MarinHealth

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report — July 2026 Edition

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

Focused on MarinHealth Medical Center, the Haynes Heart & Vascular Institute, and MarinHealth Cardiovascular Medicine | A UCSF Health Clinic — the employed cardiology platform of the MarinHealth Medical Network.

Prepared: July 9, 2026 by CoachCare — supersedes the January 27, 2026 edition (updated facts, current CMS data, and a recomputed 24-month value analysis forecast).

Audience: MarinHealth leadership, Haynes Heart & Vascular Institute leadership, and MarinHealth Cardiovascular Medicine | A UCSF Health Clinic leadership.

Purpose: A performance-focused, implementation-ready plan that places a managed, enterprise-wide Remote Care Service Line at the center of cardiovascular optimization — with two coordinated arms: a cardiology specialty arm (Transitional Care Management, Remote Patient Monitoring, and Principal Care Management) and a primary-care arm (Chronic Care Management and Advanced Primary Care Management). The thesis: this service line has substantial standalone value — a modeled $5.29M in 24-month net reimbursement — and simultaneously acts as the connective tissue that powers performance in TEAM (live since January 1, 2026, with MarinHealth Medical Center a confirmed participant), the Ambulatory Specialty Model (2027), and procedural growth (structural heart, renal denervation) — while defending and converting MarinHealth's five-star quality position.

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Executive Summary

MarinHealth's cardiovascular franchise is anchored by **MarinHealth Medical Center** (327 beds, Greenbrae — the Marin Healthcare District's flagship) and the **Haynes Heart & Vascular Institute** — relaunched under that name on June 30, 2026 — operationally extended by **MarinHealth Cardiovascular Medicine | A UCSF Health Clinic**, the employed cardiology group of the MarinHealth Medical Network, with clinics in Larkspur, Novato, Petaluma, Sonoma, and Napa plus a dedicated Cardiovascular Performance Center. Since May 2025 MarinHealth has performed CABG and complex cardiac surgery through its **own comprehensive cardiothoracic surgery program** (Medical Director Luis Castro, MD), delivered at the Medical Center under the UCSF Health co-brand; the long-standing UCSF affiliation supplies tertiary referral depth and the shared Epic / MyChart platform across the 65+ clinic Medical Network.[1]

MarinHealth enters the second half of 2026 from a genuine position of strength: a **five-star CMS Overall Hospital Quality rating in the current 2026 release**, Healthgrades **America's 250 Best Hospitals (top 5% nationwide, 2024 and 2025)**, Newsweek Best-in-State recognition, and U.S. News “High Performing” designations across heart attack, heart failure, heart arrhythmia, pacemaker implantation, and TAVR. On current CMS data the hospital-wide readmission measure is **better than national (13.7%)**, and every condition-level readmission measure — including heart failure (18.7%) and CABG (10.7%) — sits statistically **at the national rate**. This is not a fix-a-gap story. The strategic question for 2026-2027 is different: **how to defend the quality halo under new episode- and specialty-accountability models, and how to convert it into growth**.[2]

The defining shift is that cardiovascular payment is moving from “be excellent at the procedure” to “be accountable for the patient over time.” Two CMS Innovation Center models drive it: **TEAM** (mandatory surgical episodes including CABG, live January 1, 2026 — and **MarinHealth Medical Center is a confirmed participant on the CMS TEAM hospital list**, in the San Francisco-Oakland-Fremont CBSA) and the **Ambulatory Specialty Model (ASM)** (cardiology accountability for heart failure, beginning January 1, 2027).[3] MarinHealth's market amplifies both the exposure and the opportunity: Marin is the Bay Area's oldest county, with roughly a quarter of residents 65+, and its Medicare population remains **majority Traditional Medicare** (only ~17,700 Medicare Advantage enrollees county-wide as of December 2025) — favorable fee-for-service economics for remote care, and maximum TEAM episode exposure, since TEAM applies to Traditional Medicare beneficiaries.[4]

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[1]MarinHealth launches the Haynes Heart & Vascular Institute (renamed from the Haynes Cardiovascular Institute, honoring founders Bill and Reta Haynes), Business Wire, June 30, 2026; MarinHealth Cardiothoracic Surgery Program launch, Business Wire, May 20, 2025; MarinHealth / UCSF Health partnership, ucsfhealth.org/about/marinhealth.

[2]MarinHealth awards and accreditations page (badge: Overall Hospital Quality Ranking, 5 Stars, 2026) and the current CMS Hospital General Information dataset; Healthgrades America's 250 Best Hospitals / Top 5% (2024 and 2025); Newsweek America's Best-in-State Hospitals 2026; U.S. News High Performing designations. Note: in the current CMS release, Novato Community Hospital (Sutter Health) is also rated 5 stars, so MarinHealth is no longer the county's only 5-star hospital. Confirm all current ratings on Medicare Care Compare before external use.

[3]CMS TEAM model overview and the CMS-published TEAM participant hospital list (cms.gov/team-model-participant-list; also mirrored by the American Society of Anesthesiologists), which lists MarinHealth Medical Center in the San Francisco-Oakland-Fremont, CA CBSA. Participation is determined at the facility/CCN level; re-validate CCN 050360 against the CMS list for each performance year.

[4]U.S. Census Bureau QuickFacts, Marin County, CA (roughly a quarter of residents 65+; Bay Area's oldest county by median age); CMS/third-party Medicare Advantage enrollment reporting for Marin County (~17,700 MA enrollees, December 2025) vs. a county Medicare population in the tens of thousands, implying MA penetration well below the ~55% 2026 national share (KFF). Exact county penetration is an estimate; confirm against CMS monthly MA

The central argument

A Remote Care Service Line (TCM + RPM + PCM) is the core of cardiovascular optimization in 2026 for two reasons at once. First, it has substantial **standalone value** — recurring, professional-fee revenue that compounds as the panel grows, delivered by a team-based, top-of-license staffing model, margin-positive before any value-based upside: the recomputed CoachCare value analysis models **$5.29M in 24-month net reimbursement and $2.53M in network margin after fees** on the cardiology Medicare panel alone. Second, it is the **connective tissue** that powers every other lever: the same enrollment, device, monitoring, navigation, pharmacist-titration, billing, and analytics infrastructure — bi-directionally integrated with the UCSF-shared Epic instance — simultaneously drives TEAM (CABG episodes), ASM (heart failure), and procedural throughput and outcomes (structural heart, renal denervation) — and defends the five-star quality halo. Build the infrastructure once; monetize and reuse it everywhere.

The current public data reframe the operational target. With heart failure and CABG readmissions statistically at national and the hospital-wide measure better than national, MarinHealth's five-star position is an asset under active competition — Novato Community Hospital (Sutter) also holds five stars in the current release — and “at national” is precisely the level that episode accountability now prices against. Under TEAM, CABG episodes are reconciled against a CMS target price: every avoidable ED visit or readmission in the 30-day window is now episode spend, not just a quality statistic. Under ASM, cardiologists are scored relative to peers on HF cost and quality, with the first payment year spanning −9% to +9% of Part B revenue. A remote care service line focused on early post-discharge surveillance, medication titration, and rapid follow-up is the most direct mechanism to push at-national cardiac measures into better-than-national territory — and it doubles as the TEAM CABG bundle, the ASM engine, and the recovery-surveillance layer that lets structural-heart procedures discharge same- or next-day.

CMS's CY2026 Physician Fee Schedule strengthens the standalone case: effective January 1, 2026 it added two RPM codes — **99445** (device supply for 2-15 days of data, not just the prior 16-day floor) and **99470** (first 10 minutes of management) — explicitly suited to shorter, transitional monitoring after procedures, discharge, or acute events. That makes post-TAVR and post-CABG monitoring windows cleanly billable and removes the main friction that previously limited episodic remote care.[5] The primary-care arm makes the system whole: through the Medical Network's primary-care practices, CCM and APCM manage the whole-person comorbidity picture beneath every cardiac patient, and APCM's service elements are, in effect, the electronic collaborative-care substrate ASM requires. One coordination rule governs the interface: APCM bundles and cannot be billed with CCM, PCM, or TCM for the same patient in the same month (RPM stacks), so MarinHealth must set a clear attribution policy for shared patients.

The financial case is quantified in Section 2.4. CoachCare's Value Analysis Model 2.0, recomputed in July 2026 with client-approved inputs and MAC-locality rates auto-resolved for ZIP 94939 (Noridian JE), models — on an estimated ~9,500-patient cardiology Medicare panel — **net reimbursement of $1.29M in Year 1, $4.0M in Year 2, and $5.29M over 24 months**, with **network margin after CoachCare fees of $2.53M over 24 months**, ~126 hospitalizations avoided (≈ $1.9M at $15,000 per admission), and 3,348 program enrollments by month 24.

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state/county enrollment files.

[5]CMS CY2026 Medicare Physician Fee Schedule Final Rule, remote monitoring valuation: adds CPT 99445 (RPM device supply, 2-15 days of data) and CPT 99470 (RPM treatment management, first 10 minutes), effective January 1, 2026. National non-facility rates are illustrative; California payment is set by the Noridian JE MAC and adjusted by locality.

