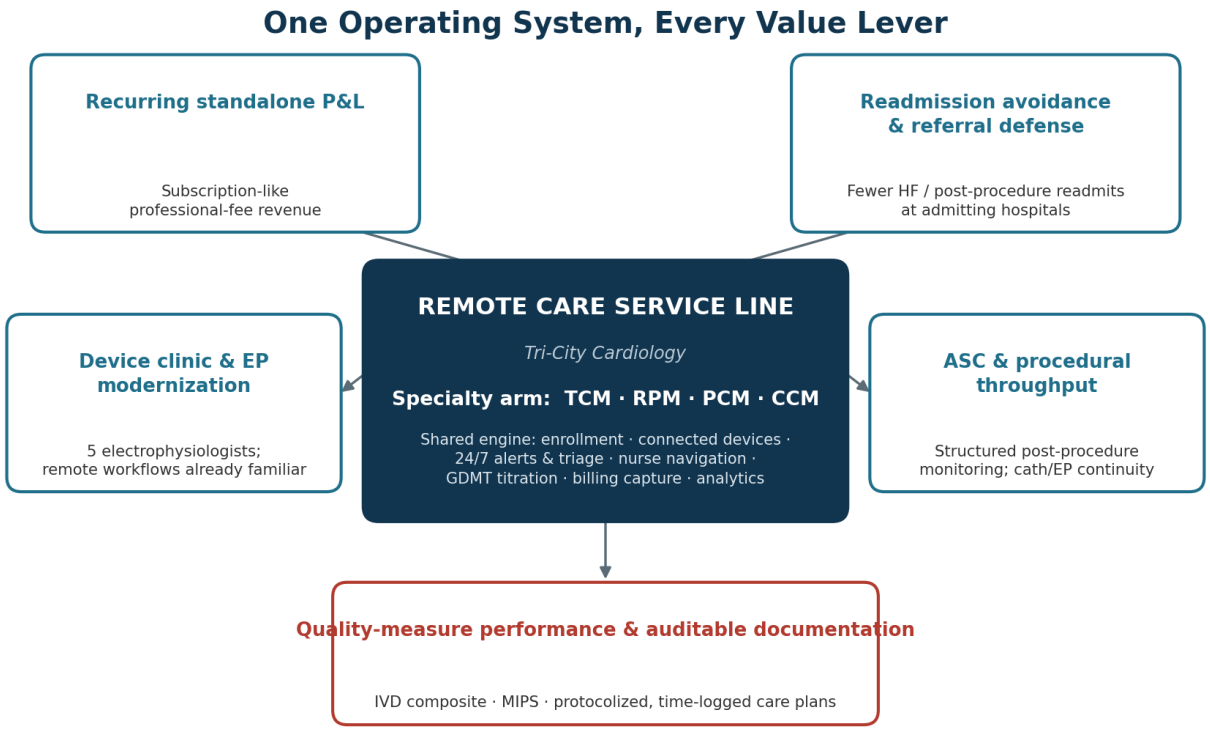

Figure 1. The Remote Care Service Line as a single operating system — one shared engine (center) driving every value lever for an independent cardiology group. Build once, reuse everywhere.

The matrix below maps how the same shared capabilities show up in each lever — the point being that the group does not staff, license or integrate five different programs, but one:

Value lever	How the same shared engine powers it
Standalone P&L	Enrollment + connected devices + monitoring time → recurring RPM / CCM / PCM professional fees; automated billing capture ensures eligible encounters are not left uncoded
Readmission avoidance & referral defense	24/7 alerts + nurse triage + GDMT titration catch decompensation early → fewer HF and post-procedure readmits at Banner and Dignity facilities → protected referral relationships and a measurable contribution to partners' quality performance
Device clinic & electrophysiology	Continuous physiologic data alongside implantable-device transmissions gives the five-EP device clinic a longitudinal view between checks — the same staff, alerts and escalation pathway serve both
ASC & procedural throughput	Post-PCI, post-ablation and post-implant RPM supports safe same- and next-day discharge and keeps the two-cath-lab ASC pipeline continuous; the short-window codes make that follow-up billable
Quality measures & documentation	Between-visit BP control, statin/antiplatelet adherence and titration are what all-or-none composites such as the IVD optimal-care measure actually test — and every touch produces a protocolized, time-logged, auditable record

