NEW JERSEY CARDIOLOGY ASSOCIATES

Part of the RWJBarnabas Health Medical Group

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

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

Purpose of this report

This report assesses New Jersey Cardiology Associates' cardiovascular operating position — as a 21-physician subspecialty group and as the inpatient cardiology coverage for three hospitals that became mandatory TEAM participants on January 1, 2026 — and lays out a 2026 strategy in which a managed Remote Care Service Line, delivered in partnership with CoachCare, functions as both a standalone margin-positive program and the connective tissue behind episode performance, procedural growth, and quality defense. It is written for a dual audience: practice leadership and system service-line leadership.

Prepared July 2026 · Prepared with CoachCare · Confidential — for discussion purposes

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Executive Summary

New Jersey Cardiology Associates (NJCA) is one of the larger single-specialty cardiology groups in northern New Jersey: **21 cardiologists** on the published roster (site copy references 20 board-certified cardiologists — a count to confirm), including **seven electrophysiologists** and interventional and structural subspecialists, supported by **12 nurse practitioners** and an APN-led preventive cardiology and lipid clinic. The group operates five offices — West Orange (HQ), Belleville, Bloomfield, Clifton, and Toms River — has been part of the Barnabas Health (now RWJBarnabas Health) Medical Group since 2014, and runs on the system's enterprise Epic platform with MyChart as the patient front door. NJCA provides inpatient cardiology coverage at **Cooperman Barnabas Medical Center** (Livingston), **Clara Maass Medical Center** (Belleville), and **Hackensack Meridian Mountainside Medical Center** (Montclair).

The 2026 payment environment changed on January 1. All three of those coverage hospitals are mandatory participants in CMS's Transforming Episode Accountability Model (TEAM), which went live January 1, 2026 in 188 selected core-based statistical areas — including CBSA 35620 (New York–Newark–Jersey City), where all three sit. TEAM makes each hospital financially accountable for the full cost of five surgical episode families, including **coronary artery bypass graft (CABG)**, from the anchor procedure through 30 days after discharge. The 30-day post-discharge window — where readmissions and avoidable utilization live — is precisely the terrain the cardiology group controls. At the same time, the CY2026 Medicare Physician Fee Schedule added short-window remote monitoring codes (99445, 99470) that for the first time make the 2–15-day post-discharge monitoring window billable — a direct tailwind for transitional cardiac care.

NJCA has already proven the clinical model in-house. The NJCA Heart Failure Clinic equips patients to transmit daily blood pressures, weights, and a symptom questionnaire, reviewed each day by nursing staff, with same-day escalation to in-office IV diuresis. That is a working remote-monitoring program built on clinical conviction — before any dedicated enrollment engine, cellular device logistics, 24/7 coverage, or systematic billing capture. Meanwhile the panel is growing faster than the care team: in the past two years NJCA absorbed the patients and referring relationships of a retiring Bloomfield cardiology practice and added new physicians, without a matching expansion in advanced-practice capacity. The gap between what the group's clinicians believe in and what its current infrastructure can scale to is the opportunity this report addresses.

> **The central argument**
>
> **Build once, reuse everywhere.** A managed Remote Care Service Line — TCM at every discharge, RPM for physiologic monitoring, and PCM as the longitudinal care-management wrapper, delivered with CoachCare's full-service model (telephonic enrollment, a CoachCare-funded on-site enrollment specialist, cellular connected devices, 24/7 alert and triage, automated claim generation, and direct bi-directional Epic integration) — pays for itself as a standalone program: an illustrative modeled $3.71M in 24-month practice net reimbursement and $1.59M retained by the practice — a 42.7% practice margin on net reimbursement. The same infrastructure is the connective tissue for the TEAM episodes its three coverage hospitals now own, the scale engine for the heart failure program NJCA already built, and the growth platform for structural heart, EP, and renal denervation. One service line, every value lever. Illustrative, modeled — verify against practice data.

The readmission wedge. At the three TEAM hospitals, heart failure 30-day readmissions run at or above the national rate at two of three (Clara Maass 20.4%, Mountainside 20.2%, vs. 19.7% national), CABG readmissions at Cooperman Barnabas run above national (11.1% vs. 10.6%), and excess-days-in-acute-care measures for heart failure are flagged “more days than average” at both Cooperman Barnabas and

Clara Maass (CMS Care Compare, July 2021–June 2024 data). Every point of that gap is now, under TEAM, a reconciliation-payment question for the hospitals NJCA staffs — and remote transitional care is the most direct operational response available to a cardiology group.

The economics. Modeled on an estimated Medicare panel of 4,450 (range 4,000–4,500 — an estimate to validate with chart counts), the service line reaches its modeled RPM enrollment ceiling of ~1,168 in month 11 and produces the following. All figures are illustrative, modeled — verify against practice data:

	Year 1	Year 2	24-Month Total
Practice net reimbursement	$1,203,649	$2,506,044	$3,709,693
CoachCare program fees	$698,078	$1,426,608	$2,124,686
Practice margin (retained by the practice)	$505,571	$1,079,436	$1,585,007
Practice margin, % of net reimbursement	42.0%	43.1%	42.7%

Month 1 is modeled at −$3,475 as one-time implementation and Epic integration setup fees land against a small starting census (~60 active enrollments); margin turns positive in month two (+$7,830), the setup cost is recovered inside the first quarter, and there is no negative-margin quarter. Alongside the professional-fee line, the model projects ~146 avoided hospitalizations over 24 months (~$2.20M at an illustrative $15,000 per admission) and ~29,048 care-team hours absorbed by the CoachCare clinical team — capacity NJCA does not have to hire.