TEAM episode reconciliation upside, avoided-readmission savings, and the primary-care APCM arm are additive — none are counted in the modeled revenue. All figures are illustrative, modeled — verify against practice data.[6]

2026-2027 Priority Recommendations

1. **Establish the Remote Care Service Line (TCM + RPM + PCM) as a named, governed service line** with its own owner, P&L, scorecard, and enrollment engine — positioned as the operating spine of cardiovascular care across the Medical Center and the Medical Network cardiology group, not a point program bolted onto one condition.
2. **Launch Larkspur-first.** Run a 90-day pilot at Cardiovascular Medicine - Larkspur (2 Bon Air Road — one road from the Medical Center and the Haynes Heart & Vascular Institute): Epic integration and protocol sign-off by day 30, first billable enrollments by day 30-45, roughly 260 active patients by day 90, and a go/scale decision at day 90 — then extend to Novato and Petaluma, then Sonoma and Napa (Section 9.7).
3. **Run the TEAM CABG episode through the service line** — TCM (99496, high complexity) plus a first-14-day RPM bundle — now that CCN 050360 is live in TEAM and CABG is performed by MarinHealth's own cardiothoracic surgery program, so episode accountability and the post-acute response sit inside one organization.
4. **Build the ASM Heart Failure IPU on top of the service line before January 1, 2027:** protocolized GDMT titration, multidisciplinary management (pharmacy, nursing, dietitian, social work), and electronic collaborative-care arrangements with primary care across Marin, Sonoma, and Napa.
5. **Use remote care to convert the quality halo into growth:** RPM-enabled same/next-day discharge to unlock structural-heart throughput (TAVR, TEER, WATCHMAN); BP RPM paired to the renal denervation program — the first commercial RDN program on the West Coast — to satisfy the CMS coverage-with-evidence pathway and scale volume; and a remote wrap-around for the Pritikin intensive cardiac rehabilitation launch.
6. **Activate the primary-care arm (CCM + APCM) as the ASM collaborative-care engine:** enroll Medicare panels, set a written attribution policy for shared cardiac patients (no double-billing across APCM/CCM/PCM/TCM), and use APCM's value-model requirement as the forcing function that moves primary care into a value-based posture ahead of ASM.
7. **Integrate through Epic from day one.** CoachCare's five-pillar, bi-directional Epic integration — integrated enrollment, health-history exchange, discrete flowsheet vitals, compliance documentation, and automated claim generation — runs inside the UCSF-shared Epic instance MarinHealth already uses, so clinicians never leave the chart and patients begin billable services in under five days from flag (Section 9.4).

[6]CoachCare Value Analysis Model (Value Analysis) 2.0, recomputed July 2026 with client-approved inputs; MAC-locality rates auto-resolved for ZIP 94939, Noridian JE. All figures are illustrative, modeled outputs — verify against practice data before financial planning.

1. MarinHealth Cardiovascular Footprint and Operating Model

1.1 System and program footprint

MarinHealth Medical Center is a 327-bed Marin Healthcare District acute-care hospital in Greenbrae with a Level III trauma center, serving the North Bay since 1952. For adult cardiovascular care it functions as the county's flagship destination site, housing the cath lab, electrophysiology suite, the cardiothoracic surgery program, advanced cardiac imaging (including cardiac MRI, added June 2024), a hybrid OR, and the multiplatform procedural area in the Oak Pavilion (opened 2020). The surrounding MarinHealth Medical Network now spans **65+ primary and specialty care clinics** across Marin, Sonoma, and Napa counties.

The market context matters for everything that follows. Marin is the **Bay Area's oldest county** — roughly a quarter of residents are 65 or older — and the county's Medicare population is **majority Traditional Medicare**: only about 17,700 Marin residents were enrolled in Medicare Advantage as of December 2025, far below the ~55% national MA share. That mix is unusually favorable for a fee-for-service remote care service line (TCM/RPM/PCM/CCM billing applies directly), and it simultaneously concentrates TEAM exposure, because TEAM episodes attach to Traditional Medicare beneficiaries. The same demographics feed sustained demand for HF, valve, arrhythmia, and hypertension care.

1.2 The Haynes Heart & Vascular Institute and the Medical Network ambulatory arm

The **Haynes Heart & Vascular Institute** — relaunched under that name on June 30, 2026, honoring founders Bill and Reta Haynes — is the cardiovascular service-line brand. It spans the cardiothoracic surgery program (launched May 2025), a structural heart program (TAVR, MitraClip transcatheter mitral repair, WATCHMAN), a nationally progressive heart-rhythm/EP program, women's heart health, sports cardiology through the Cardiovascular Performance Center, vascular surgery, heart-failure specialists, advanced cardiac imaging, a hypertension program that includes **renal denervation** (the first commercial RDN program on the West Coast), and — launching later in 2026 — an enhanced cardiac rehabilitation program built on the **Pritikin Intensive Cardiac Rehabilitation (ICR)** curriculum.

MarinHealth Cardiovascular Medicine | A UCSF Health Clinic provides the ambulatory platform: an employed cardiology group of roughly 14-16 cardiologists plus advanced-practice providers (~25-30 providers in total — directional estimate from public directories) across five North Bay clinics (Larkspur — the flagship at 2 Bon Air Road — Novato, Petaluma, Sonoma, and Napa), a dedicated cardiothoracic surgery office, and the Cardiovascular Performance Center. The entire network operates on the **UCSF-shared Epic / MyChart instance** — precisely the substrate a remote care service line needs: one record, one in-basket, one billing and analytics layer across inpatient and ambulatory settings, and the integration surface CoachCare connects to bi-directionally (Section 9.4).

> **Implication**
>
> Manage cardiovascular performance and growth as a single system service line, with the Remote Care Service Line as its longitudinal engine: the Medical Network as the care platform, the Medical Center as the procedural hub, UCSF as the tertiary/academic backstop, and TCM + RPM + PCM as the connective layer that follows the patient across all three. That operating model is the prerequisite for success under both TEAM (episode accountability, already live) and ASM (specialty accountability, 2027) — and it is how a five-star community system converts quality into durable market share against Kaiser San Rafael, Sutter's Novato Community Hospital, and San Francisco

> academic centers.

1.3 Service line design principles for 2026-2027

Design principle	What it means operationally
Longitudinal by default	Every cardiovascular patient with an eligible condition or recent procedure is considered for TCM / RPM / PCM enrollment — remote care is the default care layer, not an exception.
Single scorecard, multiple sites	One set of KPIs across inpatient, cath/EP/structural, ambulatory access, and post-acute outcomes — plus the service-line P&L — reported monthly.
Hub-and-spoke with standardized pathways	Medical Center as hub for interventions and surgery; the five Medical Network cardiology clinics as spokes; UCSF as the tertiary referral channel; the remote care service line as the thread connecting them.
One front door for navigation	Central intake and nurse navigation for valve disease, HF, arrhythmia, and hypertension — the existing structural-heart valve-coordinator line is the template — feeding the enrollment engine.
Digital as care, not marketing	Remote monitoring, asynchronous titration, and patient education treated as core, billable clinical operations inside Epic.

2. The Remote Care Service Line (TCM + RPM + PCM): The Spine of CV Optimization

This section is the heart of the strategy. Rather than treating remote monitoring as a feature of an HF program, MarinHealth should operate a distinct, named **Remote Care Service Line** — a managed, longitudinal capability assembled across two coordinated arms: a **cardiology specialty arm** (TCM + RPM + PCM) that follows the cardiac patient from acute discharge into stable chronic management, and a **primary-care arm** (CCM + APCM) that manages the whole-person comorbidity picture underneath. Both arms run on the same shared infrastructure and the same UCSF-shared Epic backbone — with CoachCare's bi-directional Epic integration carrying enrollment, vitals, documentation, and claims natively in the chart (Section 9.4).

2.1 What it is — the integrated remote care stack (specialty + primary-care arms)

Specialty arm (cardiology): TCM + RPM + PCM

Component	What it does	Where it fits in the cardiovascular journey
TCM — Transitional Care Management	Structured management of the 30-day post-discharge transition: contact within 2 business days, medication reconciliation, and a face-to-face visit within 7 days (high complexity) or 14 days (moderate). Billed per discharge (CPT 99495 / 99496).	The billable bridge from inpatient to longitudinal enrollment — the moment a HF, CABG, or structural-heart patient leaves the hospital.
RPM — Remote Patient Monitoring	Device-based physiologic monitoring (weight, blood pressure, optional SpO2) with clinical review and treatment management. Recurring monthly (CPT 99453 setup; 99454 / new 99445 device supply; 99457 / new 99470 and 99458 management).	The continuous early-warning and titration layer for HF, post-procedure recovery, and hypertension — the new 99445 code makes short, transitional windows billable.
PCM — Principal Care Management	Care management focused on a single, high-risk condition expected to last at least three months, with a disease-specific care plan. Recurring monthly (CPT 99424 / 99425 physician; 99426 / 99427 clinical staff).	The cardiology-native chronic-management wrapper for a dominant condition such as heart failure — the ASM-aligned longitudinal layer.

Primary-care arm: CCM + APCM

Roughly four in five Medicare beneficiaries carry two or more chronic conditions, and almost every cardiac patient also has a primary-care home managing diabetes, CKD, obesity, and hypertension. The primary-care arm captures that whole-person management through the MarinHealth Medical Network's primary care, internal medicine, and family medicine practices across the North Bay.

Component	What it does	Where it fits / why it matters
CCM — Chronic Care Management	Care management for two or more chronic conditions expected to last at least 12 months, with a comprehensive care plan and 24/7 access. Recurring monthly, time-	The multi-condition counterpart to specialty PCM — the primary-care wrapper for the comorbid cardiac patient (HF + DM + CKD).

