C O A C H C A R E · R E M O T E C A R E S E R V I C E L I N E

Norton Heart & Vascular Institute

Cardiovascular Service Line — Performance & Optimization 2026 Strategy Report

A CoachCare Remote Care Service Line (TCM · RPM · PCM · CCM) as the operating spine — and your ASM heart-failure chassis for January 2027.

The cardiovascular service line of Norton Healthcare, Inc. · ~30 sites across Louisville, Kentucky and Southern Indiana

Purpose of this report

This report reads Norton Heart & Vascular Institute's starting position and makes a single, disciplined case: a managed remote-care service line is the highest-return move available to the cardiovascular service line in 2026 — margin-positive on its own economics, and the operational chassis that puts NHVI in control of its heart-failure results before the CMS Ambulatory Specialty Model becomes mandatory on January 1, 2027.

Economics shown are illustrative and modeled from a CoachCare Value Analysis; every figure should be verified against the service line's own patient, payer, and utilization data during discovery.

Prepared for: Norton Heart & Vascular Institute leadership

Prepared by: CoachCare — Remote Patient Monitoring & Chronic Care Management

Date: July 2026 · Confidential — prepared for NHVI leadership

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Executive Summary

Norton Heart & Vascular Institute (NHVI) is the cardiovascular service line of Norton Healthcare, Inc. — not an independent physician group. Roughly 50 to 55 board-certified cardiovascular physicians and 40 to 45 advanced practice providers, supported by more than 200 clinical and support staff, deliver care across approximately 30 locations in Louisville and Southern Indiana, with the service-line hub at 3999 Dutchmans Lane. The physicians are employed through Norton Medical Group; the legal entities that appear in CMS files — and therefore the entities that any contract, attribution, or model participation keys off — are Community Medical Associates, Inc. in Kentucky and Norton Clark Physician Practices, LLC in Indiana. The whole enterprise runs on a single Epic instance across 100% of practices and hospitals.

The central fact. Norton owns this market's heart-failure book and is measurably underperforming on it — while already employing the care-management labor and billing none of it. In CY2024, Norton recorded 799 Medicare fee-for-service heart-failure discharges at CCN 180088 plus 106 at Norton Clark: 905 discharges, or **52.8% of Louisville's entire Medicare FFS heart-failure volume** — roughly 1.7× Baptist Health Louisville and 3.6× UofL Health – Jewish Hospital. Norton also carries 53.2% of the market's cardiac DRGs and 42.3% of Jefferson County diagnostic catheterizations. On the public CMS scorecard for the same population, 30-day heart-failure mortality at CCN 180088 is **14.3% against a national rate of 11.6% — flagged "Worse Than the National Rate"** on 1,486 cases — with heart-failure excess days in acute care at +18.8 per 100 discharges, an HRRP excess readmission ratio of 1.0261, 30-day AMI readmissions of 16.1% (also "Worse"), a hybrid hospital-wide readmission rate of 16.3% (also "Worse"), and an overall CMS star rating of 2.

And the remote-care revenue line is empty. CY2024 Medicare claims for the service line's executive medical director and both of its advanced heart-failure attendings show **zero RPM, CCM, PCM, and TCM codes** — while the heart-failure program already staffs nurse navigators, a social worker, and a dedicated pharmacist. The labor exists. It is simply unbilled. (One of those physicians does bill 93228 external ECG monitoring, so remote-data workflows are already familiar territory.)

> ★ **Time-sensitive — verify against the FINAL CMS list**
>
> **NHVI heart-failure cardiologists appear on the CMS Ambulatory Specialty Model (ASM) heart-failure participant list — but this is the PRELIMINARY list.**
>
> Four of NHVI's heart-failure cardiologists are listed in the CMS CY2027 preliminary ASM participants dataset, in the heart-failure cohort, under the service line's CMS billing entities — Community Medical Associates, Inc. (Kentucky) and Norton Clark Physician Practices, LLC (Indiana). ASM is mandatory and two-sided, begins January 1, 2027, and carries a first-year Part-B payment adjustment of −9% to +9%.
>
> **The final CMS participant list is expected in summer 2026 and the roster can change. Every ASM statement in this report must be confirmed against the final CMS participant list before it is treated as certain.**

ASM changes the question NHVI should be asking. Today the service line manages heart-failure patients episodically — visit to visit, admission to admission. Under ASM, participating cardiologists are accountable for those patients' cost and quality across the full year. The organizations that do well will be the ones already running a continuous, data-driven heart-failure operation on January 1, 2027, not the ones scrambling to stand one up. A remote-care service line is that operation.

The central argument — value two ways at once

1. **Standalone value.** Recurring, subscription-like professional-fee revenue — billed by the practice at top-of-license staffing — that is margin-positive before a single value-based dollar. The stack is TCM at discharge → short-window RPM → longitudinal RPM / CCM / PCM. Over 24 months the model projects about $16,987,371 in net professional-fee reimbursement and roughly $7,215,945 in net practice contribution after CoachCare's fees.
2. **Connective tissue.** One shared engine — enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, GDMT-titration support, billing capture, analytics — that simultaneously powers ASM heart-failure performance, converts avoided admissions into avoided cost and better public quality results, speeds safe post-procedure discharge, and strengthens referring-physician relationships. Build once, reuse everywhere.

The clinical wedge is heart failure, and Kentucky makes it sharper. Heart failure carries the highest 30-day readmission burden of any common condition — the exact patient a cardiovascular service line is best positioned to keep out of the hospital, and the exact cohort ASM makes NHVI accountable for. Kentucky's underlying burden is severe: AHRQ Prevention Quality Indicator 08 puts heart-failure admissions at **671 per 100,000 in the 65–74 age band against a national 553 — 21% above national, ranking Kentucky 9th worst of 53 reporting jurisdictions**. Continuous weight and blood-pressure monitoring, protocolized alerts, and pharmacist- or nurse-led guideline-directed medical therapy (GDMT) titration between visits are how remote care moves that number.

The billing tailwind is already here. CY2026 added short-window RPM codes — 99445 (a 2–15 day device code) and 99470 (a first-10-minute monitoring code) — that make brief, high-value monitoring windows immediately after a discharge or procedure billable for the first time. That is precisely the transitional window where a cardiovascular service line creates the most clinical and financial value.