2026–2027 Priority Recommendations

1. **Stand up the Remote Care Service Line as one program.** A single TCM + RPM + PCM stack with one enrollment funnel, one device logistics chain, one triage protocol, and one billing engine — governed jointly by practice leadership and the system's cardiovascular service line.
2. **Convert the Heart Failure Clinic into the flagship pathway.** Keep the clinical model NJCA built — daily weights, BP, symptom review, IV diuresis escalation — and scale it with CoachCare's enrollment engine, cellular devices, 24/7 monitoring, and systematic billing capture toward the modeled ~1,168-enrollment monitored RPM census.
3. **Wire transitional care to every cardiac discharge at the three TEAM hospitals.** TCM contact within two business days, device on the patient before or at discharge, and a billable first-14-day monitoring window (99445) — reported monthly to each hospital's episode team as episode-performance support for Cooperman Barnabas, Clara Maass, and Mountainside.
4. **Integrate directly with enterprise Epic.** Enrollment flags, discrete vitals, care summaries, and automated claim generation inside the existing Epic environment — scoped with the RWJBarnabas Health Epic team, with exact product and version configuration confirmed in contracting.
5. **Extend the platform to EP, structural heart, and renal denervation.** Add physiologic monitoring to the seven-EP device clinic's remote device workflow, wrap post-TAVR patients in 30-day monitoring, and treat renal denervation — now Medicare-covered under coverage-with-evidence-development — as monitored-hypertension whitespace.
6. **Validate the panel and re-run the Value Analysis.** The 4,450 Medicare panel is an estimate from claims data; chart counts in discovery will tighten the forecast, whose ceiling-driven trajectory depends directly on it.

1. Footprint & Operating Model

1.1 The practice

NJCA is a subspecialty-complete cardiology group operating across Essex, Passaic, and Ocean counties, embedded since 2014 in one of New Jersey's largest health systems. Facts below are from the practice's public materials and federal registries, retrieved July 27, 2026.

Dimension	Detail
Physicians	21 cardiologists on the published roster (site copy says 20 board-certified — confirm); newest physician welcomed in 2026
Subspecialties	7 electrophysiologists; interventional cardiology; structural heart (TAVR program); nuclear cardiology; dedicated Heart Failure Clinic; APN-led preventive cardiology & lipid clinic
Advanced practice	12 nurse practitioners (per practice materials; individual roster not published) + clinical lipid specialist (APN, DNP)
Offices	West Orange (HQ) · Belleville · Bloomfield · Clifton · Toms River
Organization	Part of Barnabas Health Medical Group / RWJBarnabas Health Medical Group since 2014; physicians bill under the medical group (group PAC ID 9537316955)
EMR / portal	Enterprise Epic (RWJBarnabas Health); RWJBarnabas MyChart patient portal
Inpatient coverage	Cooperman Barnabas Medical Center (CCN 310076) · Clara Maass Medical Center (CCN 310009) · Hackensack Meridian Mountainside Medical Center (CCN 310054)
Existing remote programs	Heart Failure Clinic daily telemonitoring (BP, weight, symptom questionnaire; nurse-reviewed); device clinic with remote ICD monitoring, transtelephonic pacemaker checks, implantable loop recorders

1.2 The hospitals NJCA staffs

NJCA's inpatient coverage footprint spans three acute-care hospitals across two systems — all three of which became mandatory TEAM participants on January 1, 2026 (Section 3). This dual-system coverage position is an asset: the same ambulatory infrastructure can support episode performance on both sides.

Hospital	CCN	System	CMS Overall Star Rating*
Cooperman Barnabas Medical Center, Livingston	310076	RWJBarnabas Health	3 of 5
Clara Maass Medical Center, Belleville	310009	RWJBarnabas Health	3 of 5
Hackensack Meridian Mountainside Medical Center, Montclair	310054	Hackensack Meridian Health	4 of 5

**CMS Care Compare Hospital General Information, retrieved July 2026 — confirm current ratings on Care Compare.*

1.3 Growth without proportional care-team growth

Two structural facts define NJCA's operating moment. First, the panel is expanding: the group absorbed the patients and referring relationships of a retiring Bloomfield cardiology practice (2025), moved two physicians into that office to hold the referral base, and added its newest cardiologist in 2026. Second,

the care team is not expanding at the same rate: the published advanced-practice complement remains 12 NPs. Every absorbed panel and each new physician adds longitudinal monitoring demand — daily readings to review, calls to make, titrations to track — that currently lands on the same nursing capacity that reviews the Heart Failure Clinic transmissions by hand.

A managed remote care program inverts that math: CoachCare's clinical team absorbs the monitoring, outreach, and documentation workload (an illustrative ~29,048 care-team hours over 24 months — the equivalent of ~14.0 clinical FTE-years), while NJCA's clinicians operate at top of license on exceptions and escalations. Growth in panel size becomes growth in program revenue rather than growth in unreviewed data.

1.4 Design principles for the 2026 operating model

Principle	What it means for NJCA
Longitudinal by default	Every cardiac discharge and every chronic cardiac patient exits into a monitored pathway, not a follow-up appointment alone
One front door	A single enrollment funnel across offices, hospitals, and programs — not per-clinic, per-nurse improvisation
Single scorecard	Practice leadership and system service-line leadership read the same monthly numbers: census, capture, readmissions, revenue
Hub-and-spoke	West Orange anchors the program; all five offices and all three coverage hospitals feed it
Digital as care, not as an app	Devices, alerts, and coaching are clinical services with billing codes and outcomes — held to service-line standards

2. The Remote Care Service Line — The Spine

2.1 What It Is

The Remote Care Service Line is a managed clinical program, not a software purchase. For a cardiology group it runs on three Medicare care-management services, coordinated as one stack:

Service	What it is	Cardiac role
TCM — Transitional Care Management (99495/99496)	30-day post-discharge management: contact within 2 business days, face-to-face within 7 or 14 days	The front edge of every CABG, HF, AMI, and procedural discharge at the three coverage hospitals
RPM — Remote Physiologic Monitoring (99453, 99454/99445, 99457/99470, 99458)	Connected-device monitoring (BP, weight, pulse ox) with monthly management time; new 2026 codes bill 2–15-day windows and first-10-minute management	Daily physiologic surveillance — the scaled version of what the Heart Failure Clinic already does
PCM — Principal Care Management (99426/99427)	Monthly management of one principal high-risk condition — or of cardiovascular disease as a single domain — expected to last at least three months	The longitudinal care-management wrapper for the condition NJCA actually owns: resistant hypertension, coronary disease, heart failure

> The coordination rule (one patient, one wrapper)
>
> Each patient carries one longitudinal care-management wrapper — PCM on the principal cardiac condition — and RPM stacks with it in the same month on discrete time and documentation. TCM owns the 30 days after discharge; the patient then lands in the longitudinal program. One consent conversation covers the stack, and CoachCare's billing engine enforces the combinations so capture never becomes a compliance question.

Why PCM, not CCM. A specialist's care management is focused on one principal condition — resistant hypertension, coronary disease, heart failure — or on cardiovascular disease as a single domain, which is precisely what Principal Care Management is written for. Chronic Care Management assumes management of all of a patient's conditions, and it is increasingly billed by the patient's primary care practice, or absorbed into a prospective payment there. PCM is the code that fits NJCA's actual scope and does not collide with the PCP's.

The full-service model. CoachCare operates the program end to end: telephonic enrollment outreach in NJCA's name, a CoachCare-funded on-site enrollment specialist embedded in the practice, cellular connected devices shipped configured (no patient Wi-Fi or pairing burden), 24/7 alert monitoring and triage, dedicated health coaches, audit-ready documentation, and automated claim generation. The enrollment specialist and clinical monitoring staff are CoachCare's expense — their output shows up in NJCA's numbers as enrolled census and captured revenue, not as practice headcount.

2.2 Standalone Value: The 24-Month Value Analysis

Before any episode-model or throughput benefit, the service line must stand on its own P&L. Four value layers, in order of immediacy:

1. **Recurring professional-fee revenue.** Subscription-like monthly billing across the monitored census — modeled at $3.71M in practice net reimbursement over 24 months, of which $1.59M is retained by the practice (a 42.7% practice margin).
2. **TEAM episode-cost performance.** Readmissions and post-acute utilization avoided inside 30-day episodes at Cooperman Barnabas, Clara Maass, and Mountainside — value that accrues to the hospitals NJCA staffs (Sections 3 and 7).
3. **Procedural and program growth.** Post-TAVR monitoring capacity, EP device-clinic modernization, and renal denervation readiness (Section 8).
4. **Quality-halo defense.** Readmission measures, excess-days flags, and star ratings at the coverage hospitals — defended by the same monitoring loop (Section 5).

The CY2026 billing stack

Service / code	Type	~CY2026 magnitude	Notes
TCM 99495 / 99496	Per discharge	~$200 / ~$280	Moderate / high complexity; contact within 2 business days
RPM 99453	One-time setup	~$20	Device setup & patient education
RPM 99454 / 99445	Monthly	~$52	99454 = 16–30 days of readings; 99445 = new 2026 code for 2–15-day windows — makes short transitional monitoring billable
RPM 99457 / 99470	Monthly	~$52 / ~$26	First 20 management minutes / new 2026 first-10-minute code
RPM 99458	Monthly	~$41	Each additional 20 minutes
PCM 99426 / 99427	Monthly	~$60 + ~$50 addl	The principal cardiac condition — HF, CAD, resistant hypertension — at least 3 months

Illustrative national non-facility magnitudes. Actual payment is locality-adjusted — NJCA's offices fall under Novitas jurisdiction (carrier 12402, NJ locality 01). Verify against the current CY2026 Physician Fee Schedule.

Model inputs

Input	Value	Basis
Medicare panel	4,450 (estimate; range 4,000–4,500)	Estimated from reported Medicare allowed charges (~$5.81M ÷ $1,300 cardiology-calibrated divisor ≈ 4,473). Implies ~213 Medicare patients per physician — conservative vs. benchmark, consistent with an employed-group billing split. Validate with chart counts.
Program eligibility	RPM 75% (3,338 patients) · PCM 85% (3,783 patients)	Cardiology eligibility profile
Enrollment acceptance	RPM 35% · PCM 30%	Modeled acceptance among eligible patients
Referring providers	33 (21 MD + 12 NP)	Published roster
EMR	Epic (enterprise)	Integration setup and per-patient fees included in the model
Enrollment staffing	1 on-site enrollment specialist	CoachCare-funded — embedded value, not a practice expense

Modeled results (illustrative — verify against practice data)

	Year 1	Year 2	24-Month
Practice net reimbursement	$1,203,649	$2,506,044	$3,709,693
CoachCare program fees (incl. integration & ancillary)	$698,078	$1,426,608	$2,124,686
Practice margin	$505,571	$1,079,436	$1,585,007
Practice margin, % of net reimbursement	42.0%	43.1%	42.7%

Program (24-month)	Net reimbursement	Practice margin
RPM	$2,419,428	$1,059,720
PCM	$1,290,265	$600,963
Implementation & ancillary	—	−$75,676
Total	$3,709,693	$1,585,007

Census trajectory and ceilings. Enrollment ramps from a ~60-enrollment first-month census. The RPM program reaches its modeled ceiling of ~1,168 enrollments at month 11 and holds; PCM is still climbing at month 24 (~1,033 enrollments against a ~1,135 ceiling). That is 2,202 active program enrollments at month 24, carried by 1,478 unique patients once dual enrollment is deduplicated — per-program figures round independently and may differ by one from the total. Two consequences: the forecast is ceiling-driven, so it moves directly with the panel estimate — and saturation this early means the constraint is the panel definition, not outreach capacity. Chart counts in discovery will tighten the whole 24-month number.