Component	What it does	Where it fits / why it matters
	based (CPT 99490 / 99439 clinical staff; 99491 / 99437 physician; complex 99487 / 99489).	
APCM — Advanced Primary Care Management	A monthly bundled per-beneficiary payment for advanced primary care with 13 service elements and no minute-tracking, stratified by complexity (HCPCS G0556 / G0557 / G0558); 2026 BHI add-ons G0568-G0570 layer collaborative-care behavioral health on top.	Folds CCM/PCM/TCM into one bundle and supplies the population-health, risk-stratification, and 24/7-access elements that constitute the ASM collaborative-care substrate.

> **The one coordination rule that governs the interface**
>
> APCM bundles care management, so for a given patient in a given month it **cannot be billed concurrently with CCM, PCM, or TCM** — but it **can** be billed alongside RPM. For shared cardiac patients, MarinHealth must therefore set a clear **attribution policy**: who owns the care-management wrapper that month — cardiology (specialty PCM for the dominant cardiac condition) or primary care (CCM/APCM for the whole person)? A workable default: primary care owns the longitudinal wrapper for comorbid patients via CCM/APCM; cardiology owns TCM at cardiac discharge and the device-based RPM layer (which stacks with either); and the two arms share one care plan in Epic. This avoids duplicate billing, keeps the patient's cost-sharing clean, and still captures every legitimately billable layer.[7]

2.2 The standalone value: four layers and the CY2026 economics

Before any TEAM or ASM upside, the Remote Care Service Line earns its place as a standalone, margin-positive service line. Its value accrues in four layers:

1. **Direct professional-fee revenue.** Recurring, “subscription-like” monthly billing that compounds as the enrolled panel grows — the closest thing in fee-for-service to recurring revenue, and the layer that funds the rest. Quantified in Section 2.4.
2. **Avoided cost and episode exposure.** Fewer avoidable readmissions and ED visits protect inpatient margin, control TEAM episode spend against the CMS target price, and defend the better-than-national hospital-wide readmission profile that underpins the five-star rating.
3. **Procedural throughput unlocked.** RPM-enabled same/next-day discharge frees beds and procedural capacity, letting the structural-heart and EP programs do more cases with the same footprint.
4. **Strategic and brand value.** Turn-key readiness for TEAM (live) and ASM (2027), leverage in value-based payer contracting, and defense of the five-star and Healthgrades standing that drives referral capture in a two-five-star-hospital county.

[7] APCM base codes G0556/G0557/G0558 (CY2025 PFS); CY2026 PFS behavioral-health add-ons G0568-G0570. APCM cannot be billed concurrently with CCM, PCM, or TCM for the same patient in the same month but may be billed alongside RPM, and requires value-model participation plus Value in Primary Care MVP reporting. Sources: CMS APCM guidance; AAFP, Using APCM Services Codes G0556-G0558.

The CY2026 billing stack (illustrative)

Service / CPT	Type	Illustrative CY2026 national non-facility magnitude	Cardiovascular use
TCM 99495 / 99496	Per discharge	~$200 (moderate) / ~$280 (high complexity)	Post-discharge transition for HF, CABG, structural-heart, and AMI patients
RPM 99453	One-time setup	~$20 (requires ≥ 2 days of data)	Device setup and patient education at enrollment
RPM 99454 / 99445	Recurring monthly	~$52 (16-30 days / new 2-15-day code, same value)	Device supply + data transmission; 99445 enables short transitional windows
RPM 99457 / 99470	Recurring monthly	~$52 (first 20 min) / ~$26 (new first-10-min code)	Monitoring review and treatment-management time
RPM 99458	Recurring monthly	~$41 (each additional 20 min)	Additional management time for higher-touch HF patients
PCM 99426 / 99427	Recurring monthly (specialty)	~$60 (first 30 min) / ~$50 (each additional 30 min)	Single-condition chronic management (clinical-staff-performed); physician-performed 99424/99425 valued higher
CCM 99490 / 99439	Recurring monthly (primary care)	~$60 (first 20 min) / ~$47 (each additional 20 min)	Multi-condition (2+) chronic management by the primary-care team; physician 99491/99437 valued higher
APCM G0556 / G0557 / G0558	Recurring monthly bundle (primary care)	~$15 / ~$49 / ~$107 by complexity (2026 BHI add-ons G0568-G0570 layer on top)	Bundled advanced primary care; no minute-tracking; supplies the ASM collaborative-care elements; stacks with RPM but not CCM/PCM/TCM

Recurring-revenue mechanics

On the **specialty side**, a typical longitudinal HF patient can generate recurring monthly professional fees in the roughly **$150-200 range** when RPM device supply, RPM management time, and PCM are each billed with discrete time and documentation (CMS permits RPM and PCM in the same month when criteria are met), plus a one-time TCM episode (~$200-280) and 99453 setup at enrollment.

On the **primary-care side**, APCM is a bundled per-beneficiary-per-month payment that scales without minute-tracking and stacks with RPM. As an order-of-magnitude illustration, a panel of 500 Medicare patients enrolled at the common G0557 level runs on the order of $0.3M per year; adding RPM to a high-risk subset pushes combined care-management revenue meaningfully higher. Across MarinHealth's 65+ clinic North Bay footprint, the addressable panel is several times that.

Across both arms, track **time-to-first-billable-enrollment**, **billing-capture rate by code**, and **revenue per enrolled patient per month** as the core unit economics — durable recurring revenue that grows with enrollment rather than with physician visit volume.

Figures are illustrative CY2026 national non-facility magnitudes for planning only; actual payment is set by the Noridian JE MAC and adjusted by geographic locality (the Section 2.4 model resolves locality rates for ZIP 94939). Not all codes are billable every month, and time/documentation must be discrete. Validate against the current CY2026 PFS and local coverage policy before financial modeling.

2.3 Connective tissue: one operating system, every value lever

The strategic power of the service line is that it is **built once and reused everywhere**. A single set of shared assets — patient identification and enrollment, connected-device logistics, a 24/7 alert-and-triage engine, nurse navigation, pharmacist-led titration, documentation and billing capture, and combined claims-plus-Epic analytics — simultaneously drives every cardiovascular value lever.

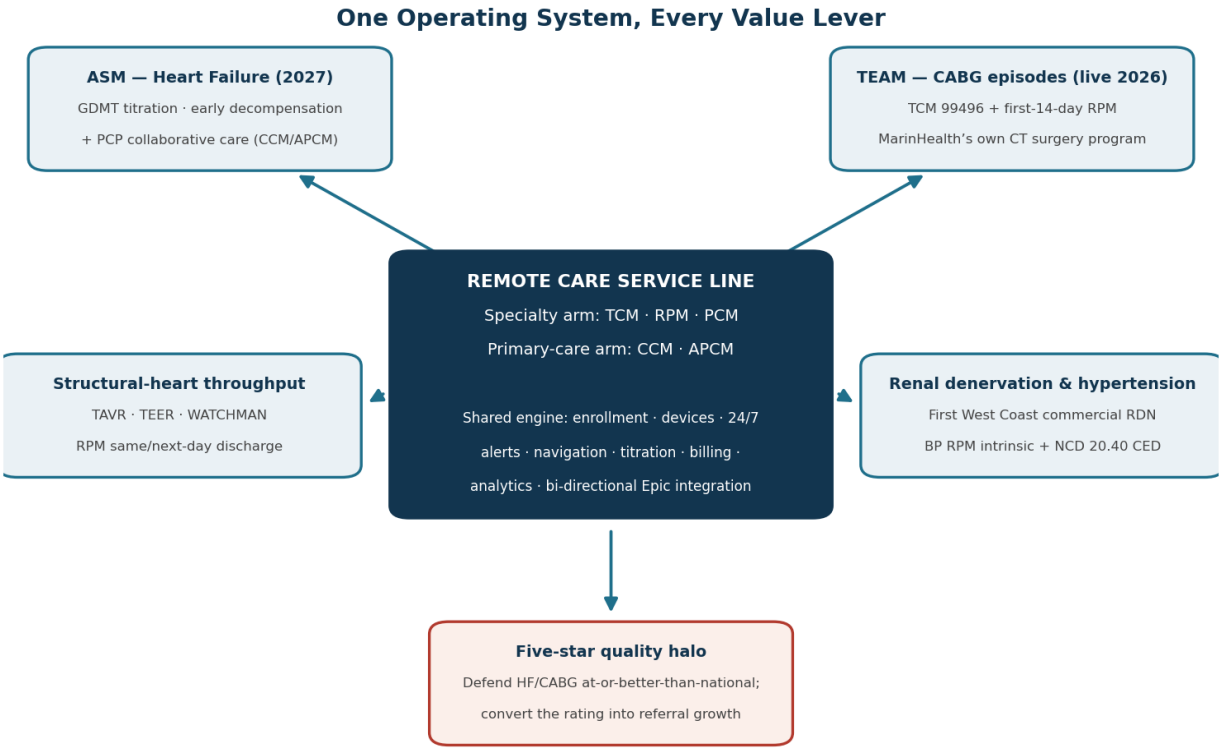

Figure 1. The Remote Care Service Line as connective tissue: one operating system powering standalone revenue plus every cardiovascular value lever.