3. The 24-Month Value Model

The figures below come from the CoachCare Value Analysis built for Tri-City Cardiology. The panel is a **discovery-stage estimate** of approximately **30,400 Medicare patients** — roughly 14,700 in traditional fee-for-service Medicare plus a comparable Medicare Advantage population, reflecting Maricopa County's Medicare Advantage penetration of roughly half. That estimate is anchored on the group's Medicare allowed amount, which independent CMS Physician & Other Practitioners data corroborates. Stated honestly: **RPM, CCM and PCM bill cleanly on the fee-for-service half**; the Medicare Advantage half requires plan-by-plan coverage confirmation, and the group's payer grid is the first thing to pull in discovery. Cardiology-specific program eligibility is modeled at 60% of the panel for RPM and 70% for CCM and PCM. Enrollment ramps through Year 1 to a steady-state active census that bills for all of Year 2. All figures are illustrative and modeled — verify against practice data — and every rate and assumption in the workbook is user-editable.

How enrollment is modeled

A referral-driven engine, not cold outreach. The primary pathway is physician referral at the appointment: eight referrals per provider per month across the group's 41 referring providers at an 80% patient-accept rate, converting to programs at 50% RPM, 35% CCM and 15% PCM. A CoachCare-funded on-site enrollment specialist and a modest telephonic-outreach pathway supplement it. Enrollment begins in month one — there is no onboarding delay — and the census then compounds through Year 1 and holds through Year 2, which is why Year 2 bills roughly 3.1× Year 1.

Financial value

Program	Year 1 net	Year 2 net	24-month net	24-mo practice net
RPM	$987,317	$3,011,421	$3,998,738	$1,656,949
CCM	$816,108	$2,551,531	$3,367,639	$1,616,664
PCM	$301,856	$943,251	$1,245,108	$563,167
Total	**$2,105,281**	**$6,506,204**	**$8,611,485**	**$3,664,567**

Program rows show practice net before shared ancillary costs; the Total ($3,664,567) is net of one-time implementation, EMR-integration and telephonic-enrollment items, so it sits slightly below the sum of the program rows.

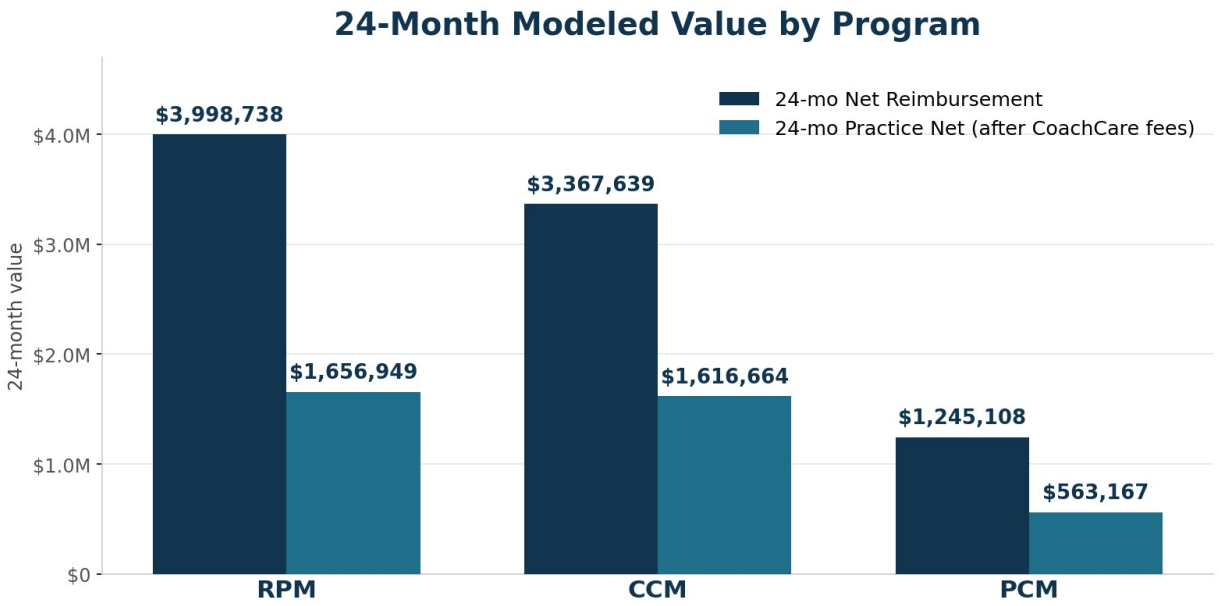

Figure 2. 24-month modeled net reimbursement and practice net by program. Each program is individually margin-positive. Illustrative, modeled — verify against practice data.