> **Month-one economics — read before quoting**
>
> Month 1 is modeled at −$3,475: one-time implementation and Epic integration setup fees land against the small starting census. Margin turns positive in month two (+$7,830), all setup cost is recovered inside the first quarter, and there is no negative-margin quarter across the 24 months. Over 24 months the practice retains $1,585,007 of $3,709,693 in net reimbursement — a 42.7% practice margin (Year 1 42.0%, Year 2 43.1%).

Clinical and operational value (24-month, modeled)

Metric	24-month value	Meaning
Claims / billable units generated	~60,560	Produced by CoachCare's automated billing engine — no manual claim work in the practice
Physiologic readings captured	~230,561	Daily BP/weight/symptom data flowing into Epic as discrete vitals
Hospitalizations avoided	~146	~$2.20M at an illustrative $15,000/admission — value accruing largely at the three coverage hospitals
Care-team hours absorbed	~29,048 (~14.0 FTE-years)	Monitoring, outreach, and documentation performed by CoachCare's clinical team

All modeled figures are illustrative, modeled — verify against practice data.

2.3 Connective Tissue: One Engine, Every Lever

The standalone P&L is the floor. The strategic case is that the same seven capabilities — enrollment, device logistics, 24/7 alert-and-triage, nurse navigation, billing capture, Epic integration, analytics — are the operating requirement behind every value lever NJCA and its hospitals face in 2026. Build the engine once; every lever reuses it.

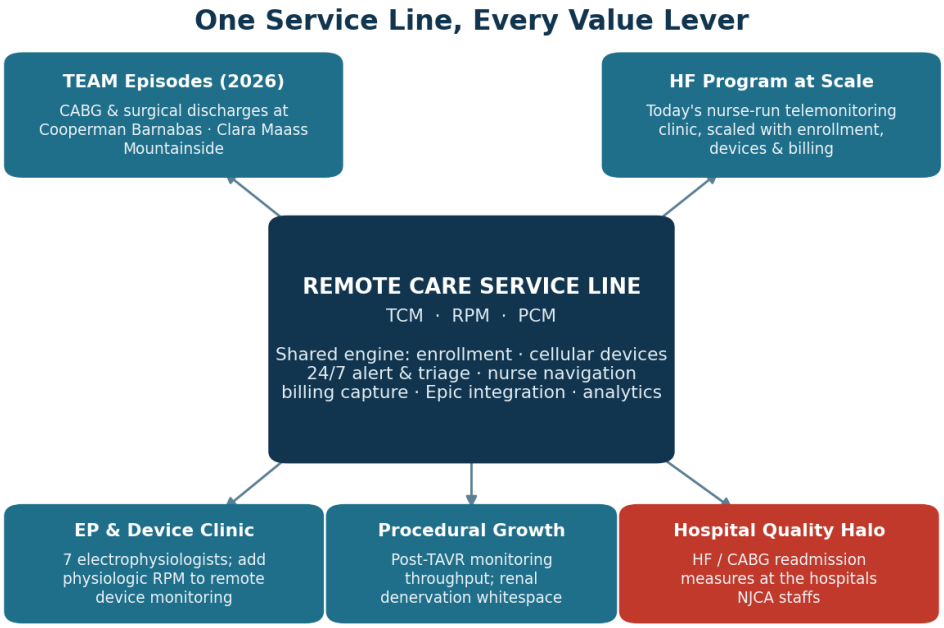

Figure 1. One service line is the connective tissue for the TEAM episodes NJCA's hospitals now own — and for every other 2026 value lever.

Value lever	What performance requires	What the shared engine supplies
TEAM episodes (Cooperman Barnabas · Clara Maass · Mountainside)	30-day post-discharge cost control on CABG and other surgical episodes	TCM at discharge + billable 14-day RPM window + escalation before readmission
Heart Failure Program at scale	Enrollment engine, devices, 24/7 review, billing capture on today's nurse-run clinic	The full-service wrapper around NJCA's proven clinical model
EP & device clinic (7 EPs)	Physiologic context around remote device data; monitored AF/HF cohorts	Cellular BP/weight monitoring in the same workflow as device checks
Structural heart (TAVR)	Confident early discharge; 30-day surveillance	Post-procedure RPM window with automated alerting
Renal denervation readiness	Documented monitored hypertension before and after therapy	BP RPM census and longitudinal data as the patient-selection substrate
Hospital quality halo	HF/CABG readmission and excess-days performance at the coverage hospitals	The same readmission-prevention loop, reported monthly

Value lever	What performance requires	What the shared engine supplies
Standalone P&L	Census, capture, compliance	Enrollment, billing engine, and audit-ready documentation

3. The 2026 Payment Environment: TEAM at the Hospitals NJCA Staffs

What TEAM is. The Transforming Episode Accountability Model is CMS's mandatory episode-based payment model, running **January 1, 2026 through December 31, 2030**. Hospitals in 188 selected CBSAs (finalized in the FY2025 IPPS Final Rule) are accountable for the cost and quality of five surgical episode families — **CABG**, lower-extremity joint replacement, surgical hip/femur fracture treatment, spinal fusion, and major bowel procedures — from the anchor procedure through **30 days after hospital discharge**. Spending is reconciled annually against a regional target price with a quality adjustment: beat the target and the hospital keeps savings; exceed it and the hospital repays CMS. Participation is determined per hospital CCN.