How the same infrastructure powers each lever

Value lever	What the remote care service line contributes	Primary mechanism / codes	KPI it moves
ASM — Heart Failure (2027)	Longitudinal HF panel management with proactive titration and early decompensation detection.	RPM + PCM (+ TCM at discharge)	HF readmissions; GDMT attainment; KCCQ; total cost of care
TEAM — CABG (live 2026)	Post-surgical transition and first-14-day surveillance to cut avoidable ED/readmission spend inside the episode.	TCM 99496 + RPM (99445/99454, 99457)	30-day readmission; episode spend; reconciliation result
Structural-heart throughput	Recovery surveillance that enables same/next-day discharge and frees procedural capacity.	RPM short-window (new 99445)	Length of stay; bed-days; case throughput
Renal denervation / hypertension	BP monitoring intrinsic to titration and CED evidence generation for the first-	RPM (BP) + hypertension PCM	BP control; CED data

Value lever	What the remote care service line contributes	Primary mechanism / codes	KPI it moves
	on-the-West-Coast RDN program.		completeness; program volume
Primary care / ASM collaborative care	Whole-person comorbidity management and the collaborative-care substrate ASM requires; upstream BP control and prevention that feed the cardiac funnel.	CCM + APCM (+ RPM)	Panel enrolled; closed-loop referrals; comorbidity control; avoidable admissions
Five-star quality halo	Keeps HF and CABG at-or-better-than-national and the hospital-wide measure better than national — the defense of a rating two Marin hospitals now hold.	Whole stack (both arms)	CMS star measures; Healthgrades standing
Standalone P&L	Recurring professional-fee revenue at top-of-license staffing, across specialty and primary care.	Whole stack, billed monthly	Revenue / enrolled patient / month; service-line margin

2.4 The 24-month value analysis forecast (CoachCare Value Analysis, July 2026)

CoachCare recomputed the MarinHealth value analysis in July 2026 using **Value Analysis Model (Value Analysis) 2.0** with client-approved inputs; **MAC-locality rates auto-resolved for ZIP 94939, Noridian JE**. The model covers the cardiology specialty arm (RPM + CCM + PCM programs run on the CoachCare platform) for the employed cardiology group's Medicare panel. All outputs below are **illustrative, modeled — verify against practice data**.[8]

Modeled scope and conversion assumptions

Model input	Value used (client-approved)
Medicare panel in scope (Year 1)	~9,500 unique Medicare patients — an estimate built from ~15 cardiologists × ~900 unique Medicare beneficiaries each × a 0.7 cross-provider deduplication factor. The full panel is in scope in Year 1 (no phased sub-panel).
Clinical eligibility	RPM 60% · CCM 70% · PCM 70% of the panel
Patient conversion (of eligible)	RPM 30% · CCM 25% · PCM 25% — enrollment ceilings of ~1,710 RPM and ~1,663 each CCM / PCM
Enrollment engine	Provider-pathway referrals of 5 per provider per month × ~25 providers × 70% patient acceptance, PLUS one on-site enrollment specialist producing 80 enrollments per month — staffed at CoachCare's expense (embedded value; not netted from margin)
Attrition	1.5% of enrolled census per month
Reimbursement rates	MAC-locality rates auto-resolved for ZIP 94939 (Larkspur), Noridian JE

[8]CoachCare Value Analysis Model (Value Analysis) 2.0, recomputed July 2026 with client-approved inputs; MAC-locality rates auto-resolved for ZIP 94939, Noridian JE. All figures are illustrative, modeled outputs — verify against practice data before financial planning.

Modeled financial results

Measure	Year 1	Year 2	24-month total
Net reimbursement (all programs)	$1,291,807	$3,997,496	$5,289,304
Network margin after CoachCare fees	$608,354	$1,918,577	$2,526,931
24-month net reimbursement mix	RPM $2,409,685	CCM $2,079,723	PCM $799,896

Modeled clinical and operational outputs (24 months)

Output	Modeled value	Why it matters
Claims / billable units generated	78,434	The auditable billing footprint the CoachCare billing engine produces automatically inside Epic (Section 9.4).
Physiologic readings captured	198,504	The early-warning data layer for titration, decompensation detection, and RDN CED evidence.
Hospitalizations avoided	~126 (≈ $1.9M at $15,000 per admission)	Avoided-cost value on top of modeled revenue — plus direct TEAM episode relief on CABG patients in the 30-day window. Not counted in modeled reimbursement.
Care-team hours delivered	36,891 (~17.7 FTE-years)	Top-of-license clinical work performed by the program — capacity MarinHealth does not have to hire for.
Enrolled census at month 24	3,348 program enrollments (RPM 1,529 / CCM 1,241 / PCM 579)	The compounding recurring-revenue base; one patient may be enrolled in more than one program.

What is deliberately NOT in the modeled revenue

The forecast counts professional-fee reimbursement only. **TEAM episode reconciliation upside** (CABG episodes against the CMS target price), **avoided-readmission savings** (~$1.9M modeled above), and the **primary-care APCM arm** are all additive value streams excluded from the $5.29M — the modeled number is the floor, not the ceiling. Conversely, all figures are modeled from client-approved assumptions, not from MarinHealth claims data: **verify against practice data** before budgeting.

3. 2026 Policy and Payment Environment (TEAM and ASM)

3.1 TEAM: MarinHealth is a confirmed participant — live January 1, 2026

CMS's Transforming Episode Accountability Model (TEAM) runs January 1, 2026 through December 31, 2030 and holds IPPS hospitals accountable for the cost and quality of five surgical episodes — including **CABG** — for Traditional Medicare beneficiaries, reconciled against a CMS target price with quality adjustment. Participation is determined by whether a hospital's CCN sits in one of 188 selected CBSAs. This is no longer a geographic inference for MarinHealth: **MarinHealth Medical Center appears by name on the CMS-published TEAM participant hospital list**, in the San Francisco-Oakland-Fremont, CA CBSA, and has been operating under the model since January 1, 2026.[9]

> **What confirmed participation means for MarinHealth**
>
> **Every CABG episode is already being scored.** The 30-day post-discharge window on every Traditional Medicare CABG — the majority of MarinHealth's Medicare surgical volume, given the county's low MA penetration — now flows into episode reconciliation. Because CABG is performed by MarinHealth's own cardiothoracic surgery program (UCSF co-branded), episode accountability and the operational response sit inside one organization: MarinHealth owns both the surgery and the post-acute window. Nearby TEAM participants — UCSF Medical Center, Novato Community Hospital, and the Santa Rosa-Petaluma CBSA hospitals — face the same accountability, so post-acute execution becomes a competitive differentiator, not just a compliance exercise. Re-validate CCN 050360 against the CMS participant list for each performance year.

3.2 ASM: specialty accountability for heart failure beginning 2027

The Ambulatory Specialty Model (ASM) begins January 1, 2027 and makes cardiology specialists accountable for **heart failure** — rewarding guideline adherence, care coordination, and prevention of avoidable hospitalizations. It runs performance years 2027-2031 with Part B payment adjustments; the first payment year ranges from **−9% to +9%**. MarinHealth Cardiovascular Medicine | A UCSF Health Clinic is the accountable unit, and the remote care service line is the capability that produces the measured outcome. Because ASM scores clinicians relative to peers, a group whose HF readmissions sit at the national rate today is scored mid-pack — the service line is how it moves into the upside band before the model starts paying.

3.3 Why TEAM and ASM are one transformation program — run on one service line

TEAM is hospital-led and ASM is specialist-led, but the success factors are identical: longitudinal ownership, early risk identification, standardized pathways, and digitally enabled follow-up. Rather than build two compliance programs, MarinHealth should build one Remote Care Service Line and point it at both — the same enrollment, monitoring, navigation, pharmacy, and analytics assets satisfy TEAM's post-acute requirements and ASM's chronic-management requirements while generating standalone revenue and defending the star rating.

[9] CMS TEAM model overview and the CMS-published TEAM participant hospital list (cms.gov/team-model-participant-list), which lists MarinHealth Medical Center in the San Francisco-Oakland-Fremont, CA CBSA. Participation is determined at the facility/CCN level; re-validate CCN 050360 against the CMS list for each performance year.

4. Operating System for Cardiovascular Service Line Performance

4.1 The cardiovascular balanced scorecard

High-performing cardiovascular service lines run like integrated operating systems: one governance structure, a unified scorecard, and repeatable pathways. In 2026 this is externalized by TEAM (live) and ASM (2027). The scorecard should explicitly include the remote care service line's own performance. Recommended monthly domains:

- **Access:** new-patient lead time, diagnostic lead time (echo/CT), 7-day post-discharge follow-up rate, and no-show rates.
- **Quality & outcomes:** HF and CABG readmissions, mortality measures, registry outcomes (TAVR/TEER), PROs, and the explicit five-star measure set — so the rating is defended, not assumed, now that two Marin hospitals hold five stars.
- **Remote care service line:** enrolled census, time-to-first-billable-enrollment, billing-capture rate by code, and revenue per enrolled patient per month — tracked against the Section 2.4 forecast curve.
- **Growth & leakage:** referral conversion, out-migration to San Francisco academic centers and Kaiser, and market share by ZIP across Marin, Sonoma, and Napa.
- **Operational efficiency:** cath/EP lab utilization, length of stay and bed-days liberated for procedures, imaging turnaround, and clinic template utilization.
- **Financial:** contribution margin by program (CABG, TAVR, TEER, ablation), episode profitability under TEAM, and the remote care service-line P&L.