Reading the ramp. Year 1 net reimbursement of $2,105,281 grows to $6,506,204 in Year 2 — roughly a 3.1× step-up — because the enrolled census built gradually through Year 1 bills for all twelve months of Year 2. The 24-month totals are $8,611,485 in net reimbursement and $3,664,567 in practice net after CoachCare's fees, with RPM and CCM as the two largest contributors and PCM adding a focused heart-failure line. By Month 24 the active census stands at 3,379 RPM, 2,508 CCM and 1,129 PCM enrollments — 7,016 program enrollments across 4,470 unique patients, since a substantial share of patients carry RPM plus a longitudinal wrapper.

Clinical & operational value

Beyond the professional fees, the model quantifies the clinical and workload effects of continuous monitoring on the enrolled panel over 24 months:

Metric	24-month modeled value	What it represents
279	hospitalizations avoided	Approximately $4.18M in system-level cost avoided at ~$15,000 per admission — the post-discharge exposure at the 2-star admitting hospitals, converted into a number
4,470	unique patients in active remote care	Distinct patients under continuous management by Month 24, across 7,016 active program enrollments
164,559	reimbursable claims / units	Total reimbursable claim lines generated across RPM, CCM and PCM over the 24 months
439,134	physiologic readings	Connected-device data points feeding titration decisions, early-warning alerts and the between-visit record

Metric	24-month modeled value	What it represents
76,649	staff-hours delivered by CoachCare	Approximately 36.9 FTE-equivalent of CoachCare-performed enrollment, monitoring and documentation work — this is work absorbed by CoachCare staff, not headcount the practice hires

How to read these numbers

Every figure in this section is illustrative and modeled from the CoachCare Value Analysis, not a guarantee of results. The inputs — the ~30,400 panel estimate, program eligibility percentages, the referral-based enrollment engine, the avoided-admission rate and the ~$15,000-per-admission cost basis — are all user-editable, and the totals recalculate live. The staff-hours and FTE-equivalent figures describe work performed by CoachCare on the practice's behalf; they are not a headcount the practice adds or replaces. The right next step is a discovery session to replace the estimated panel and eligibility inputs with the group's actual claims data and payer grid.

4. Performance Snapshot & the Readmission Wedge

An independent cardiology group is not scored on a CMS hospital star rating, but it is measured — by MIPS, by registry participation, and indirectly by the readmission performance of the hospitals it admits to. Tri-City's own published data and its admitting hospitals' published data point at the same place: the space between visits.

What the group's own quality data shows

The table below is drawn from CMS PY2023 MIPS group-level reporting for Tri-City Cardiology, covering 35 clinicians. It is a strong overall picture with one composite that stands out.

Measure (CMS PY2023, group-level)	Reported	Read
Final MIPS score	82.0	Well above the performance threshold — this is a group that measures itself and performs
Advance care plan	100%	Complete capture; documentation discipline is clearly achievable here when a workflow exists
Beta-blocker therapy after myocardial infarction	81%	Solid component performance
ACE inhibitor / ARB therapy	79%	Solid component performance
Statin therapy for cardiovascular disease	75%	Room to move, and adherence-sensitive
Antiplatelet therapy	69%	Room to move, and adherence-sensitive
Ischemic vascular disease — all-or-none optimal care	**43%**	**The hook.** Across an 18,080-patient denominator. All-or-none composites fail on whichever component slips, and the components here — BP control, statin and antiplatelet adherence, titration — are between-visit work
Hospital-wide 30-day readmission	15.5%	The group's own readmission exposure, measured at group level

Why the IVD composite is the right target. An all-or-none measure is unforgiving by design: a patient counts only if every component is met. At 43% across 18,080 patients, the gap is not a documentation problem — the group scores 100% on advance care planning, so it can document — and it is not a knowledge problem in a group of 29 cardiologists. It is a *frequency-of-contact* problem. Blood pressure drifts, statins get stopped, antiplatelet adherence lapses, and none of it surfaces until the next office visit. A remote-care service line is, functionally, a machine for closing exactly that gap: connected BP data, monthly documented contact, protocol-driven titration, and adherence follow-up between visits. Making this composite a named service-line KPI turns an abstract quality score into an operational target with a workflow attached to it.