3.1 Which hospitals are in — verified

All three hospitals where NJCA provides inpatient cardiology coverage are mandatory TEAM participants. Their shared CBSA — 35620, New York–Newark–Jersey City — is on the 188-CBSA list, and each facility appears on the CMS-published TEAM participant hospital list (verified against the American Society of Anesthesiologists' republication of the CMS list, updated June 4, 2025; confirm against the current CMS participant file, which CMS may update):

Hospital	CCN	CBSA	TEAM status (effective Jan 1, 2026)
Cooperman Barnabas Medical Center	310076	35620	Mandatory participant — verified
Clara Maass Medical Center	310009	35620	Mandatory participant — verified
Hackensack Meridian Mountainside Medical Center	310054	35620	Mandatory participant — verified

Scope note: this report addresses TEAM only at these three facilities — the hospitals where NJCA provides inpatient coverage. The TEAM status of any other facility is outside this report's scope.

3.2 Why a hospital model lands on a cardiology group

TEAM accountability sits with the hospital, but episode performance is decided in the 30 days after discharge — in medication titration, symptom surveillance, decongestion, and the decision between an office visit, an infusion chair, and an emergency department. For CABG episodes specifically, the patient is a cardiology patient before the surgeon ever sees them and returns to cardiology management the week they leave the hospital. The group that controls the post-discharge cardiac pathway controls the episode's variable cost.

That gives NJCA an unusual dual-system position: it is the ambulatory cardiology partner that can deliver measurable episode support to Cooperman Barnabas and Clara Maass on the RWJBarnabas side and to Mountainside on the Hackensack Meridian side — with one infrastructure. For system service-line leadership, that is episode-cost defense from a group already inside the buildings. For practice leadership, it is professional-fee revenue on work that simultaneously makes the practice more valuable to both systems it serves (Section 7 details the operational bundle).

> **Timing**
>
> TEAM is live now — episodes have been accruing since January 1, 2026, and the first reconciliation will settle against calendar-2026 performance. Every month without a systematic discharge-to-monitoring pathway is a month of episodes settled on unmanaged 30-day utilization.

4. An Operating System for Service-Line Performance

A service line is managed by a scorecard, not a slogan. The recommended monthly view — shared between NJCA leadership and system cardiovascular service-line leadership — adds a remote-care row to the standard access/quality/financial panel:

Domain	Example monthly metrics
Access & growth	New-patient lag by office; referral volume by source; post-discharge appointment lead time
Quality & outcomes	30-day readmissions (HF, post-CABG, AMI) at the three coverage hospitals; GDMT optimization rate; BP control rate
Episode performance (TEAM)	Episode volume by hospital; 30-day post-discharge utilization; % of episode discharges reached within 2 business days
Remote Care Service Line	Enrolled census by program (RPM/PCM) and unique enrolled patients; time-to-first-billable-enrollment; monthly capture rate; revenue per enrolled patient per month; alert-resolution time
Financial	Program net reimbursement vs. model; profit vs. model; payer mix of enrolled census
Patient experience	Enrollment acceptance rate; device adherence (days transmitting per month); program retention

4.1 TEAM readiness checklist (the three coverage hospitals)

Capability	Status today	With the Remote Care Service Line
Identify every episode-eligible cardiac discharge within 24 hours	Manual, rounder-dependent	Discharge feed from each hospital + enrollment flag in Epic
TCM contact within 2 business days	Ad hoc	Systematic, staffed by the program, tracked to a capture-rate metric
Device on patient at/before discharge	Not in place (HF clinic devices are clinic-issued)	Cellular kit shipped or handed at bedside; readings from home on the first evening
Billable 2–15-day monitoring window	Not billable before CY2026	99445 short-window RPM as standard on every appropriate discharge
Escalation path short of the ED	IV diuresis clinic (West Orange)	24/7 triage routes alerts to same/next-day office or infusion slots at all offices
Monthly episode reporting to hospital leadership	None	Standing episode-support report per hospital: discharges reached, readmissions vs. baseline

5. Performance Snapshot: The Three TEAM Hospitals

The empirical starting position for episode and quality performance is the readmission profile of the three hospitals NJCA staffs. Data: CMS Care Compare unplanned-visits file, measure period July 2021–June 2024 (hospital-wide measure: July 2023–June 2024), retrieved July 2026. This is a directional snapshot — refresh against the current file before external use.

Hospital	CMS overall rating	Hospital-wide readmission (hybrid HWR)	vs. national 15.0%
Cooperman Barnabas Medical Center	3 of 5	15.9%	Worse than national
Clara Maass Medical Center	3 of 5	16.1%	No different than national
HMH Mountainside Medical Center	4 of 5	15.1%	No different than national