4.2 Ambulatory performance levers in the Medical Network

Because the cardiology group spans five sites across three counties, ambulatory performance is primarily a throughput-and-standardization challenge. The highest-yield levers feed the remote care service line:

Lever	How it improves performance
Centralized referral intake & triage	Single queue for valve, HF, EP, and hypertension referrals — extend the structural-heart valve-coordinator model — feeding the remote care enrollment engine.
Template standardization	Protected slots for post-discharge (TCM), titration, and urgent access; reduce unnecessary physician follow-ups through team-based protocols.
Diagnostic bundling	One-stop valve/HF workups (echo + CT + labs) to compress cycle time; centralize pre-authorizations.
Virtual-first for stable patients	Telehealth and asynchronous titration for stable HF and hypertension cohorts — the RPM/PCM layer — to preserve scarce in-person capacity.

4.3 Readiness checklists: TEAM and ASM

TEAM operating workplan (CABG focus — model already live)

Workstream	Purpose	High-yield actions (Medical Center + Network + CT surgery)
Episode governance &	Track target price and reconciliation risk on live	CCN 050360 is on the CMS participant list — validate each performance year; run a CABG episode steering

Workstream	Purpose	High-yield actions (Medical Center + Network + CT surgery)
finance	episodes.	committee with the cardiothoracic surgery medical director; assign a finance owner; build a monthly episode dashboard.
Clinical pathway standardization	Reduce variation and avoidable complications.	Standardize the peri-operative pathway (ERAS-style), discharge criteria, and medication reconciliation across the surgery program and the cardiology group.
Post-discharge bundle (first 14 days)	Cut ED use and readmissions in the highest-risk window.	Run the bundle through the remote care service line: TCM enrollment, default RPM, nurse-navigation calls at 48 hours and day 7, rapid-access slots, rehab-referral verification.
Post-acute partner network	Control total episode spend across SNF, HHA, and rehab.	Preferred-partner list with shared metrics; closed-loop communication; rehab scheduling within 7-14 days — including the Pritikin ICR program as it launches.
Analytics & risk stratification	Identify the patients and services driving variance.	Segment CABG into risk cohorts using claims + Epic flags; monitor high-cost outliers; CDI for risk adjustment.

ASM readiness matrix (heart failure focus — build during 2026)

ASM element (CMS)	What it means operationally	Medical Network action plan
Electronic Collaborative Care Arrangement with primary care	Shared care plans, closed-loop referrals, electronic communication between cardiology and PCPs.	Deploy an HF shared-care-plan template in Epic; enable e-consults and closed-loop referral tracking; set PCP communication SLAs (note within 48 hours of medication changes). Stand up the primary-care arm (CCM / APCM) as the operating substrate — APCM's 13 service elements largely constitute this arrangement (see Section 6.4).
Preventive screening + lifestyle support	Specialists contribute to prevention (BP, obesity, tobacco) and behavior change.	Embed BP-control protocol, tobacco-cessation referral, nutrition-consult triggers, and cardiac-rehab prompts (Pritikin ICR) into HF and valve workflows.
Health-related social needs (HRSN)	Screen for HRSN; connect to resources; document interventions.	Standardize HRSN screening at enrollment and post-discharge; assign a social-work care coordinator on the service line.
Health information exchange	Interoperable data exchange across settings.	Leverage the shared UCSF Epic instance for bi-directional exchange; ensure discharge summaries and med lists reach the Network within 24 hours; CoachCare's integration writes vitals and care summaries directly to the chart.
Care-improvement & Promoting Interoperability (group-level)	Group-level reporting and continuous improvement.	Stand up a small cardiology quality office (analyst + RN QI); dashboards aligned to ASM; the remote care service line is the data source.
Patient-reported outcomes	Collect PROs for quality scoring.	Implement KCCQ at baseline and 90 days via the service line's digital workflow.

5. Performance Snapshot (Publicly Available Indicators)

5.1 Quality recognition and overall positioning

MarinHealth operates in the TEAM/ASM era from a strong, externally validated quality position — the brand asset the remote care service line is designed to defend and convert.

Indicator	MarinHealth Medical Center	Source / note
CMS Overall Hospital Quality Star Rating	**5 stars in the current (2026) release.** Note: Novato Community Hospital (Sutter) is also 5-star in this release — MarinHealth is the county's only 5-star full-service hospital with comprehensive cardiac surgery, but no longer the county's only 5-star hospital.	CMS Hospital General Information dataset; confirm current value on Care Compare
Healthgrades	America's 250 Best Hospitals — top 5% of hospitals nationwide, 2024 and 2025 (two consecutive years).	Healthgrades / MarinHealth awards page
Newsweek	America's Best-in-State Hospitals, 2026.	MarinHealth awards page
U.S. News & World Report	“High Performing” in Heart Arrhythmia, Heart Attack, Heart Failure, Pacemaker Implantation, and TAVR.	U.S. News hospital profile
Cardiovascular program brand	Haynes Heart & Vascular Institute (relaunched June 30, 2026) — cardiothoracic surgery, structural heart, EP, women's heart health, sports cardiology, hypertension/RDN, cardiac rehab.	June 30, 2026 launch release; mymarinhealth.org
Academic partnership	UCSF Health clinical affiliation (since 2019) — tertiary referral depth, co-branded clinics, shared Epic / MyChart; MarinHealth remains independent.	ucsfhealth.org/about/marinhealth

5.2 Readmissions: defend the halo — and why “at national” is not enough

On current CMS Care Compare unplanned-visit data (condition measures: July 2021-June 2024 vintage), MarinHealth performs **statistically no different than national on every condition-level readmission measure** — heart failure 18.7%, CABG 10.7% (small denominator, n=35), AMI 12.5%, pneumonia 14.9%, COPD 18.1%, hip/knee 4.5% — and **better than national on the hybrid hospital-wide readmission measure (13.7%)**. The ED-based excess-days measures reinforce the halo: HF excess days are −16.5 per 100 discharges and AMI −11.8, both better than average.[10]

[10]CMS Care Compare / Provider Data Catalog, Unplanned Hospital Visits dataset (632h-zaca) for MarinHealth Medical Center, CCN 050360, retrieved July 2026. Condition-measure data vintage July 1, 2021 - June 30, 2024; hybrid hospital-wide readmission vintage July 1, 2023 - June 30, 2024. Refresh against the current dataset before target-setting.

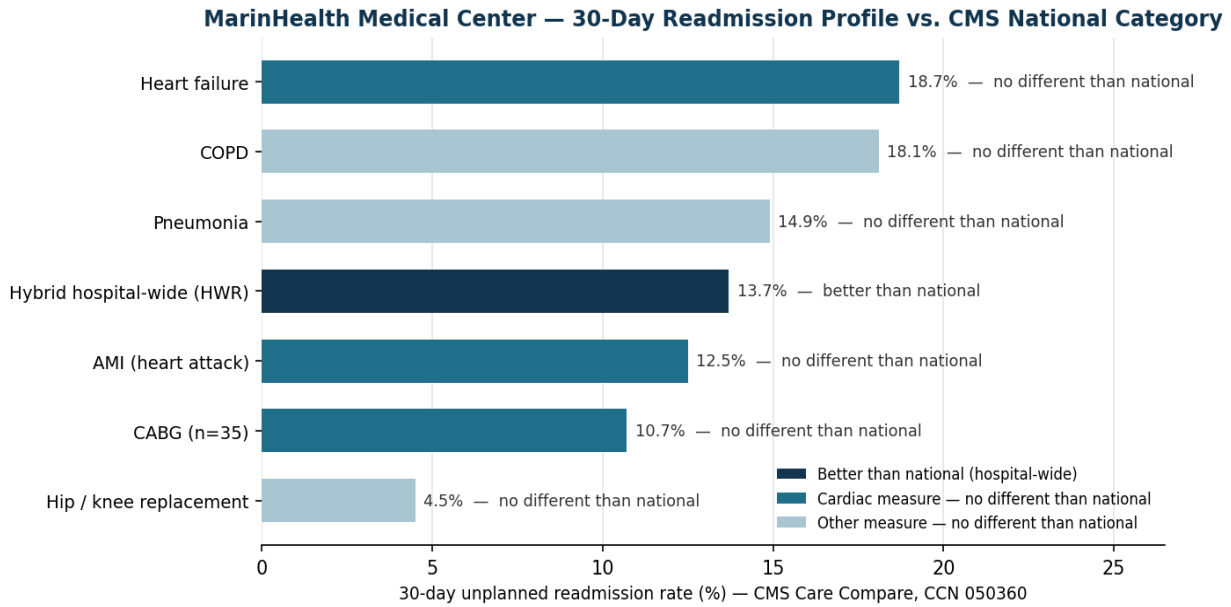

Figure 2. MarinHealth Medical Center 30-day readmission profile with CMS national-comparison categories. Lower is better. Directional public-data snapshot (condition measures: Jul 2021-Jun 2024; HWR: Jul 2023-Jun 2024) — refresh against the current Care Compare dataset before target-setting.