The admitting-hospital exposure, quantified

Roughly 73% of the group's admissions go to three Banner facilities that all carry a CMS Overall Hospital Star Rating of 2, while the two Dignity Health hospitals the group also affiliates with are rated 4 and 5. CMS's FY2026 Hospital Readmissions Reduction Program data — covering discharges from July 2021 through June 2024 — quantifies what that means. An excess readmission ratio above 1.000 means the facility readmits more patients than CMS's risk adjustment expects.

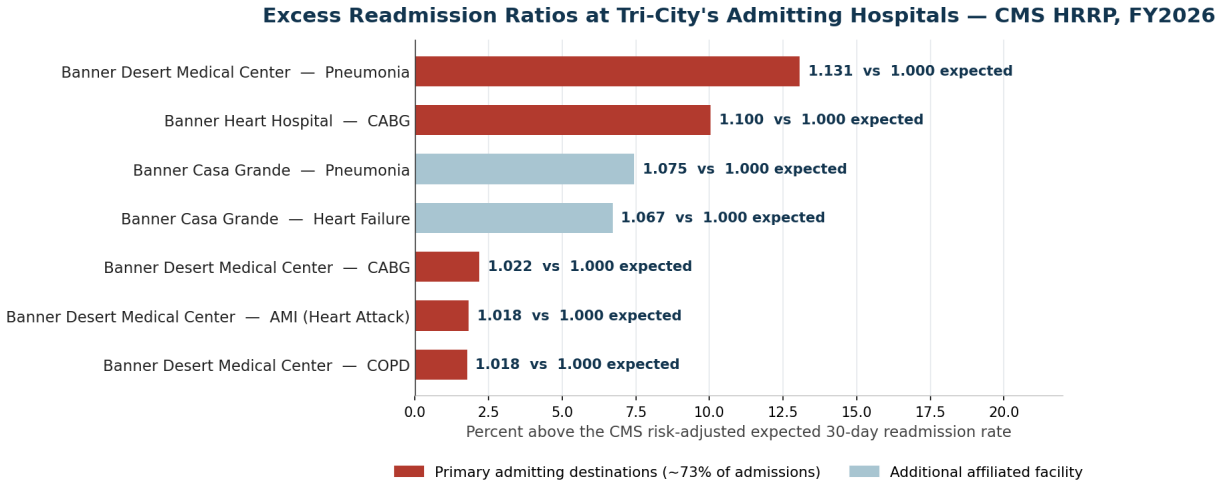

Figure 3. CMS FY2026 excess readmission ratios above 1.000 at hospitals Tri-City admits to. Ratios above 1.000 indicate more readmissions than CMS's risk adjustment expects. Lower is better; refresh against current HRRP data before citation.

Data-vintage note

The ratios above are CMS Hospital Readmissions Reduction Program figures for FY2026, covering the performance period 1 July 2021 – 30 June 2024, and only measures above 1.000 are shown. They describe the hospitals' performance, not Tri-City's — but they describe the destinations Tri-City's patients are discharged from, which is the point. Star ratings and readmission ratios should be refreshed against current CMS Care Compare data before any figure is cited to the practice.

Why the wedge matters to this group specifically

The referral relationship is the asset. Tri-City holds privileges at both Banner and Dignity facilities and has deliberately kept those relationships non-exclusive — no professional services agreement, no co-management deal, no joint venture. That independence is valuable, but it also means the relationships are maintained rather than contracted. A cardiology group that can show measurable heart-failure and post-procedure readmission reductions at facilities already exceeding their expected rates becomes materially harder to substitute. In a metro where Banner also operates employed cardiology in the East Valley, that matters.