The modeled economics (illustrative). A CoachCare Value Analysis built on the Kentucky locality and an estimated Medicare panel projects, over 24 months: **$16,987,371 in net professional-fee reimbursement** ($4,148,709 in Year 1, $12,838,662 in Year 2) and **$7,215,945 in net practice contribution after CoachCare fees** ($1,737,788 / $5,478,157). Per program, 24-month net reimbursement is $7,980,250 (RPM), $6,616,457 (CCM), and $2,390,664 (PCM). The same program is modeled to avoid roughly **589 hospitalizations — about $8,838,212 in avoided cost at $15,000 per admission** — while generating 340,498 reimbursable claims, 928,012 physiologic readings, and 157,918 staff-hours of remote management delivered by CoachCare (about 75.9 FTE-equivalents of CoachCare-performed work, not practice headcount). By Month 24 the model carries **9,358 unique patients in active remote care across 14,520 total program enrollments**. These are modeled figures; verify against practice data.

Why this is fundable — the margin math

Norton's audited FY2025 patient service margin was **1.28%** — $64.3 million on $5.02 billion of revenue. Expense growth of $253.4 million almost exactly consumed revenue growth of $253.1 million. (Norton Healthcare, Inc. consolidated financial statements; Ernst & Young LLP opinion dated March 26, 2026.)

The modeled program contributes roughly **$3.6 million a year of practice net** — about **5.6% of the system's entire annual patient service margin, from one service line**. That is the difference between asking the board to fund a cost center and asking it to fund a margin-positive service line. It is the version of this proposal that survives a capital committee.

2026–2027 Priority Recommendations

1. **Stand up the remote-care service line now, heart-failure cohort first.** Treat the ASM heart-failure population as the launch cohort so monitoring, titration, and documentation workflows are live and generating data well before January 1, 2027.
2. **Anchor the stack on TCM at discharge → short-window RPM → longitudinal RPM / CCM / PCM.** Capture the post-discharge transitional window with 99495/99496 and the new 99445/99470 codes, then carry patients into longitudinal monitoring.
3. **Convert existing heart-failure care-management labor into billed service.** The nurse navigators, social worker, and dedicated pharmacist already on the program are doing care-management work that currently generates no professional fee. Documented, time-tracked, and billed through the stack, the same work becomes recurring revenue.
4. **Confirm the FINAL CMS ASM list (expected summer 2026) and align the go-live plan to it.** The preliminary selection is the planning basis; the final list is the commitment basis. Re-query the CMS ASM participants dataset against both billing entities before contract language is drafted.
5. **Build it inside Epic from day one.** Enrollment flags and trigger ordering in the existing clinical workflow, device readings landing as discrete vitals in the chart, and automated claim generation — no new system for clinicians to learn, and no manual monthly claim step.
6. **Set a referring-PCP collaboration model for shared heart-failure patients.** ASM anticipates a collaborative-care arrangement with primary care. For a cardiovascular service line this is a shared care plan and structured data exchange with referring primary-care clinicians — not a primary-care billing arm.
7. **Take the case to the board as a service line, not a pilot.** At 52.8% market share of Medicare FFS heart-failure volume and roughly 100 billing cardiovascular providers across 30 sites, this is a service-line-scale opportunity. Model it, staff it, and measure it accordingly.

1. Footprint & Operating Model

NHVI operates as a regional cardiovascular service line rather than a standalone practice. Norton's own published figures describe more than 50 board-certified cardiovascular physicians, more than 40 advanced practice providers, and a multidisciplinary team of more than 200 support professionals — roughly 100 billing cardiovascular providers in total — working across nearly 30 locations spanning Louisville metro and Southern Indiana. Named sites include the Springs hub on Dutchmans Parkway, the Audubon campus, Brownsboro, Dixie, Downtown, West Louisville, and Dupont in Kentucky, with Clark, Clarksville, Corydon, Madison, and Scottsburg in Indiana plus Kentucky regional sites in Elizabethtown, Shelbyville, Campbellsville, Leitchfield, and Carrollton.

Clinically the service line is comprehensive: an Advanced Heart Failure & Recovery Program (mechanical circulatory support and ventricular assist devices, transplant referral, ECMO, Barostim), general and interventional cardiology, a structural heart program (TAVR, MitraClip, PASCAL, and the Edwards EVOQUE transcatheter tricuspid valve), electrophysiology through the Heart Rhythm Center, cardiac, thoracic and vascular surgery, cardiovascular diagnostics and imaging, a cardiometabolic clinic, a Women's Heart Program with cardio-obstetrics and cardio-oncology, adult congenital heart disease, and six AACVPR-certified cardiac rehabilitation centers.

Recent investment signals a service line in growth mode. In October 2023 Norton opened a new 31,000-plus square-foot NHVI building on the Norton Audubon Hospital campus — a $10 million investment inside an $88 million multiphase campus project — consolidating seven specialty services into one outpatient location. Audubon operates four catheterization labs, two electrophysiology labs, and two hybrid operating rooms, and holds the American College of Cardiology **HeartCARE Center National Distinction of Excellence — the only one in Louisville**. NHVI is also part of UK HealthCare's Gill Heart

& Vascular Affiliate Network: the University of Kentucky performs heart transplants, while Norton implants ventricular assist devices at Audubon under a VAD program accredited since 2021.

> **A note on structure and contracting**
>
> NHVI is a brand and a service line, not a legal entity. The employed-physician entity that enrolls with CMS is Community Medical Associates, Inc. (operating under Norton Community Medical Associates / Norton Medical Group names) in Kentucky, with Norton Clark Physician Practices, LLC on the Indiana side. Contracting, attribution, model participation, and claims all key off those legal names — not "Norton Heart & Vascular Institute." Confirm the intended contracting counterparty early; it determines the paper, not the plan. This report is written to hold regardless of how that resolves.

Remote-care posture: a precise read

It would be wrong to call this account greenfield, and it would be equally wrong to call it served. Norton has already proven it can operate remote monitoring at scale. Its post-acute "virtual hospital" monitors discharged patients at home with pulse oximetry and blood-pressure devices supported by nurse video visits, and Norton eCare provides 24/7 virtual visits inside MyNortonChart — though eCare is urgent-care-style episodic telehealth for minor illness, not chronic-disease management. On the cardiac side, CardioMEMS pulmonary-artery pressure sensors, wearable defibrillators, and a pacemaker/ICD device clinic are all in service.

What is absent is the longitudinal, billable remote-care service line. None of the above is a scalable RPM / CCM / PCM program billed on the cardiology panel. The CY2024 Medicare claims record for the service line's executive medical director and both advanced heart-failure attendings shows no RPM, CCM, PCM, or TCM codes at all. The conclusion is not that Norton cannot do remote care — it plainly can — but that the capability has never been built as a reimbursed, longitudinal service line on the cardiovascular panel. That is the gap this report addresses. (One caveat worth resolving in discovery: if care management is being billed "incident to" under a different supervising NPI or a facility TIN, it would not surface in physician-level claims data. One question resolves it.)