Actionable takeaway

This profile is a **halo to defend and convert, not a gap to fix** — and that is precisely why the remote care service line matters now. Under TEAM, "at national" CABG performance is what the target price already assumes: reconciliation upside comes only from being better, and the small CABG denominator (n=35) means a handful of readmissions can swing both the public measure and episode economics. Under ASM's tournament-style scoring, at-national HF performance earns a mid-pack score against a −9%/+9% payment band. And the five-star rating itself — now shared with a second Marin hospital — depends on holding the readmission measure group where it is. Routing HF discharges into the service line (TCM at discharge, then RPM + PCM longitudinally) and running every CABG through the TEAM bundle is how an at-national cardiac profile becomes a better-than-national one while the revenue engine runs.

Data-vintage note: measure-level figures reflect the CMS Provider Data Catalog snapshot retrieved July 2026 for CCN 050360 and are directional. Refresh against the current-year Care Compare datasets before target-setting.

5.3 Cardiac surgery: MarinHealth's own program as the differentiation asset

Since May 2025, MarinHealth has operated its **own comprehensive cardiothoracic surgery program** — CABG, valve repair and replacement, minimally invasive and re-operative cardiac surgery — at the Medical Center, led by Medical Director Luis Castro, MD, with the surgery clinic co-branded "MarinHealth Cardiothoracic Surgery | A UCSF Health Clinic" in Larkspur. That is a meaningful community-hospital differentiator: MarinHealth is the only Marin County hospital performing comprehensive cardiac surgery, and the program keeps North Bay patients — historically prone to crossing the Golden Gate for tertiary care — inside the system. Under TEAM, that capability must be matched by post-acute coordination and readmission control; the remote care service line is the mechanism that keeps CABG episodes inside the target price and the readmission measure at-or-better-than-national.[11]

[11]MarinHealth Launches Comprehensive Cardiothoracic Surgery Program as Part of Its Heart and Vascular Institute, Business Wire, May 20, 2025 (Medical Director Luis Castro, MD); MarinHealth Cardiothoracic Surgery | A UCSF

6. Powering ASM: Heart Failure and Primary-Care Collaboration

6.1 The service line is the ASM operating model

ASM rewards guideline-based chronic-disease management, close coordination with primary care, and measurable reductions in avoidable utilization. These are not separate build items — they are the outputs of the remote care service line applied to heart failure. PCM provides the single-condition chronic-management wrapper, RPM provides the physiologic early-warning and titration layer, and TCM captures the high-risk post-discharge window. Together they move the cardiology group from a visit-centric model to a longitudinal, panel-management model for HF — and because ASM scores relative to peers, the group that builds this during 2026 enters the 2027 performance year already operating the model everyone else is scrambling to assemble.

6.2 The Heart Failure Integrated Practice Unit (IPU)

- **Clinical scope:** HFrEF, HFpEF, advanced HF (in collaboration with UCSF's advanced-HF / transplant program), post-CABG HF optimization, and post-TAVR functional recovery.
- **Staffing core (shared with the service line):** HF advanced-practice provider (lead), HF RN navigator(s), clinical pharmacist (GDMT titration), dietitian, social worker (HRSN), and an EP / structural liaison.
- **Access design:** 48-72-hour post-discharge contact (TCM), 7-10-day follow-up, dedicated titration slots, and a “rescue” clinic for early decompensation.
- **Measurement:** KCCQ functional status, BP control, GDMT dose attainment, 30- and 90-day readmissions, and total cost of care for the HF cohort — the ASM scorecard.

6.3 GDMT titration as a production process

The dominant driver in ambulatory HF is not more visits — it is faster, safer GDMT optimization and early identification of instability. Treat titration as a standardized production process running on the service line: **eligibility → initiation / uptitration → lab & biomarker monitoring → symptom / volume checks → adherence reinforcement**. RPM and PCM make this scalable across five clinics without exhausting physician capacity, and pharmacists can perform RPM management and protocol titration under supervision, capturing the associated billing.

6.4 Primary care as the ASM collaborative-care engine: CCM and APCM

ASM does not make cardiology accountable in isolation — it requires an electronic **Collaborative Care Arrangement (CCA)** with primary care: shared care plans, defined roles, closed-loop referrals, and electronic communication between the cardiologist and the PCP. That arrangement is only real if MarinHealth's primary-care team is actually operating care management. CCM and APCM are how it does so — which makes the primary-care arm a direct dependency of the cardiology HF score, not a separate initiative.

APCM is especially well-suited to this role. Its 13 service elements — consent, an initiating visit, 24/7 access, continuity of care, comprehensive care management, a patient-centered care plan, care-transition coordination, enhanced communication, population-level data analysis, risk stratification, and performance measurement — are substantially the same capabilities ASM expects the collaborative-care arrangement to deliver. Standing up APCM in primary care therefore builds the ASM substrate as a by-product, and because APCM requires participation in a value model (an MSSP or REACH ACO, Making Care Primary, or Primary Care First) plus

Health Clinic, Larkspur.

reporting on the Value in Primary Care MIPS Value Pathway, adopting it pulls the primary-care organization into exactly the value-based posture ASM will reward in 2027.

The clinical value compounds the financial case. Primary-care CCM and APCM drive upstream blood-pressure control, comorbidity management (DM, CKD, obesity), and prevention — improving the very denominators ASM and the five-star measures depend on, and feeding appropriate, well-prepared referrals into cardiology for HF optimization, structural-heart evaluation, EP, and renal denervation. A healthy primary-care arm is both the floor under the cardiology accountability and the top of the cardiac referral funnel.

Design decisions for the primary-care arm

Attribution: set a written policy for shared cardiac patients so only one care-management wrapper is billed per month (default: primary care CCM/APCM for comorbid patients; cardiology TCM at discharge + RPM, which stacks).

Targeting: prioritize Medicare panels with HF, hypertension, DM, and CKD; APCM Level 2/3 (G0557/G0558) for the comorbid and dual-eligible cohorts where the bundle and the clinical need are both highest.

Shared care plan: one HF/cardiometabolic care plan visible to both arms in the UCSF-shared Epic instance, satisfying the ASM CCA and avoiding duplicate work.

Readiness: confirm value-model participation and MVP reporting before billing APCM; obtain and document consent; use the Annual Wellness Visit as the initiating visit where possible. Note the APCM arm is additive — it is not counted in the Section 2.4 forecast.

7. Powering TEAM: CABG Episodes on the Remote Care Service Line

7.1 What changes operationally

TEAM makes CABG episodes a 30-day accountability — and for MarinHealth this is already live, on every Traditional Medicare CABG performed since January 1, 2026. Even for a high-quality surgical program, margin and quality risk shift to the post-acute and ambulatory phases — preventable ED visits, readmissions, medication gaps, missed rehab. This is precisely the window the remote care service line owns. Because the surgery is performed by MarinHealth's own cardiothoracic surgery program, the hospital carries the episode accountability and controls the operational response end-to-end — a cleaner position than systems whose cardiac surgery is outsourced, provided the post-acute machinery actually exists.

7.2 The CABG episode bundle: TCM + first-14-day RPM

Lever	Operational design (delivered through the service line)
Pre-op optimization	Risk stratification, anemia/diabetes optimization, smoking cessation, prehab, medication reconciliation, patient education.
TCM at discharge	High-complexity transitional management (99496): contact within 2 business days, reconciliation, face-to-face within 7 days.
First-14-day RPM bundle	Default remote vitals/weight monitoring — the new 99445 (2-15-day) code makes this billable even for short windows — with nurse-navigation calls at 48 hours and day 7 and rapid escalation access.
Post-acute network	Preferred SNF / home-health / cardiac-rehab partners with shared metrics and closed-loop communication; route eligible patients to the Pritikin ICR program as it launches.
PROs and experience	Embed PROM collection into rehab and follow-up workflows.

7.3 Build once, reuse everywhere

The CABG episode bundle is not a separate build — it is the same enrollment, device, monitoring, navigation, and analytics assets pointed at a surgical cohort. The identical infrastructure then serves structural-heart episodes (TAVR) and HF longitudinal care, which is what lets a community-scale organization run an enterprise-grade care model without program sprawl. The Section 2.4 forecast deliberately excludes TEAM reconciliation upside — every dollar of episode-spend reduction the bundle produces lands on top of the modeled professional-fee revenue.

8. Powering Procedural Growth: Structural Heart and Renal Denervation

8.1 Remote care as a throughput multiplier

The remote care service line is not only a chronic-care and episode tool — it is a procedural throughput multiplier. Reliable post-procedure physiologic surveillance is the clinical precondition for same/next-day discharge after TAVR, transcatheter mitral repair (TEER), and WATCHMAN. Discharging appropriate patients a day earlier frees beds and procedural slots, letting the structural-heart and EP programs do more cases with the same footprint — and the new 99445 (2-15-day) RPM code makes the short post-procedure monitoring window cleanly billable rather than uncompensated. The result is higher throughput, better recovery monitoring, and stronger margin per case.