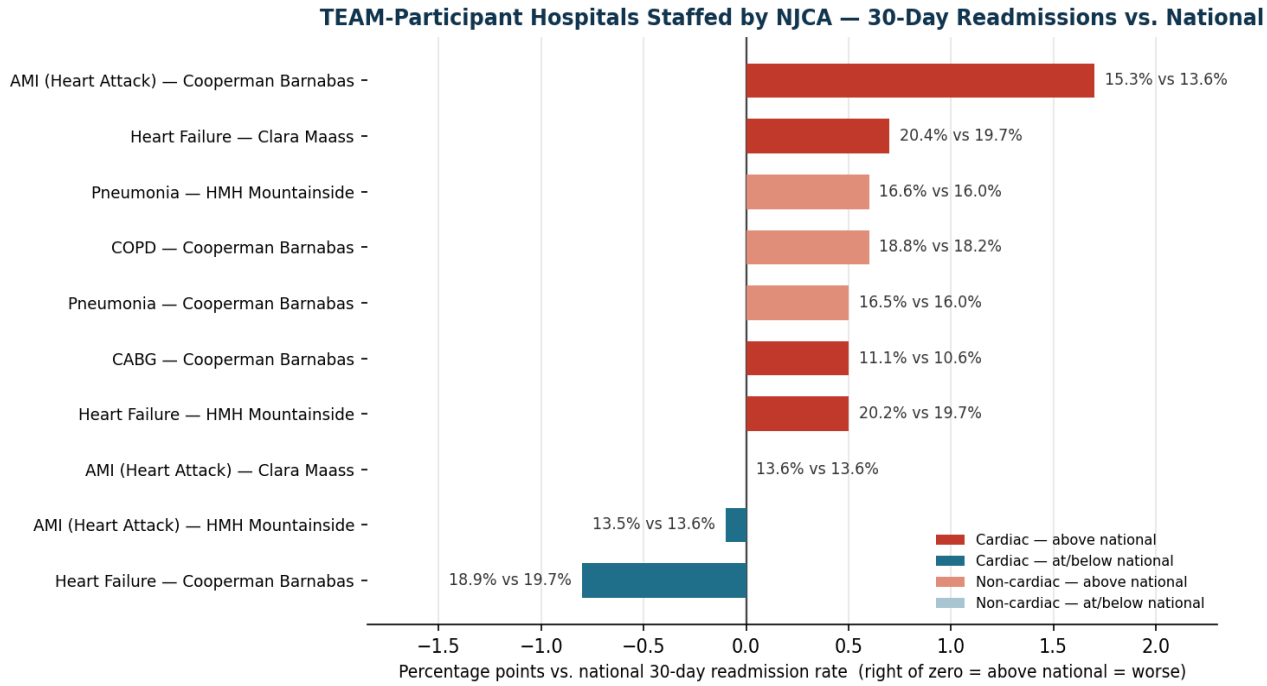

Figure 2. 30-day readmission rates minus the national rate, by measure and hospital. Bars right of zero are above national (worse). Lower is better. CMS Care Compare, Jul 2021–Jun 2024; directional snapshot — refresh against current data.

Read the cardiac rows. Heart failure readmissions sit above the 19.7% national rate at Clara Maass (20.4%) and Mountainside (20.2%); Cooperman Barnabas is below on the rate (18.9%) but carries an excess-days flag (below). CABG readmissions at Cooperman Barnabas — the flagship cardiac-surgery site among the three, and the direct TEAM-episode measure — run 11.1% against 10.6% national. AMI readmissions at Cooperman Barnabas run 15.3% vs. 13.6%. None of these gaps is catastrophic; all of them are exactly the utilization a monitored 30-day pathway compresses, and under TEAM each point now has a reconciliation price attached.

The excess-days signal (EDAC)

CMS's excess-days-in-acute-care measures count every extra day patients spend back in the hospital or ED within 30 days. For heart failure, Clara Maass runs +33.4 excess days per 100 discharges and Cooperman Barnabas +9.2 — both flagged “more days than average.” For heart attack, Cooperman Barnabas runs +58.9 and Clara Maass +22.8. Rate-based measures can look “no different than national” while the days pile up; the days are where episode cost lives.

For a cardiology group, this profile is an agenda: the HF and post-surgical cardiac measures at the hospitals NJCA staffs are the measures its own post-discharge pathway touches most directly. Section 6 covers the HF engine; Section 7 the episode bundle.

6. Scaling What NJCA Built: The Heart Failure Program

6.1 Honor the build

NJCA did not wait for a payment model to take heart failure monitoring seriously. The NJCA Heart Failure Clinic already operates the clinical core of a remote-monitoring program: patients receive equipment to transmit **daily blood pressures, weights, and a short symptom questionnaire**, nursing staff review the data every day, and decompensating patients are pulled into **in-office IV diuresis** rather than the emergency department. That is the correct clinical model — surveillance, early detection, treatment short of admission — and it was built on conviction, in-house. The strategy question is not whether the model works. It is what it takes to run it at panel scale, and whether the practice is being paid for it.

6.2 What scale requires

Capability	Today (from public materials)	At scale (with CoachCare)
Enrollment	Clinic-by-clinic, clinician-initiated	Telephonic outreach across the eligible panel + a CoachCare-funded on-site enrollment specialist; modeled ramp to ~1,168 RPM enrollments by month 11
Devices	Clinic-issued equipment	Cellular-connected BP cuffs and scales shipped configured; no Wi-Fi, no pairing, no office inventory burden
Daily review	Nurse-reviewed by hand — linear in census	24/7 alert-and-triage: exceptions surface, normals don't consume nursing time; escalations route to NJCA's own IV diuresis pathway
Billing capture	No billed remote-monitoring or care-management program is evident in public materials (the current program's billing and vendor status is a first-call discovery item)	Automated claim generation across TCM/RPM/PCM — modeled ~60,560 billable units over 24 months
Economics	Program cost center	Modeled $3.71M net reimbursement over 24 months, of which $1.59M is retained by the practice — a 42.7% practice margin, turning positive in month two

6.3 GDMT titration as a production process

The clinical payoff of daily physiologic data is guideline-directed medical therapy run as a production process: every monitored HF patient tracked to target doses of the four pillars, with BP, weight, and symptom trends arriving continuously instead of at quarterly visits. Titration encounters become data-triggered rather than schedule-triggered, and the funnel is closed-loop: hospital discharge → TCM → 14-day intensive monitoring window → longitudinal RPM with the PCM wrapper on the principal cardiac condition → IV diuresis or urgent visit on alert → back to steady state. The modeled program projects ~146 avoided hospitalizations over 24 months; at the three coverage hospitals, each one is simultaneously an avoided readmission on the measures in Section 5 and avoided episode cost under TEAM.