Design principles for the service line

Principle	What it means for NHVI
Longitudinal by default	Heart-failure and high-risk cardiac patients are monitored continuously between visits, not managed only at episodic appointments.
One scorecard	A single view of enrolled census, alerts, titration actions, billable capture, and avoided admissions — clinical and financial on the same page.
Hub-and-spoke	All ~30 NHVI sites across both states share one remote-care engine; patients are enrolled wherever they are seen and managed centrally.
Top-of-license	The nurse navigators, social worker, and pharmacist already on the heart-failure program run monitoring and GDMT titration to protocol; physicians work on exceptions and escalations.
Digital as care	Connected devices and structured Epic data are part of the care model — feeding both clinical decisions and ASM performance measurement.

2. The Remote Care Service Line — The Spine

This is the centerpiece. The remote-care service line is not a point solution bolted onto the cardiology clinics; it is the operating spine that carries recurring revenue, heart-failure performance, and procedural throughput on one shared engine.

2.1 What It Is: The Care-Management Stack

NHVI bills the full care-management stack on its own cardiovascular patients. Because a cardiovascular service line has no primary-care panel of its own, this is a specialty stack — there is no APCM (Advanced Primary Care Management) arm, and none is proposed. Where longitudinal wraparound is needed for a patient's primary-care conditions, it is coordinated with the patient's primary-care clinician through a shared care plan and structured data exchange, not billed by the cardiovascular service line.

Layer	Codes	Role in the cardiovascular stack
TCM	99495 / 99496	Transitional Care Management at discharge — the on-ramp. Two-business-day contact plus a face-to-face visit; the moment a heart-failure or post-procedure patient is most fragile and most winnable. With 905 Medicare FFS heart-failure discharges a year, this is a high-volume front door.
RPM	99453/99454; 99445; 99457/99470; 99458	Remote Physiologic Monitoring — weight, blood pressure, and symptoms. Short-window codes (99445/99470) cover the 2–15 day post-discharge window; 99454/99457 carry longitudinal monitoring.
PCM	99426 / 99427	Principal Care Management for a single dominant high-risk condition (heart failure) in patients who do not need full multi-condition management.
CCM	99490 / 99439	Chronic Care Management for multimorbid cardiac patients (2+ chronic conditions) — the majority of an NHVI heart-failure panel, where hypertension, ischemic heart disease, chronic kidney disease, and diabetes cluster heavily.

> **The one coordination rule**
>
> RPM stacks with PCM or CCM (distinct time and documentation). PCM and CCM are not billed together for the same patient in the same month — set a simple attribution policy: heart-failure-dominant patients → PCM; multimorbid patients → CCM; RPM runs alongside either. For patients co-managed with a referring primary-care clinician, agree who owns the longitudinal wrapper so the same patient-month is never double-counted.

2.2 Standalone Value: Four Value Layers

Before any value-based dollar, the service line pays for itself through four layers of value.

1. **Direct professional-fee revenue.** Recurring monthly RPM / CCM / PCM billing plus TCM at each discharge — a subscription-like revenue line the practice owns, on the largest cardiovascular panel in the Louisville market.
2. **Avoided cost and quality-position repair.** Fewer heart-failure admissions and readmissions — modeled at roughly 589 avoided hospitalizations over 24 months (about $8,838,212 at $15,000 per

admission) — which also acts directly on the public measures where CCN 180088 is currently flagged: 30-day heart-failure mortality, heart-failure excess days in acute care, and the HRRP excess readmission ratio.

3. **Procedural throughput unlocked.** Short post-procedure monitoring windows support faster, safer discharge, freeing catheterization-lab, EP-lab, and inpatient-bed capacity at Audubon and across the network for additional structural, interventional, and device cases.
4. **Strategic and model readiness.** A functioning remote-care chassis is the ASM heart-failure operating model — built and generating data before the model becomes mandatory in January 2027.

The CY2026 billing stack (illustrative local rates)

Service / code	Type	Rate	Notes
TCM 99495 / 99496	Per discharge	~$200 / ~$280	2-business-day contact; face-to-face at 14 / 7 days
RPM 99453 setup	One-time	$19.32	Requires ≥ 2 days of data
RPM 99454 / 99445	Monthly	$46.33	99454 = 16–30 days; 99445 = new 2–15 day short-window code
RPM 99457 / 99470	Monthly	$48.32 / $24.33	First 20 min / new first-10-min code (2026)
RPM 99458	Monthly	$39.12	Each additional 20 min
PCM 99426 / 99427	Monthly	$64.05 / $50.78	Single high-risk condition (heart failure)
CCM 99490 / 99439	Monthly	$62.56 / $47.48	Two or more chronic conditions

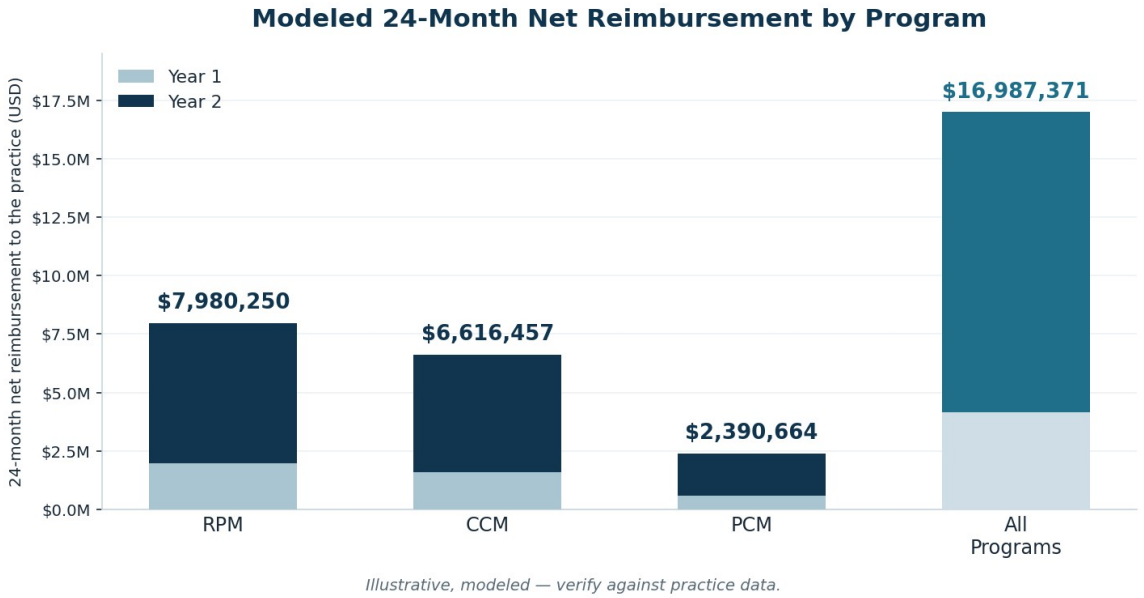


Figure 1. Modeled 24-month net professional-fee reimbursement by program, split Year 1 / Year 2. Illustrative, modeled from a CoachCare Value Analysis on an estimated Medicare panel — verify against practice data.