A genuine local void in advanced heart failure. Two facts compound here. Tri-City has **no advanced heart-failure sub-specialist** among its 29 physicians — heart failure sits with the general and interventional cardiologists. And **Banner Heart Hospital has no LVAD program, no mechanical circulatory support and no transplant program**; Banner's advanced heart-failure program is at Banner–University Medical Center Phoenix, well outside the East Valley. So an East

Valley heart-failure patient who progresses leaves the East Valley entirely. A longitudinal remote heart-failure program run by Tri-City does not duplicate a service that already exists nearby — it fills a real gap in the corridor the group serves, and it keeps patients stable in the community for longer.

GDMT titration as a production process. Guideline-directed medical therapy works only when it is actually titrated to target — a task that fails in the gaps between quarterly visits, and the same failure mode that shows up in the IVD composite. Running titration as a structured, between-visit process on the remote-care engine (protocol-driven up-titration, nurse-led follow-up, connected weight and BP data) is how the group converts a guideline into an outcome. It is the single highest-ROI clinical workflow the service line enables, and it is directly measurable.

The device clinic is already halfway there. Five electrophysiologists — two recruited in December 2025 — implant and manage pacemakers, ICDs and loop recorders, with loop recorders placed in the group's own ASC. Remote transmission review is routine work for this team. RPM is not a foreign concept to be introduced; it is the same operating pattern extended from device telemetry to physiologic data, run by the same alert-and-escalation discipline. That materially shortens the adoption curve relative to a group meeting remote monitoring for the first time.

5. The NextGen Integration & Documentation Layer

Tri-City runs NextGen as its ambulatory EMR — independently corroborated, not assumed: the practice's patient-portal tenant resolves on NextGen's own PxP portal domain, the successor to Medfusion, which NextGen acquired in 2019. NextGen is one of the EHRs CoachCare integrates natively, which makes this an integrated-EHR deployment rather than a bolt-on.

What the integration does

Capability	How it works in NextGen
Bidirectional enrollment by service	Patients are enrolled into RPM, CCM or PCM from the NextGen workflow, and enrollment status flows back into the chart — the clinical team sees program status where it already works, with no second system to check
Discrete vitals into the chart	Connected-device readings — blood pressure, weight, pulse oximetry — are written into NextGen as structured, discrete data rather than scanned documents or free text, so they are visible at the point of care, trendable, and available to quality reporting
Order and results flow	Program orders and monitoring results move through the existing NextGen order/results pathway, keeping the remote-care program inside the clinical record rather than beside it
Automated claim generation	Billable encounters are generated automatically as monitoring-time and code-completion thresholds are met, and flow into the practice's existing billing workflow — the difference between a program that breaks even and one that compounds
Documentation & time logging	Care plans, monitoring minutes, patient interactions and device-data provenance are captured by the workflow at the moment of service and stored against the encounter

Integration scope — a contracting confirmation item

Confirm the NextGen product and hosting model in discovery. The NextGen integration is available at implementation. What remains to be confirmed is the exact NextGen Enterprise version, whether the group is on NextGen Cloud or self-hosted, and where it stands in the migration from the legacy Medfusion portal to PxP. Those answers set the integration scope and the implementation sequence, and they should be resolved in discovery and contracting before the build is finalized.

Auditable documentation, produced by construction

A managed remote-care service line is, among other things, a documentation system. Everything the program bills for is generated by a defined workflow rather than reconstructed from memory afterwards:

- **Protocolized care plans.** Each enrolled patient carries a documented, condition-specific care plan with defined goals and review cadence, versioned in the record.
- **Time-logged minutes.** Every care-management minute billed is logged against the encounter with the staff member, the date and the activity — the evidentiary basis for the time-based codes, captured at the moment of service.
- **Device-data provenance.** Physiologic readings carry device identity, timestamp and transmission path, so the data supporting a monitoring claim is traceable to its source.
- **Code-completion tracking.** Thresholds for each code are tracked continuously, so encounters bill when — and only when — the requirements are met.
- **HIPAA-compliant data handling under a BAA.** Patient data is handled under a Business Associate Agreement with HIPAA-compliant safeguards; security architecture and data-handling review are standard parts of the contracting process.

One layer, not another point solution

The group's leadership has been explicit about how it buys technology: it consolidated its administrative automation onto a single partner rather than assembling three or four vendors solving separate pieces. A remote-care service line native to NextGen is that same decision applied to the clinical side — one integrated layer that writes into the record the practice already uses, rather than another portal for staff to check and another dataset to reconcile. For a 13-site group running one EMR across all of them, that architectural consistency is worth as much as the economics.