The nurse-capacity arithmetic makes the case on its own: the modeled census generates ~230,561 physiologic readings over 24 months. Reviewing that by hand is roughly 29,048 hours of clinical labor —

~14.0 FTE-years — which is precisely the load CoachCare's monitoring team absorbs so that NJCA's nurses handle only the exceptions their clinical judgment is needed for.

7. Powering TEAM: Episode Performance Where NJCA Rounds

7.1 What changed for the hospitals on January 1

Since January 1, 2026, every TEAM episode initiated at Cooperman Barnabas, Clara Maass, or Mountainside carries a target price, and the 30 days after discharge are the hospital's financial exposure. The hospitals own the accountability; they do not own the ambulatory cardiac pathway their episode patients return to. NJCA does. That asymmetry is the practice's strategic leverage — and its opportunity to be paid, in professional fees, for work that defends its hospitals' reconciliation.

7.2 The episode discharge bundle

For every appropriate cardiac discharge — CABG episodes at the cardiac-surgery site, and medical cardiology discharges (HF, AMI, arrhythmia) at all three hospitals, which drive the readmission measures and returning-patient flow — the bundle is:

Step	Window	Service & code
Identify + flag at discharge	Day 0	Discharge feed + Epic enrollment flag; device handed at bedside or shipped same day
Contact	Within 2 business days	TCM initiation (99496 high-complexity for CABG/HF discharges)
Intensive monitoring	Days 1–14	Short-window RPM (99453 setup + 99445, new for CY2026) — daily BP/weight/symptoms with 24/7 triage
Face-to-face	Within 7 days (99496)	Office visit with monitoring data on the screen
Management	Month 1 and ongoing	99457/99470 + 99458 management time; escalation to IV diuresis / urgent slots instead of the ED
Longitudinal hand-off	Day 30+	PCM wrapper on the principal cardiac condition + continuing RPM (99454) for chronic-phase management

7.3 Directly accretive — to the practice and to its hospitals

The bundle pays twice. The practice bills TCM and the monitoring stack — professional-fee revenue already counted in the Section 2 model. The hospitals get compressed 30-day utilization on episodes they now own: the modeled ~146 avoided hospitalizations over 24 months (~$2.20M at an illustrative $15,000 per admission) land disproportionately in the 30-day windows that TEAM reconciles and the readmission measures score. For system service-line leadership, this is an episode-performance capability that requires no hospital hiring; for practice leadership, it is the strongest possible answer to “what does the group contribute to episode performance?” — with a monthly report per hospital to prove it.

> **Build once, reuse everywhere**
>
> The engine that manages a CABG episode discharge at Cooperman Barnabas is identical to the one that manages an HF discharge at Clara Maass or Mountainside and an AF ablation discharge from the EP service: same devices, same triage, same billing engine, same Epic workflow. TEAM is one payer of many for the same infrastructure — which is why the service line, not the episode, is the unit of investment.

8. Procedural & Program Growth: Structural Heart, EP, Renal Denervation

8.1 Structural heart: post-TAVR monitoring

NJCA maintains a TAVR program with its hospital partners. Post-TAVR patients are a natural monitored cohort: 30-day surveillance for conduction issues, volume status, and BP management supports confident early discharge and clean 30-day outcomes — the metrics on which structural-heart programs are judged and grown. The same short-window RPM codes that serve TEAM episodes (99445) make this monitoring billable. (TAVR is not itself a TEAM episode; the value here is throughput, outcomes, and program reputation, not episode reconciliation.)

8.2 EP and the device clinic: add physiology to device data

With seven electrophysiologists, NJCA already runs one of the region's larger device clinics — remote ICD monitoring, pacemaker checks, implantable loop recorders. That means remote monitoring is already culturally normal for a large slice of the panel. What device telemetry lacks is physiologic context: a loop recorder sees the arrhythmia, not the blood pressure, weight trend, or symptom burden around it. Layering RPM onto AF and HF device patients puts rhythm and physiology in one workflow — richer pre/post-ablation management, earlier decompensation detection in CRT/ICD heart-failure patients, and a monitored cohort that is already comfortable with the concept. Operationally it is the easiest expansion in the plan: the patients are identified, engaged, and seen on a device-clinic cadence today.

8.3 Renal denervation: policy-aligned whitespace

Medicare established national coverage for renal denervation for uncontrolled hypertension effective October 28, 2025 (NCD 20.40) under coverage-with-evidence-development. Every step of that pathway is remote-monitoring-dependent: documented uncontrolled BP on optimized therapy for patient selection, and longitudinal BP evidence after the procedure. NJCA's public materials show no renal denervation program today — which makes a monitored-hypertension census the low-cost option on the future: build the BP monitoring backbone now inside the service line, and the group holds the patient-selection substrate and evidence infrastructure whether it ultimately performs, refers, or co-manages RDN with its hospital partners.

9. Implementation Playbook

9.1 Scope and target populations

Cohort	Source	Entry pathway
Heart Failure Clinic census	Existing program	Convert first — devices, triage, billing capture on the proven model
Cardiac discharges — Cooperman Barnabas, Clara Maass, Mountainside	Inpatient coverage	TCM + 14-day RPM bundle on every appropriate discharge (Section 7)
EP / device-clinic patients (AF, HF with devices)	Device clinic	Physiologic RPM layered on device follow-up (Section 8)
Principal-condition & hypertension panel	Five offices; preventive & lipid clinic	PCM wrapper + BP monitoring; feeds RDN readiness

9.2 Staffing and operating model

- **CoachCare provides:** telephonic enrollment in NJCA's name, one on-site enrollment specialist (CoachCare's expense — embedded value, never netted against practice margin), dedicated health coaches and 24/7 monitoring clinicians, cellular device logistics, compliance documentation, and automated claim generation.
- **NJCA provides:** clinical protocols and standing orders, physician/APP oversight at top of license, the escalation pathway (urgent slots, IV diuresis), and the clinical champion — the practice's existing preventive and HF program leadership are natural fits.
- **Governance:** a monthly service-line review attended by practice leadership and system cardiovascular service-line leadership, run off the single scorecard (Section 4), with a standing episode-support report per coverage hospital.