Rates shown are the local Kentucky-locality magnitudes (carrier 15102, locality 00) used in the Value Analysis model — illustrative, not quotes. Actual payment is locality-adjusted and set by the regional MAC; verify current-year PFS values in contracting. TCM magnitudes are shown as national reference

figures. APCM (G0556–G0558) is intentionally excluded throughout this report: it is billed by a primary-care panel, which a cardiovascular service line does not have.

How the recurring-revenue math works

Each enrolled heart-failure or high-risk cardiac patient generates a recurring monthly professional fee (RPM device plus monitoring, plus PCM or CCM), on top of a TCM fee at each qualifying discharge. As the enrolled census ramps across 24 months, that recurring line compounds — which is why modeled Year 2 net reimbursement ($12,838,662) is roughly 3.1× Year 1 ($4,148,709). By Month 24 the model carries 9,358 unique patients in active remote care across 14,520 total program enrollments (7,146 RPM, 5,120 CCM, 2,254 PCM). NHVI bills; CoachCare supplies the enrollment, devices, monitoring labor, and billing capture as a service.

Modeling assumptions (read before quoting any figure)

Panel is a discovery-stage estimate. The model uses approximately 61,400 total Medicare patients — roughly 30,000 in traditional fee-for-service plus a comparable Medicare Advantage population, reflecting Jefferson County's ~51% Medicare Advantage penetration — with about 49,000 in scope as carrying a qualifying chronic condition, across 100 referring providers. It is a modeled estimate anchored to published CMS per-physician panel data, not a Norton-supplied headcount. Replace it with actual panel and payer-mix data at the first discovery session.

Medicare Advantage is modeled at fee-for-service rates. Federal rules set Medicare Advantage payment for these services at no less than traditional Medicare, so pricing the MA population at FFS magnitudes is a conservative floor. In Louisville this matters more than most markets: roughly 51% of Jefferson County Medicare beneficiaries are in MA, and a single carrier holds about 61% of that book. RPM, CCM, and PCM bill cleanly on the fee-for-service half today; the MA half requires plan-by-plan confirmation before it can be counted.

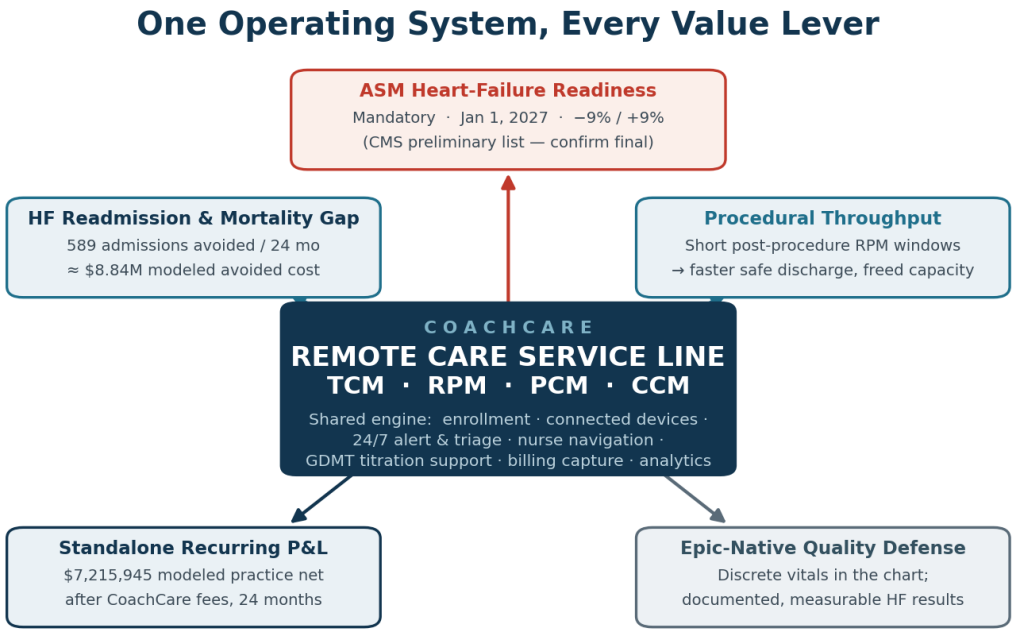
Enrollment mechanics. One CoachCare-funded on-site enrollment specialist, roughly 8 referrals per provider per month at an 80% patient-accept rate, and program conversion rates of 30% (RPM), 25% (CCM), and 25% (PCM) drive the 24-month ramp.

Rates are Kentucky locality magnitudes. CY2026 PFS magnitudes for carrier 15102, locality 00 — verify current-year values against the fee schedule and the local MAC in contracting.

Avoided-admission value is directional. Modeled at $15,000 per admission and an RPM-attributable reduction on an assumed baseline; a planning estimate, not a guarantee. Norton's own facility-level heart-failure readmission performance is cited separately from public CMS data and is not the basis of the avoided-cost model.

2.3 Connective Tissue: One Engine, Every Lever

The reason to build this as a service line — rather than a series of disconnected point programs — is that one shared engine powers every lever NHVI cares about. Enroll a patient once; monitor, triage, titrate, document, and bill on the same infrastructure; and that same infrastructure simultaneously improves ASM heart-failure performance, avoids admissions, moves the public quality measures, speeds procedural discharge, and strengthens referral relationships.



Build the remote-care chassis once; the same enrollment, device, triage, titration and billing infrastructure powers each lever.

Figure 2. One operating system, every value lever. The ASM lever reflects the CMS preliminary participant list — confirm against the final CMS list expected summer 2026.