6. Building the Remote Care Service Line

The service line is a build, not a purchase — but a light one, because CoachCare supplies the enrollment labor, devices, monitoring staff and billing capture. The playbook below sequences the first twelve months.

Goals, scope & target populations

- **Scope.** RPM + CCM + PCM, with TCM at every discharge, across the group's Medicare panel — run as a single enrollment and triage pathway shared by all 13 sites.
- **Lead cohorts.** Heart-failure and multimorbid patients (PCM or CCM plus RPM) first, then post-PCI, post-ablation and post-device patients on short-window RPM, then the broader hypertension and ischemic-vascular-disease population that drives the IVD composite.
- **Panel.** A discovery-stage estimate of approximately 30,400 Medicare patients — roughly 14,700 in traditional fee-for-service plus a comparable Medicare Advantage population — with cardiology eligibility modeled at 60% for RPM and 70% for CCM and PCM. Replace both the panel and the eligibility assumptions with the group's actual claims data in discovery.
- **Payer confirmation.** Pull the actual payer grid early. RPM, CCM and PCM bill cleanly on fee-for-service Medicare; the Medicare Advantage share of this panel is large enough that plan-by-plan coverage policy materially affects the ramp, particularly for the Pinal County sites where MA penetration runs higher.

Staffing, technology & billing architecture

- **Top-of-license staffing with embedded enrollment.** CoachCare-funded health coaches and nurses run telephonic enrollment, device logistics, and 24/7 monitoring and triage; a CoachCare-funded on-site enrollment specialist works the group's referral flow. The group's physicians and APPs own clinical decisions and titration — the model adds roughly 36.9 FTE-equivalent of delivered work without the practice hiring for it.
- **Native NextGen integration from day one.** Enrollment, discrete vitals, compliance documentation and claim generation live inside the existing NextGen workflow, so the service line is visible in the chart rather than in a parallel system.
- **Connected devices.** Cellular-connected BP cuffs, scales and pulse oximeters with real-time data — no patient Wi-Fi or app friction — shipped and supported by CoachCare. This matters across a footprint that stretches from Mesa to Casa Grande.
- **Alignment with the existing device clinic.** Define, at design time, how physiologic alerts and implantable-device transmissions are triaged together, so the electrophysiology team sees one escalation pathway rather than two queues.
- **Billing capture.** Automated claim generation and code-completion tracking ensure each eligible encounter is captured, with the supporting time log attached.

KPI dashboard

The service line runs on a single scorecard blending clinical, operational and financial measures:

Category	Metrics tracked
Clinical	Enrolled census; heart-failure cohort on titrated GDMT; IVD all-or-none composite (baseline 43%); BP control rate; statin and antiplatelet adherence; readings reviewed; alerts actioned; readmissions

Category	Metrics tracked
	among enrolled patients
Operational	Time-to-first-billable-enrollment; device-deployment cycle time; monitoring-time compliance; referrals per provider per month; staff-hours delivered by CoachCare
Financial	Billable-capture rate; revenue per patient per month; net reimbursement versus model; practice net after fees
Documentation	Care-plan completeness; time-log completeness per billed code; device-data provenance coverage

Expected impact & 12-month roadmap

Phase	Window	Focus	Milestone
1 Launch	Months 1–2	NextGen integration live; staff trained; HF and post-procedure cohorts identified; device-clinic escalation pathway agreed	First billable enrollments from month one
2 Ramp	Months 3–6	Enrollment ramp across RPM/CCM/PCM through the referral engine; titration protocols in production; IVD composite baselined	Census and capture rate climbing to plan
3 Scale	Months 7–12	Full panel penetration across all sites; device clinic integrated; readmission reporting shared with hospital partners	Year-1 net reimbursement (~$2,105,281 modeled)
4 Compound	Year 2	The enrolled book bills for the full year; Prescott and San Tan Valley expansion supported remotely from Mesa	Year-2 step-up (~$6,506,204 modeled)

The bottom line for Tri-City

A 29-physician independent cardiology group with its own ASC, five electrophysiologists, a NextGen EMR, a demonstrated appetite for remote technology — and zero RPM, CCM or PCM — is close to an ideal setting for a partner-built Remote Care Service Line. The model shows it is margin-positive before any value-based dollar, at $3,664,567 in modeled 24-month practice net, while closing the between-visit gap that the group's own IVD composite exposes and defending the patients it discharges into hospitals with measured excess readmissions. For a physician-owned group in a consolidating metro, a recurring, non-procedural revenue line is also revenue diversification that supports independence rather than trading it away. The right next step is a discovery session to validate the panel, eligibility and payer-grid inputs against the group's own data.