8.2 Structural heart pipeline and optimization levers

MarinHealth's structural heart program offers TAVR, MitraClip transcatheter mitral repair (TEER), and the WATCHMAN left-atrial-appendage implant, with a dedicated valve coordinator and a multidisciplinary team. Remote care optimization levers attach to each lane:

Program lane	Current / candidate therapies	Remote-care-enabled optimization levers (2026-2027)
Aortic valve	TAVR	Same/next-day discharge with RPM surveillance; valve-clinic throughput; CT/echo capacity; referral-network expansion across Marin/Sonoma/Napa; TVT/STS registry discipline.
Mitral valve	MitraClip (TEER)	RPM-supported early discharge; standardized echo triage; multidisciplinary “mitral conference”; optimized cath/OR scheduling.
Tricuspid valve	Transcatheter tricuspid repair (evaluation / candidate lane)	Assess adding T-TEER to close the one structural gap vs. larger programs; tie to a right-heart-failure pathway anchored in the HF IPU and service line.
LAA closure	WATCHMAN	Post-procedure RPM monitoring; standard anticoagulation management; referral targeting from the AF/EP clinic.
Hypertension & vascular innovation	Renal denervation (Symplicity Spyral) — operating today	BP RPM paired to every RDN patient; CED/registry operations run on the service line's data engine; cross-referral with nephrology and PCPs (see Section 8.3).

8.3 Renal denervation: defend and scale the first-on-the-West-Coast lead

MarinHealth is not evaluating renal denervation — it pioneered it. MarinHealth interventional cardiologists were the **first on the West Coast to perform the Medtronic Symplicity Spyral RDN procedure commercially (outside clinical trials), in December 2023**, and the Haynes institute markets a dedicated hypertension program with an RDN service line. Policy has since caught up with that early-adopter position: CMS issued **NCD 20.40**, national coverage for RDN for uncontrolled hypertension, effective October 28, 2025 under **Coverage with Evidence Development (CED)**, and the 2025 ACC/AHA hypertension guideline gives RDN a Class IIb recommendation.[12]

[12]MarinHealth interventional cardiologists are first on the West Coast to perform the Symplicity Spyral renal denervation procedure outside clinical trials, mymarinhealth.org blog, December 2023; MarinHealth Hypertension /

The growth question is now scale and evidence, and both run on remote care. **BP remote monitoring is intrinsic to RDN** — clinically (titration and response assessment) and for the CED evidence requirement, which demands longitudinal BP data on covered patients. The service line is therefore not just supportive of the RDN program; it is the operating layer that lets MarinHealth convert its head start into durable volume:

- Formalize the interdisciplinary **Hypertension Care Team** (cardiology, nephrology, primary care) with clear referral criteria feeding the RDN pipeline from the CCM/APCM primary-care panels.
- Run **CED requirements on the service line's data engine** — consent workflows, registry documentation, and the longitudinal BP record produced automatically by RPM.
- Pair **every RDN patient with BP RPM and hypertension PCM** for titration and evidence generation — billable follow-up that also produces the coverage evidence.
- Maintain payer / prior-authorization pathways and coding expertise as contractor implementation of NCD 20.40 matures.

8.4 Cardiac rehabilitation: the Pritikin ICR launch as a remote-care on-ramp

Later in 2026, MarinHealth launches an enhanced cardiac rehabilitation program built on the **Pritikin Intensive Cardiac Rehabilitation (ICR)** curriculum — supervised exercise, nutrition, and stress management. This is directly adjacent to the remote care service line: RPM supplies the between-session physiologic record, TCM feeds discharges into rehab enrollment, and the service line's navigation layer closes the referral loop that cardiac rehab programs chronically leak. A remote wrap-around also extends ICR's reach to Sonoma and Napa patients for whom travel to Greenbrae is the barrier — the same geography argument that motivates the Larkspur-first, then-northward rollout in Section 9.7.

Renal Denervation program pages; CMS National Coverage Determination 20.40, Renal Denervation for Uncontrolled Hypertension (effective October 28, 2025, under Coverage with Evidence Development); FDA PMAs P220023 / P220026; 2025 ACC/AHA hypertension guideline (Class IIb for RDN).

9. Implementation Playbook: Building the Remote Care Service Line

9.1 Program goals and scope

Stand up a standardized Remote Care Service Line (TCM + RPM + PCM) that spans hospital discharge, ambulatory follow-up, medication titration, post-procedure recovery, and long-term panel management — designed to (a) generate recurring professional-fee revenue at positive margin (the Section 2.4 forecast: $5.29M net reimbursement and $2.53M network margin over 24 months, modeled), (b) reduce preventable utilization (ED visits, readmissions — ~126 hospitalizations avoided over 24 months, modeled), (c) optimize guideline-directed therapy and BP control, (d) enable same/next-day procedural discharge, and (e) sustain performance under TEAM (live) and build readiness for ASM (2027) while defending the five-star position.

9.2 Target populations and enrollment rules

- **HF (default):** all HF discharges from MarinHealth Medical Center, unless the patient opts out — TCM at discharge, then RPM + PCM.
- **Post-CABG (TEAM):** every Traditional Medicare CABG discharge — TCM (99496) + first-14-day RPM bundle; high-risk non-Medicare CABG by protocol.
- **Post-procedure (structural heart):** TAVR / TEER / WATCHMAN patients eligible for same/next-day discharge — short-window RPM surveillance.
- **Hypertension / RDN:** uncontrolled-hypertension and RDN patients — BP RPM + hypertension PCM, doubling as CED evidence capture.
- **Ambulatory rising-risk:** the five cardiology clinics identify weight gain, med nonadherence, BP instability, or recurrent volume overload — flagged directly in Epic.
- **Primary-care panels (CCM / APCM):** Medicare beneficiaries with multiple chronic conditions — prioritizing HF, hypertension, DM, and CKD — enrolled by the Medical Network primary-care practices, with attribution coordinated against specialty PCM/TCM (additive to the Section 2.4 forecast).

9.3 Operating model and staffing

The model is deliberately top-of-license and lean, because CoachCare's managed service carries the monitoring, outreach, and enrollment load: the Section 2.4 model has the program delivering **36,891 care-team hours (~17.7 FTE-years) over 24 months** — capacity MarinHealth does not have to hire for. MarinHealth-side roles:

Role	FTE (pilot)	Core responsibilities
RN navigator / remote-monitoring nurse	2.0	Daily alert review, TCM outreach, patient education, escalation, documentation.
Clinical pharmacist	0.5-1.0	GDMT/BP titration under protocol, RPM management time, medication access, adherence coaching.
APP (HF lead)	1.0	Clinical oversight, medication changes, complex visits, escalation decisions.
Medical director (cardiology)	0.1-0.2	Clinical governance, protocol approval, quality review.
Care coordinator / social work	0.5	HRSN screening; transportation/food/financial

Role	FTE (pilot)	Core responsibilities
		barriers; resource linkage.
Program analyst / billing specialist	0.5	Dashboarding, billing-capture audit, claims analytics, ASM/TEAM reporting.
On-site enrollment specialist — staffed at CoachCare's expense	1.0 (CoachCare-funded)	Bedside and clinic enrollment at ~80 enrollments/month, consent capture, device logistics — embedded value in the program fee, not netted from the Section 2.4 margin.

9.4 Technology, data, and billing architecture — Epic integration at the core

MarinHealth runs the UCSF-shared Epic instance across the Medical Center and the Medical Network — which makes the integration architecture the decisive design choice. CoachCare integrates **directly and bi-directionally with Epic**, so the service line runs inside the chart clinicians already live in — they never leave Epic. Five integration pillars:

Pillar	What it does in the MarinHealth workflow
1. Integrated enrollment	Care teams flag eligible patients with Epic patient flags or trigger orders; CoachCare receives the flag, and the CoachCare team completes enrollment on the practice's behalf — consent, device shipment, onboarding — with real-time enrollment status written back to Epic. Patients begin billable services in **under 5 days from flag**.
2. Health-history exchange	Problem lists, medications, allergies, and demographics flow to CoachCare at enrollment; program-relevant history flows back — no duplicate intake, no swivel-chair charting.
3. Integrated discrete vitals	RPM readings land in the Epic flowsheet as **discrete data — not PDF attachments** — so trends are visible in the same views clinicians use for in-clinic vitals and feed Epic-native decision support.
4. Compliance documentation	Time logs, care-plan updates, and an integrated care summary post to the chart automatically, producing an audit-ready record for every TCM/RPM/PCM/CCM claim.
5. Automated claim generation	The CoachCare billing engine assembles and submits claims automatically as billing thresholds are met — CoachCare is the only care-management application integrated with Epic that provides automated claims creation. This is the mechanism behind the 78,434 modeled claims/units and the capture-rate KPI in Section 9.6.

- **Devices:** cellular-connected weight scale + BP cuff as the minimum; optional pulse oximetry for advanced HF or COPD overlap.
- **Data routing:** device → CoachCare platform → Epic flowsheet / in-basket → alert-rules engine → work queue.
- **Escalation logic:** symptom + vitals thresholds, trend detection (3-day weight gain), and adherence gaps (missing transmissions).
- **Analytics:** combine Epic data with claims analytics to quantify avoidable utilization, run the service-line P&L against the Section 2.4 forecast, and build ASM/TEAM-ready cost/quality reporting.

9.5 Clinical workflow: from discharge to stable maintenance

Phase	Key activities
Day 0-2 (discharge + onboarding)	TCM contact within 2 business days; Epic flag triggers CoachCare enrollment; device deployed; meds reconciled; follow-up scheduled; HRSN assessed.
Day 3-14 (high-risk window)	Daily RPM monitoring; nurse calls for alerts; rapid diuretic protocol; telehealth escalation; TCM face-to-face visit; PCP loop-in.
Week 2-6 (titration window)	Pharmacist/APP titration visits; labs; education; cardiac-rehab referral (Pritikin ICR as available); transition to RPM + PCM.
Month 2-3 (stabilization)	Reduce monitoring intensity by risk; continue PCM panel management.
Longitudinal (maintenance)	Quarterly virtual check-ins, PROs (KCCQ), adherence reinforcement, early-warning detection.