How the same infrastructure powers each lever

Lever	What the shared engine contributes
ASM heart failure (2027)	Continuous monitoring, protocolized GDMT titration, and structured documentation — the operating model ASM rewards. Preliminary list; confirm final.
HF readmission, mortality and excess days	Weight and blood-pressure trend alerts catch decompensation days before a symptomatic crash; ~589 admissions avoided over 24 months (about $8,838,212 modeled), acting on the exact measures where CCN 180088 is flagged.
Structural heart, EP and device throughput	Short post-procedure RPM windows support faster safe discharge → freed cath-lab, EP-lab, and bed capacity for more cases.
Referral & reputation defense	A visible, continuous touch between visits strengthens referring-clinician relationships and supports the service line's market position across a 30-site network.
Employer-direct differentiation	Norton Healthcare Direct, the tiered-network product sold to self-funded employers, gains a chronic-care benefit that competitors in the market do not offer.
Standalone P&L	Recurring RPM/CCM/PCM plus TCM revenue — modeled $7,215,945 net practice contribution after fees over 24 months.

3. The 2027 Payment Shift — Ambulatory Specialty Model

The Ambulatory Specialty Model (ASM) is the CMS Innovation Center's mandatory, specialty-focused payment model. For cardiology, the accountable condition is heart failure. ASM begins January 1, 2027, runs through 2031, and adjusts participating clinicians' Part-B payments based on cost and quality performance — a −9% to +9% adjustment in the first payment year, with two-sided risk from the outset. It holds the cardiologist accountable for a heart-failure patient's cost and quality across the full year, and it anticipates an electronic collaborative-care arrangement with the patient's primary-care clinicians.

★ ASM verification status — PRELIMINARY

NHVI is on the CMS preliminary ASM participant list, not the final list.

Four of NHVI's heart-failure cardiologists appear in the CMS CY2027 preliminary ASM participants dataset, all in the heart-failure cohort, listed under the service line's CMS billing entities: Community Medical Associates, Inc. (Kentucky) and Norton Clark Physician Practices, LLC (Indiana). Individual clinicians are deliberately not named here — the preliminary list is built on historical claims and the roster will be reconciled to the service line's current staffing.

The final CMS participant list is expected in summer 2026, and the roster can change. Treat the preliminary selection as the planning basis and confirm the final list before making commitments that depend on participation. Re-query the CMS ASM participants dataset against both legal entity names — not against "Norton Heart & Vascular Institute," which does not appear in CMS files.

Why the service line is the ASM operating model. ASM does not ask NHVI to do anything philosophically new — it asks the service line to manage heart failure continuously and measurably, and then pays on the result. A remote-care service line is exactly that capability: enrollment and risk stratification, continuous weight and blood-pressure monitoring, protocolized alerting, GDMT titration between visits, and the structured data that both drives care and documents performance. Standing it up now means NHVI enters 2027 with the workflows live and a year of data in hand, rather than building the plane while flying it. As of this report's date there are roughly five months of runway before PY1 begins.

The primary-care collaboration — framed correctly. ASM anticipates a collaborative-care arrangement with primary care. Because NHVI is a cardiovascular service line with no primary-care panel of its own, this is not a CoachCare-billed primary-care arm and not APCM. It is a shared heart-failure care plan and structured data exchange with each patient's referring primary-care clinician — the cardiovascular service line owns the specialty wrapper (TCM at discharge, RPM, PCM/CCM), and coordinates the primary-care wrapper with the clinician who owns it. Norton already runs EpicCare Link for affiliated and referring providers, which is the natural surface for that exchange.

Where accountability actually lands

Louisville/Jefferson County (CBSA 31140) is not among the mandatory CBSAs selected for the Transforming Episode Accountability Model, while Lexington-Fayette is — so federal accountability reaches Norton's cardiovascular business through the ambulatory/cardiology door (ASM), not the hospital-surgical door. That is precisely the door a remote-care service line sits behind.

This report also makes no claim about Norton's participation in any other CMS value-based model. No evidence of Medicare Shared Savings Program or ACO REACH participation was found in public sources; that should be confirmed on discovery rather than assumed in either direction.

4. Operating System for Service Line Performance

Running the service line well means managing it like a service line — with a balanced scorecard that puts clinical, operational, and financial measures on one page, reviewed on the same cadence as procedural volume and clinic throughput.

Dimension	Representative measures
Remote-care service line	Enrolled census by program; unique patients vs. total program enrollments; time-to-first-billable-enrollment; billable-capture rate; net revenue per patient per month; alerts actioned within target.
Heart-failure quality	GDMT titration to target; 30-day HF readmissions and the HRRP excess readmission ratio; 30-day HF mortality; excess days in acute care; days at home; symptom-driven visit avoidance.
Access & throughput	Post-procedure length of stay; same/next-day discharge rate; catheterization- and EP-lab utilization; new-patient access time across the 30-site network.
Financial	Recurring RPM/CCM/PCM revenue; TCM capture at discharge; denial rate; program contribution to service-line and system margin.
ASM readiness	HF cohort enrolled and monitored; titration protocol live; referring-PCP collaborative-care agreements in place; performance data captured. Confirm against the final CMS list.

ASM readiness checklist

- **Cohort defined and enrolled** — every attributed heart-failure patient on continuous weight and blood-pressure monitoring, with enrollment triggered at the TCM touch after discharge.
- **Titration as a production process** — nurse- and pharmacist-led GDMT titration to protocol, using the staff the heart-failure program already employs, with physician escalation paths.
- **Referring-PCP collaborative care** — shared care plans and structured data exchange with referring primary-care clinicians through EpicCare Link (not an APCM arm).
- **Documentation & data capture** — structured monitoring and titration data flowing into Epic as discrete vitals and care summaries, feeding ASM performance measurement.
- **Final-list confirmation** — go-live plan reconciled to the final CMS ASM participant list expected summer 2026, re-queried against both billing entities.

5. Performance Snapshot — The Heart-Failure Gap

Norton publishes its own cardiovascular market position, and CMS publishes its outcomes. Read together, the two tell one story: NHVI has won the market and has not yet won the measures. This section states both plainly, from public sources, because the gap between them is the business case.