References & Data Sources

This report combines the CoachCare Value Analysis built for Tri-City Cardiology with the account research dossier, live CMS provider and quality datasets, and public sources. Items that could not be independently confirmed are flagged in-text for discovery.

1. **CoachCare Value Analysis — Tri-City Cardiology (2026).** Practice-specific model of net reimbursement, practice net, and clinical/operational value across RPM, CCM and PCM; AZ carrier/locality 03102-00. All rates and inputs user-editable; figures illustrative and modeled.
2. **Account research dossier — Tri-City Cardiology (Mesa, AZ), July 2026.** Practice profile, physician roster, sub-specialty mix, leadership, ownership, EMR, market and payer posture. Organizational NPIs 1144288416 and 1689417636; CMS Organization PAC ID 2062303076.
3. **CMS Doctors & Clinicians National Downloadable File and NPPES, queried July 2026.** Physician and advanced-practice roster, CMS primary-specialty distribution (16 interventional / 5 electrophysiology / 8 cardiovascular disease), group size and practice locations.
4. **CMS Merit-based Incentive Payment System (MIPS) public reporting, PY2023 — group level.** Final score 82.0 across 35 clinicians; ischemic vascular disease all-or-none optimal care 43% (denominator 18,080); hospital-wide 30-day readmission 15.5%; component measures for advance care planning, beta-blocker after MI, ACE/ARB, statin and antiplatelet therapy.
5. **CMS Hospital Readmissions Reduction Program, FY2026 (performance period 1 Jul 2021 – 30 Jun 2024).** Excess readmission ratios at Banner Desert Medical Center, Banner Heart Hospital and Banner Casa Grande. Refresh against current data before citation.
6. **CMS Hospital General Information file and Facility Affiliation data, queried July 2026.** Overall Hospital Star Ratings for the group's admitting facilities: Banner Desert, Banner Baywood and Banner Heart Hospital at 2 stars; Chandler Regional at 4; Mercy Gilbert at 5. Confirm current ratings on CMS Care Compare.
7. **Medicare Advantage penetration — Maricopa and Pinal counties (CMS monthly enrollment, 2026).** Maricopa approximately 51%, close to the national average; Pinal approximately 57%. Verify the current-year figures and the group's plan contracts in discovery.
8. **NextGen Healthcare — CoachCare native integration.** Bidirectional enrollment by service, discrete vitals written to the chart, order/results flow, compliance documentation and automated claim generation. NextGen confirmed via the practice's PxP patient-portal tenant; exact product version and hosting model to be confirmed in contracting.
9. **CY2026 Medicare Physician Fee Schedule — remote-care code set.** TCM, RPM (including the new 99445 and 99470 short-window codes), PCM and CCM magnitudes, locality-adjusted by the regional MAC. Confirm current-year PFS values before contracting.
10. **Public practice sources, 2024–2026.** Tri-City Cardiology website (locations, care team, services, leadership, careers); press announcements covering the ambulatory surgery center, CardioMEMS implantation in the ASC, the December 2025 electrophysiology recruitment, and the San Tan Valley campus development.

Global verification & validation caveat

All financial, clinical and operational figures in this report are illustrative and modeled from the CoachCare Value Analysis, not guarantees of outcomes. The panel (~30,400 Medicare patients) is a discovery-stage estimate; program eligibility, the referral-based enrollment engine, the avoided-admission rate, reimbursement rates and the per-admission cost basis are all user-editable assumptions that should be replaced with Tri-City Cardiology's actual claims, panel and payer data in discovery. Medicare Advantage coverage of RPM, CCM and PCM varies by plan and must be confirmed plan-by-plan. CMS billing rates are locality-adjusted and set by the regional MAC; confirm current-year Physician Fee Schedule values before contracting. Quality and readmission figures are point-in-time CMS reported data and should be refreshed before citation. NextGen product version, hosting model and integration scope are flagged in-text for confirmation.