9.3 Technology, data, and billing: Epic integration

NJCA runs on RWJBarnabas Health's enterprise Epic, so the program must live inside Epic — and CoachCare's integration is built for exactly that. Five pillars:

1. **Integrated enrollment** — enrollment flags and trigger ordering inside the clinical workflow; CoachCare enrolls qualified Medicare patients on the practice's behalf, with status visible in Epic in real time.
2. **Health-history exchange** — bi-directional at intake.
3. **Discrete vitals** — device readings land as discrete vitals in the chart, not PDFs.
4. **Compliance documentation** — audit-ready care summaries in the record.
5. **Automated claim generation** — CoachCare is the only care-management platform integrated with Epic that provides automated claims creation, eliminating the per-patient, per-month manual claim step.

Patients typically begin receiving services within five days of an enrollment flag. Because this is an enterprise Epic instance, integration scoping runs through the RWJBarnabas Health Epic team — a governance step to start early — with exact product, version, and interface configuration confirmed in contracting. In the words of CoachCare's product leadership: “Key to achieving a program that is efficient,

effective and sustainable is creating a seamless, intuitive user experience for the patient and provider, and that's what our integration with Epic accomplishes."

9.4 KPI dashboard

Category	KPIs
Clinical	30-day readmission rate for monitored vs. unmonitored discharges; GDMT target-dose rate; BP control rate; alert-to-intervention time
Operational	Enrolled census by program; time-to-first-billable-enrollment; device adherence (transmitting days/month); enrollment acceptance rate
Financial	Capture rate (billed vs. billable); revenue per enrolled patient per month; program profit vs. model; month-over-month census vs. ramp curve
Episode support	% of episode-eligible discharges contacted in 2 business days; 14-day monitoring coverage rate; per-hospital readmission trend

9.5 Twelve-month roadmap

Phase	Months	Milestones
Foundation	1–2	Contracting; Epic integration scoping with the system Epic team; protocols and standing orders; enrollment specialist on site; HF Clinic census conversion begins. (One-time setup lands in month 1; margin turns positive in month two.)
Ramp	3–6	Discharge bundle live at all three coverage hospitals; telephonic enrollment across the eligible panel; first monthly scorecard and first per-hospital episode-support report
Scale	7–12	RPM census approaches its ~1,168-enrollment modeled ceiling (month 11); EP/device-clinic and post-TAVR cohorts onboard; RDN-readiness cohort defined; Value Analysis re-run on validated chart counts

9.6 Discovery items (first-call agenda)

1. Validate the Medicare panel (modeled at 4,450; range 4,000–4,500) with chart counts, and re-run the Value Analysis on actuals.
2. Confirm the Heart Failure Clinic telemonitoring program's current device platform and billing status — no billed remote-monitoring program is evident from public materials, but this is absence of evidence, not a finding.
3. Map the Epic integration governance path with the RWJBarnabas Health Epic team; confirm product/version and interface configuration in contracting.
4. Align with cardiovascular service-line leadership at each coverage hospital on episode data sharing (discharge feeds) and the monthly episode-support report.
5. Confirm current TEAM participant status for the three CCNs against the live CMS participant file, and obtain each hospital's episode volumes.
6. Confirm CY2026 locality rates (Novitas 12402, NJ locality 01) for the billing stack.

About CoachCare

CoachCare manages remote care for 500,000+ patients across 400+ conditions, supports 10,000+ providers, and has completed 1,000+ implementations — generating over 5 million claims, 100 million+ recorded vitals, and 4 million+ care actions. The full-service model — enrollment, devices, monitoring, billing — is the productized version of that experience.

References & Data Sources

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5. CMS Care Compare — Hospital General Information (dataset xubh-q36u): overall star ratings for CCNs 310076, 310009, 310054; retrieved July 2026.
6. CMS — Transforming Episode Accountability Model (TEAM): model overview and participant hospital list (cms.gov/priorities/innovation/innovation-models/team-model; participant list republished by the American Society of Anesthesiologists, updated June 4, 2025). FY2025 IPPS Final Rule (CMS-1808-F): 188 selected CBSAs.
7. CMS CY2026 Medicare Physician Fee Schedule — care-management and remote-monitoring code values (illustrative national non-facility magnitudes; Novitas 12402 / NJ locality 01 adjustment applies).
8. CMS NCD 20.40 — Renal Denervation for Uncontrolled Hypertension (effective October 28, 2025; coverage with evidence development).
9. RWJBarnabas Health — enterprise Epic and MyChart (rwjbh.org; mychart.rwjbh.org; retrieved July 27, 2026).
10. CoachCare Value Analysis workbook for New Jersey Cardiology Associates (July 2026) — all modeled economics, census trajectories, and clinical-operations values.

Global caveat

All modeled figures in this report are illustrative, modeled — verify against practice data. Reimbursement values are illustrative magnitudes; actual payment is locality-adjusted and set by the regional MAC. Readmission and rating data carry the vintages noted and should be re-confirmed on CMS Care Compare before external use. The Medicare panel size is an estimate (range 4,000–4,500) pending chart-count validation. TEAM participant status should be confirmed against the current CMS participant file. Nothing in this report constitutes billing, coding, legal, or clinical advice.

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