Market position

Measure	Position	Source / vintage
Medicare FFS heart-failure discharges	905 in CY2024 (799 at CCN 180088 + 106 at Norton Clark) — 52.8% of Louisville's Medicare FFS HF volume; ~1.7× Baptist Health Louisville, ~3.6× UofL Health – Jewish Hospital	CMS, CY2024
Cardiac DRG share	53.2% of the Louisville market	CMS, CY2024
Diagnostic catheterizations	42.3% of Jefferson County volume	KY CHFS, CY2023
Cardiovascular market share (Norton-published)	More than 57% of total cardiovascular market share; ~50% of inpatient and ~57% of outpatient CV cases in the service area	Norton Quality Report, 2024 performance
Metro ranking	Norton Hospitals ranked No. 1 in the Louisville metro; "High Performing" in heart bypass surgery and pacemaker implantation. Not nationally ranked in Cardiology & Heart Surgery.	U.S. News, 2025–26 cycle

Public quality position

Measure (CCN 180088)	Score	Denominator	vs. national
30-day death rate, heart failure	14.3%	1,486	Worse than national
HF excess days in acute care (per 100 discharges)	+18.8	—	Worse than national
HRRP excess readmission ratio, heart failure	1.0261	1,668	Above 1.0 — penalized
30-day readmission, AMI	16.1%	642	Worse than national
Hybrid hospital-wide readmission	16.3%	—	Worse than national
CMS Overall Hospital Quality Star Rating	2 of 5	—	Baptist Health Louisville: 4 of 5

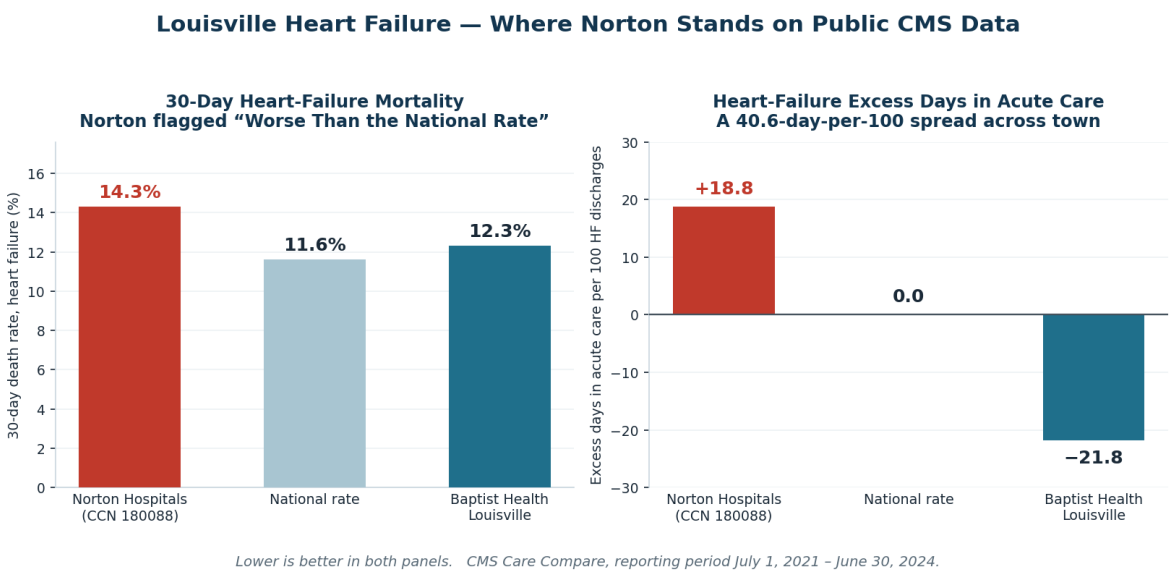


Figure 3. Public CMS heart-failure outcomes for Norton Hospitals (CCN 180088), the national rate, and Baptist Health Louisville (CCN 180130). Lower is better in both panels. Reporting period July 1, 2021 – June 30, 2024 — confirm current values on CMS Care Compare before citing.

The competitive fact, stated factually. Baptist Health Louisville posts 30-day heart-failure mortality of 12.3% and heart-failure excess days in acute care of −21.8 per 100 discharges, and holds a 4-star CMS overall rating. Against Norton's +18.8, that is a **40.6 excess-day-per-100 swing on heart-failure discharges** between the two largest cardiac programs in the same city. This is public CMS data, not an attack, and it is not a judgment about clinical skill — case mix, referral patterns, and the fact that Norton takes the market's largest and likely sickest heart-failure volume all bear on it. But it is the number a payer, an employer, a referring physician, or a board member can look up. The operational answer to excess days and excess readmissions is continuous management between visits, which is exactly what the service line delivers.

Why the volume makes this a service line, not a pilot. Owning 52.8% of a market's Medicare FFS heart-failure discharges means Norton inherits the market's heart-failure risk whether or not it builds the infrastructure to manage it. Under ASM, that risk becomes priced. The same scale that makes the measures hard makes the remote-care economics work: a per-patient-per-month program compounds across the largest cardiovascular panel in Louisville.

Data vintage and what to confirm

All CMS quality figures above are drawn from the Care Compare reporting period July 1, 2021 through June 30, 2024, retrieved July 2026, for CCN 180088 (Norton Hospitals, Inc.) and CCN 180130 (Baptist Health Louisville). Norton's four adult Louisville hospitals share the single CCN 180088, so CCN-level measures describe the whole Louisville adult enterprise as one hospital — which is worth naming when the numbers are discussed internally.

Confirm current values on CMS Care Compare before citing, and pull the service line's own internal heart-failure readmission, mortality, and length-of-stay data in discovery. Internal data almost always tells a more nuanced story than the public file, and the goal is to work from the real numbers.

6. Powering ASM: Heart Failure + Referring-PCP Collaboration

This section makes the ASM connection concrete. The remote-care service line is not adjacent to ASM readiness — it is the ASM operating model, expressed as day-to-day workflow. (ASM participation reflects the CMS preliminary participant list; confirm against the final CMS list expected summer 2026.)

The heart-failure operation, as a production process

- **Identify & enroll —** every attributed heart-failure patient is risk-stratified and enrolled onto connected weight and blood-pressure monitoring, most efficiently at a TCM touch after discharge. With 905 Medicare FFS heart-failure discharges a year across the two entities, the TCM on-ramp alone is a substantial enrollment channel.
- **Monitor & alert —** daily physiologic data flows into a 24/7 alert-and-triage layer; weight and blood-pressure trends surface decompensation days before a symptomatic crash. This is the mechanism that moves excess days in acute care.
- **Titrate to target —** nurse- and pharmacist-led GDMT titration runs to protocol between visits, turning guideline-directed therapy into a repeatable process instead of an every-few-months office event. NHVI already staffs the pharmacist and the navigators this requires.
- **Document & measure —** structured monitoring and titration data flow back into Epic as discrete vitals and care summaries, both driving care and producing the performance record ASM is scored on.