9.6 KPI dashboard (clinical, operational, and financial)

Domain	Metric	Year-1 target
Access & follow-up	7-day post-discharge follow-up rate	≥ 70%
Access & follow-up	48-hour TCM outreach rate	≥ 90%
Clinical quality	GDMT optimization rate (HFrEF at target / max-tolerated by 90 days)	Track & improve quarterly
Utilization	30-day HF readmission rate (align to CMS measure)	Hold below national; push toward “better than national”
Utilization	Avoidable ED visits per 100 patients (90-day window)	Downward vs. baseline
Throughput	Structural-heart same/next-day discharge rate	Upward vs. baseline
Patient experience	KCCQ improvement at 90 days	Improve vs. baseline
Operations	Alert-to-action time (high-severity)	≤ 2 hrs (business hours)
Financial	Time-to-first-billable-enrollment	< 5 days from Epic flag
Financial	Billing-capture rate (TCM / RPM / PCM / CCM)	≥ 70% of eligible
Financial	Enrolled census vs. Value Analysis curve (M1-M3: 54 → 142 → 264)	On-curve; 3,348 by month 24
Primary care	Medicare panel enrolled in CCM / APCM	Grow quarterly; prioritize HF/HTN/DM/CKD
Financial	Revenue per enrolled patient per month	Track & grow with panel

9.7 Larkspur first: the 90-day pilot and the North Bay rollout

Start where density, proximity, and integration payoff are highest: **Cardiovascular Medicine - Larkspur (2 Bon Air Road, Suite 100)** — the group's flagship clinic, one road from MarinHealth Medical Center and the Haynes Heart & Vascular Institute. Larkspur sees the highest share of post-discharge and post-procedure patients, sits closest to the discharging hospital for TCM handoffs, and is the natural site for the CoachCare-funded on-site enrollment specialist to cover both clinic and bedside enrollment.

Milestone	Timing	Definition of done
Epic integration + protocol sign-off	By day 30	Five-pillar integration live on the UCSF-shared Epic instance (flags/trigger orders, history exchange, flowsheet vitals, documentation, automated claims); clinical protocols and escalation rules signed off by the medical director.
First billable enrollments	Day 30-45	First patients flagged, enrolled, and monitored with claims generated — validating the < 5-day flag-to-billable standard.
Outreach and follow-up standards	Continuous from launch	≥ 90% of discharges receive TCM outreach within 48 hours; ≥ 70% complete a 7-day post-discharge follow-up.
Census ramp	Day 90	~260 active patients by day 90 (modeled month 1-3 census: 54 → 142 → 264), against the Value Analysis ramp.
Go / scale decision	Day 90	Leadership review against the pilot KPIs above → scale decision: extend to **Novato and Petaluma**, then **Sonoma and Napa** — carrying the same protocols, the same Epic build, and the same enrollment engine north.

The rollout sequence mirrors the system's own growth geography: the northern clinics (Petaluma, Sonoma, Napa) are where MarinHealth is recruiting new patient populations, where travel distance makes remote care most valuable to patients, and where the Pritikin ICR wrap-around (Section 8.4) extends rehab reach without asking patients to drive to Greenbrae.

9.8 Expected impact and 12-month roadmap

Clinical: targets the primary drivers of HF utilization (volume status, nonadherence, delayed follow-up) and the post-surgical/post-procedure recovery window — the modeled 24-month program delivers 198,504 physiologic readings and ~126 avoided hospitalizations (≈ $1.9M at $15,000 per admission), directly defending the readmission profile the five-star rating rests on.

Operational: converts episodic work into queue-based, top-of-license team work (36,891 modeled care-team hours delivered by the program) and liberates bed-days for procedural growth.

Financial: recurring TCM/RPM/PCM professional-fee revenue ($1.29M Year 1, $4.0M Year 2, $5.29M over 24 months net reimbursement; $2.53M 24-month network margin after CoachCare fees — modeled, Section 2.4), plus the value streams deliberately excluded from the model: avoided readmissions, TEAM episode reconciliation, structural-heart throughput, and the primary-care APCM arm — the four value layers compounding on one infrastructure.

Timing	Deliverables
0-30 days	Charter the service line (owner, P&L, scorecard); protocol and billing-template design; Epic integration build (five pillars); confirm current-year TEAM episode dashboard; align the Medical Center discharge workflow to the Larkspur pilot.
31-90 days	Larkspur pilot live: first billable enrollments (day 30-45); HF discharges + post-CABG cohort routed by default; weekly huddles; refine alert rules; census to ~260 by day 90; go/scale decision.
91-180 days	Scale to Novato and Petaluma; add pharmacist titration clinics; launch the structural-heart same/next-day discharge protocol; stand up the HF IPU; begin CCM/APCM activation in primary care.

Timing	Deliverables
181-365 days	Extend to Sonoma and Napa; pair BP RPM to the RDN/hypertension program (CED evidence engine); integrate the Pritikin ICR wrap-around; PROMs live; ASM reporting build ahead of January 1, 2027; report the service-line P&L against the Value Analysis curve.

References and Data Sources

- CMS Innovation Center — Transforming Episode Accountability Model (TEAM): model overview and the CMS-published TEAM participant hospital list (cms.gov/team-model-participant-list), which includes MarinHealth Medical Center (San Francisco-Oakland-Fremont, CA CBSA); FY2025 IPPS Final Rule (188 selected CBSAs).
- CMS Innovation Center — Ambulatory Specialty Model (ASM): model overview factsheet (heart failure + low back pain; PY 2027-2031; first payment year −9% to +9%).
- CMS CY2026 Medicare Physician Fee Schedule Final Rule — remote monitoring valuation; adds CPT 99445 (RPM device supply, 2-15 days) and 99470 (RPM management, first 10 minutes) effective January 1, 2026. National non-facility rates are illustrative; California payment is set by the Noridian JE MAC and adjusted by locality.
- AMA / CPT and CMS guidance on TCM (99495-99496), RPM (99453, 99454, 99445, 99457, 99470, 99458), PCM (99424-99427), and CCM (99490, 99439, 99491, 99437, 99487, 99489) services.
- Advanced Primary Care Management (APCM): HCPCS G0556 / G0557 / G0558 (CY2025 PFS); CY2026 BHI add-ons G0568-G0570; concurrency rules (APCM may not be billed with CCM/PCM/TCM for the same patient in the same month; may be billed with RPM); 13 service elements and value-model participation requirement. Sources: AAFP and CMS APCM guidance.
- CMS Provider Data Catalog — Hospital General Information dataset (overall star ratings, current 2026 release) and Unplanned Hospital Visits dataset (632h-zaca) for MarinHealth Medical Center, CCN 050360, retrieved July 2026 (condition-measure vintage Jul 2021-Jun 2024; hybrid HWR Jul 2023-Jun 2024).
- MarinHealth — Haynes Heart & Vascular Institute launch release (Business Wire, June 30, 2026); Cardiothoracic Surgery Program launch (Business Wire, May 20, 2025; Medical Director Luis Castro, MD); Cardiovascular Medicine, Structural Heart Program, WATCHMAN, Hypertension / Renal Denervation, Cardiovascular Performance Center, and Oak Pavilion pages, mymarinhealth.org; cardiac MRI expansion release (June 2024).
- MarinHealth awards & accreditations page — CMS 5-star badge (2026); Healthgrades America's 250 Best Hospitals / Top 5% (2024, 2025); Newsweek America's Best-in-State Hospitals (2026); U.S. News High Performing designations (heart arrhythmia, heart attack, heart failure, pacemaker implantation, TAVR).
- MarinHealth / UCSF Health affiliation (since 2019), ucsfhealth.org/about/marinhealth; MyChart powered by UCSF Health (shared Epic instance), mymarinhealth.org; MarinHealth CEO interview on independence, out-migration strategy, and payer mix (HealthLeaders).
- MarinHealth renal denervation first-on-the-West-Coast announcement (mymarinhealth.org blog, December 2023); CMS National Coverage Determination 20.40 — Renal Denervation for Uncontrolled Hypertension (effective October 28, 2025; CED); FDA PMAs P220023 / P220026; 2025 ACC/AHA hypertension guideline (RDN Class IIb).
- Market context: U.S. Census Bureau QuickFacts (Marin County, CA); Bay Area median-age comparisons (SF Standard analysis of Census data); Medicare Advantage enrollment for Marin County (~17,700, December 2025) and KFF Medicare Advantage 2026 enrollment update (~55% national MA share).
- CoachCare Value Analysis Model (Value Analysis) 2.0 — recomputed July 2026 with client-approved inputs; MAC-locality rates auto-resolved for ZIP 94939, Noridian JE.

This report synthesizes publicly available information for internal planning and supersedes the January 27, 2026 edition. Reimbursement figures are illustrative CY2026 magnitudes (Section 2.2) or modeled Value Analysis outputs (Section 2.4) and must be validated against the current PFS, the Noridian JE MAC, and MarinHealth practice data; performance figures should be re-validated against current CMS Care Compare datasets; hospital star ratings should be confirmed on Care Compare; and TEAM participation re-validated by CCN (050360) for each performance year. Provider headcounts and the Medicare-panel scope are directional estimates. No figures herein are guarantees of financial performance.