The labor already exists

The most unusual feature of this account is that the hardest part is already done. Norton's heart-failure program is staffed with nurse navigators, a social worker, and a dedicated pharmacist alongside its heart-failure cardiologists and advanced practice providers. That is the exact team composition a billable care-management program requires — and the CY2024 claims record shows none of that work converting into RPM, CCM, PCM, or TCM revenue. The proposal here is not to hire a care-management team. It is to give the one that exists the monitoring infrastructure, documentation discipline, and billing capture that turn its work into a funded service line, with CoachCare supplying the incremental monitoring labor, devices, and enrollment capacity so that scale does not require proportional hiring.

The collaborative-care arrangement, done right

ASM anticipates an electronic collaborative-care arrangement with primary care. For NHVI this is a coordination relationship, not a billing arm: a shared heart-failure care plan in Epic and structured data exchange with each patient's referring primary-care clinician, using the EpicCare Link surface Norton already operates. NHVI owns the cardiology wrapper (TCM, RPM, PCM/CCM); the primary-care clinician owns the primary-care wrapper. This keeps attribution clean and avoids any double-counting of the same patient-month.

Design decisions to lock before go-live

Attribution: HF-dominant → PCM; multimorbid → CCM; RPM alongside either; the referring primary-care clinician owns primary-care management for shared patients.

Targeting: launch with the attributed ASM heart-failure cohort, then widen to the broader high-risk cardiac panel across the 30-site network.

Shared care plan: one plan of record in Epic; agreed data exchange with referring clinicians via EpicCare Link.

Two-state operating model: Kentucky and Indiana sites bill under different legal entities; confirm enrollment, supervision, and billing attribution rules for each before go-live.

Readiness: workflows live and generating data in 2026; go-live reconciled to the final CMS ASM list expected summer 2026.

7. Epic Integration — Building Inside the System of Record

Norton runs a single, integrated Epic instance across 100% of its practices and hospitals — one of the cleanest integration profiles in this market. There is no separate ambulatory instance to bridge, no interface to build twice: one integration serves all ~30 NHVI sites, both states, and the referring primary-care base. Patients already hold MyNortonChart, and referring and affiliated providers already work in EpicCare Link. Norton has also demonstrated willingness to embed third-party workflows directly into Epic — the Bamboo Health prescription-monitoring integration is the precedent, and Norton reported cutting opioid prescriptions roughly in half after deploying it.

CoachCare integrates directly and bi-directionally with Epic, using built-in Epic workflows so clinicians enroll and monitor remote-care patients without learning a new system. The program lives in the Epic environment rather than beside it.

Integration pillar	What it does in Norton's Epic environment
Integrated enrollment	Enrollment flags and trigger ordering sit inside the existing clinical workflow. The CoachCare team enrolls qualified Medicare patients on the service line's behalf, and enrollment status is visible in Epic in real time — patients begin receiving CCM and RPM services in under five days from flag.
Exchange of health history	Bi-directional exchange at intake, so the monitoring program starts from the chart rather than from a blank form.
Integrated discrete vitals	Device readings land in the chart as discrete flowsheet vitals — not scanned PDFs — so weight and blood-pressure trends are visible to the cardiologist, usable in Epic reporting, and available as ASM performance evidence.
Compliance documentation	Audit-ready care summaries and time documentation written back into the record, which is what makes time-based care-management codes defensible.
Automated claim generation	Claims created automatically through the CoachCare billing engine. CoachCare is the only care-management application integrated with Epic that provides automated claims creation, eliminating the manual per-patient, per-month claim step.

Why this matters more here than at a typical account. A service line spread across ~30 sites and two states, billing under two legal entities, cannot run a care-management program on manual claim creation and PDF vitals. Automated claim generation is the difference between capturing the recurring revenue modeled in Section 2 and leaving a large share of it on the floor in unbilled months. Discrete vitals in Epic are the difference between an ASM performance story you can evidence and one you have to assert.

> **Epic integration — confirm in contracting**
>
> Norton's single-instance Epic estate is confirmed from Norton's own published description of Norton Medical Group. The specific Epic hosting model, version, and interface engine, and the internal owner of the existing remote-monitoring budget (the post-acute virtual-hospital team is a candidate) should be confirmed in discovery, as they determine integration sequencing. Integration setup follows the standard catalog for Epic; confirm scope and timeline in contracting.

8. Powering Procedural Growth: Structural Heart, EP & Devices

The same engine that manages heart failure also protects the procedural economics of one of the busiest cardiovascular programs in Kentucky. NHVI leads the state in annual TAVR volume by its own account, was first in Kentucky to implant the Edwards EVOQUE transcatheter tricuspid valve, was first in Louisville to offer PASCAL and MitraClip and to implant a dual-chamber leadless pacemaker, and runs a full electrophysiology and device service. Audubon's four catheterization labs, two EP labs, and two hybrid operating rooms are the capacity constraint that procedural growth runs into.

How the throughput math works. The CY2026 short-window RPM codes — 99445 for a 2–15 day device window, 99470 for the first 10 minutes of monitoring — make it billable, and clinically defensible, to monitor a patient closely for the first two weeks after a procedure. That short, structured window supports faster, safer same- or next-day discharge: the patient goes home sooner with a monitoring safety net, which frees catheterization-lab, EP-lab, and inpatient-bed capacity for additional cases. Build the monitoring chassis once for heart failure, and the post-procedure window is a reuse, not a new build.

The hypertension and cardiometabolic adjacency. NHVI runs a cardiometabolic clinic and has been building an advanced-hypertension program, with renal denervation on its own continuing-education agenda. Blood-pressure RPM is intrinsic to any hypertension program — it is how titration is managed and how outcomes are documented. A service line built for heart failure covers this population on the same infrastructure, with no second build.

> **Scope discipline**
>
> This lever is limited to what Norton's own public sources establish: structural heart, interventional, electrophysiology and device throughput, and the cardiometabolic/hypertension adjacency. Absolute procedural volumes (TAVR, PCI, open-heart, ablation) are not published and are deliberately not estimated here — pull them in discovery before any throughput claim is quantified. No surgical-episode or bundled-payment framing is applied, because Norton's Louisville facilities are not in a mandatory episode model.

9. Implementation Playbook

Goals & scope

Stand up a managed remote-care service line that is margin-positive on its own economics and ASM-ready before January 1, 2027. Scope: TCM + RPM + PCM + CCM, billed by the Norton cardiovascular entities, on the heart-failure and high-risk cardiac panel across all NHVI sites in Kentucky and Southern Indiana.

Target populations (in launch order)

- **Attributed ASM heart-failure cohort (launch first)** — the patients NHVI will be measured on in 2027.
- **Post-discharge and post-procedure patients** — captured at the TCM and short-window RPM on-ramp, drawing on 905 Medicare FFS heart-failure discharges a year plus the structural, interventional, and device volume.
- **Broader high-risk cardiac panel** — multimorbid patients for CCM, single-dominant-condition patients for PCM. Published CMS panel data for NHVI cardiologists shows roughly 75% hypertension, 32% heart failure, 32% chronic kidney disease, and 35% diabetes prevalence — the multi-condition criteria are met across most of the panel.

Staffing, technology & billing architecture

- **Top-of-license clinical model —** the nurse navigators and pharmacist already on the heart-failure program run monitoring and GDMT titration; CoachCare supplies the enrollment (including a funded on-site enrollment specialist), connected-device logistics, monitoring labor, and billing capture as a service, so the service line adds program capacity without adding headcount it must hire and manage. The model projects roughly 157,918 staff-hours of remote management delivered by CoachCare over 24 months — about 75.9 FTE-equivalents of CoachCare-performed work, not practice headcount.
- **Native Epic integration, day one —** enrollment flags and trigger ordering in the existing workflow, telephonic patient enrollment, cellular-connected devices with real-time vitals landing as discrete chart data, and automatic claim creation, all inside the single Epic instance.
- **Two-entity billing architecture —** Community Medical Associates, Inc. and Norton Clark Physician Practices, LLC bill separately; the program is configured once and mapped to both, with attribution rules set before the first enrollment.

Clinical workflow (steady state)

Enroll at a TCM touch or clinic visit → ship and activate connected devices → daily physiologic data into 24/7 alert-and-triage → protocolized GDMT titration between visits → structured documentation written back to Epic → monthly billable capture (RPM plus PCM or CCM) and TCM at each qualifying discharge.

KPI dashboard

Clinical	Operational	Financial
GDMT titration to target; 30-day HF readmissions and mortality; excess days in acute care; days at home	Enrolled census (unique patients and total program enrollments); time-to-first-billable-enrollment; alerts actioned on time; device compliance	Net revenue per patient per month; billable-capture rate; denial rate; contribution to service-line margin

Expected impact & 12-month roadmap

Modeled 24-month impact (illustrative; verify against practice data): **$16,987,371 net professional-fee reimbursement, $7,215,945 net practice contribution after CoachCare fees, ~589 avoided hospitalizations (about $8,838,212 in avoided cost), 340,498 reimbursable claims, 928,012 physiologic readings, and 157,918 staff-hours of remote management delivered by CoachCare — with 9,358 unique patients in active remote care across 14,520 program enrollments by Month 24.**

1. **Months 1–2 — Stand up.** Contract with the correct legal entities; scope and schedule the Epic integration; define the heart-failure cohort; set attribution and referring-PCP collaboration models; train staff.
2. **Months 3–6 — Enroll & ramp.** Enroll the ASM heart-failure cohort first via TCM on-ramps and clinic referral; go live on monitoring, titration, and billing capture; begin the post-procedure short-window program.
3. **Months 7–12 — Scale & prove.** Widen to the broader high-risk panel across all sites and both states; stand up the balanced scorecard; accumulate the ASM performance-data record; reconcile the plan to the final CMS list.
4. **Into 2027 — ASM go-live.** Enter January 1, 2027 with a live heart-failure operation and a year of data, not a standing start — and with the public quality measures already moving.

A secondary channel worth naming

Norton Healthcare Direct, the direct-to-employer tiered-network product sold to self-funded employers, is a natural second home for this program. A managed chronic-care and remote-monitoring benefit is a differentiator in employer-direct contracting that competing networks in this market do not currently offer, and it monetizes the same infrastructure against a commercial population. Panel size, employer count, and whether chronic-care management is in scope for that product should be confirmed in discovery.

References & Data Sources

1. CMS Innovation Center — Ambulatory Specialty Model (ASM) Participants dataset, data.cms.gov (CY2027 preliminary file); heart-failure cohort entries under Community Medical Associates, Inc. and Norton Clark Physician Practices, LLC.
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3. CMS Provider Data Catalog — Complications & Deaths and Hospital Readmissions Reduction Program files for CCN 180088 (Norton Hospitals, Inc.) and CCN 180130 (Baptist Health Louisville); reporting period July 1, 2021 – June 30, 2024; Hospital General Information for overall star ratings. Retrieved July 2026.
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8. CMS FY2025 IPPS/LTCH PPS Final Rule — list of mandatory CBSAs selected for the Transforming Episode Accountability Model (Louisville/Jefferson County CBSA 31140 not selected).
9. Norton Healthcare — published system, service-line, program, and locations pages (Norton Heart & Vascular Institute, Norton Medical Group, heart-failure program, electrophysiology, structural heart, cardiac rehabilitation, MyNortonChart, Norton eCare); Norton Quality Report (2024 performance data).
10. Norton Healthcare, Inc. — consolidated financial statements for the year ended December 31, 2025; independent auditor's report of Ernst & Young LLP dated March 26, 2026 (patient service margin of 1.28%: $64.3M on $5.02B).
11. CMS CY2026 Physician Fee Schedule — remote-care billing codes (TCM, RPM including the new 99445 and 99470, PCM, CCM); Kentucky locality magnitudes (carrier 15102, locality 00) used in the model.
12. CoachCare Value Analysis (2026) — modeled economics for NHVI on an estimated Medicare panel; source of all illustrative financial, clinical, and operational figures in this report.
13. CoachCare — Epic integration overview (integrated enrollment, exchange of health history, integrated discrete vitals, compliance documentation, automated claim generation).

Verification & validation caveat

This report is a planning artifact, not an audited financial or legal document. Every present-day fact should be re-verified before it is relied upon.

In particular: (1) NHVI's ASM participation reflects the CMS **preliminary** participant list — confirm against the final list expected summer 2026, queried against Community Medical Associates, Inc. and Norton Clark Physician Practices, LLC; (2) all economics are illustrative and modeled on an estimated panel of approximately 61,400 total Medicare patients (fee-for-service plus Medicare Advantage, with MA priced at fee-for-service magnitudes) — re-run against actual practice data; (3) the CMS quality figures carry a July 1, 2021 – June 30, 2024 reporting period and should be refreshed on Care Compare; (4) physician-roster, contracting-entity, Epic hosting, procedural-volume, and Medicare Advantage contract details must all be confirmed on discovery.

Figures labelled modeled are illustrative and require verification against Norton's own patient, payer, and utilization data.