# CHARLESTON NEPHROLOGY ASSOCIATES

## Nephrology Service Line Performance & Optimization

## 2026 Strategy Report

*A Remote Care Service Line (RPM + PCM + TCM) as the operating spine of CKD management and Kidney Care Choices performance*

**Purpose of this report**

Prepared for the physicians and leadership of Charleston Nephrology Associates as a strategy assessment of a managed Remote Care Service Line for the practice's chronic kidney disease population. It combines the practice's public footprint, its verified value-model position, the 2026 Medicare payment environment, and a modeled 24-month economic forecast built at 2026 South Carolina locality rates.

*All modeled figures are illustrative, modeled — verify against practice data. The Medicare panel size is an estimate presented with its method and range, framed for validation in discovery.*

Prepared by CoachCare · July 2026

*Confidential draft for discussion*

# Table of Contents

## Executive Summary

Charleston Nephrology Associates, LLC is an independent, physician-owned, single-specialty nephrology group serving the Charleston–North Charleston, SC metropolitan area: **nine board-certified physicians and ten advanced-practice providers (four NPs, six PAs — 19 providers in total)**, operating from offices in North Charleston and Goose Creek, rounding at six hospital campuses across the metro area — acute-care, long-term acute-care, and inpatient-rehabilitation facilities — and covering 19 affiliated dialysis clinic assignments, including at least seven home-dialysis programs (practice website, retrieved July 2026). It is one of the region's principal independent kidney-care groups, with a clear clinical orientation toward home dialysis and transplant coordination.

The practice's value-based position is already verified and strong. It participates in the CMS Comprehensive Kidney Care Contracting (CKCC) model via **Carolina Kidney Partners, LLC**, a Kidney Contracting Entity (KCE) on the CMS Kidney Care Choices CY2025 and CY2026 participant lists (CKCC Professional option, Cohort 1, GA/SC). CMS lists the KCE legal entity; the practice-to-KCE link rests on the KCE's published roster, which lists Charleston Nephrology Associates and all nine of its physicians by name. The KCE publicly reports 2025 results of **79.23% optimal dialysis starts (vs. a ~29% national average) and 39.5% home-dialysis starts (vs. ~14%)** — top-tier numbers that the practice's physicians help produce.

The gap sits at the practice level. The public site shows **no remote physiologic monitoring, no care-management program, and no telehealth offering** — the patient portal is the only patient-facing digital tool, and CKD education is delivered through static booklets (site review, July 2026). The KCE supplies predictive analytics and care coordination at the network level; the practice-level engine that generates daily physiologic data and a documented monthly touch between office visits is unbuilt. That is the whitespace this report addresses.

> ### The central argument
>
> **Between quarterly nephrology visits is where CKD progression actually happens.** A managed Remote Care Service Line — BP/weight remote physiologic monitoring (RPM), Principal Care Management (PCM) for the dominant renal condition, and Transitional Care Management (TCM) at discharge — is the interstitial care layer that fills those gaps. It delivers value two ways at once:
>
> **1. Standalone value.** Recurring, subscription-like professional-fee revenue at top-of-license staffing: a modeled $1.05M in net reimbursement and $314K in practice profit over 24 months (42.85% margin), margin-positive from month two, with enrollment and engagement staffing funded by CoachCare rather than added to practice payroll.
>
> **2. Connective tissue.** The same enrollment, device, monitoring, and billing engine powers the practice's CKCC total-cost performance, sustains and extends its optimal-start and home-dialysis results, and intercepts crash starts upstream of its six-facility hospital rounding footprint. Build the infrastructure once; reuse it on every kidney-care lever.

The 2026 payment environment is a tailwind. The CY2026 Medicare Physician Fee Schedule expanded the RPM code family — notably **99445** (device supply for 2–15 days of data, where 99454 previously required 16+) and **99470** (first 10 minutes of treatment management) — making short-window and lighter-touch monitoring billable for the first time. For a nephrology group, that means post-discharge stabilization windows, medication-titration bursts, and early-stage cohorts that never fit the old thresholds now carry revenue.

The economics below are modeled on a **1,850-patient Medicare panel estimate (plausible range 1,500–1,950)** derived from Medicare allowed-amount triangulation — an estimate to be validated against chart counts in discovery, not a chart-derived figure. The forecast models RPM + PCM only; CCM is structurally zero in the model for nephrology, with PCM serving as the care-management vehicle. All figures are illustrative, modeled at 2026 South Carolina locality rates — verify against practice data.

### 2026–2027 Priority Recommendations

1. **Stand up the RPM arm** for the CKD 3b–5 and hypertension cohort — connected BP cuffs and scales, 24/7 alert-and-triage, telephonic clinical monitoring. Modeled census reaches its ceiling of 333 enrolled patients by month 7.
2. **Layer PCM** as the monthly care-management vehicle for the single dominant renal condition (modeled census 277 by month 14). PCM — not CCM — is the vehicle for this specialty; CCM is intentionally excluded from the model.
3. **Wire the service line to CKCC measures.** Report enrolled census, BP control, weight/fluid trends, unplanned starts, and modality-education completion quarterly, alongside the KCE's network-level analytics — the practice-level engine behind the network-level results.
4. **Build the crash-start-avoidance pathway** upstream of the hospital rounding footprint: monitoring-triggered escalation, structured modality education, and timely access planning for the CKD 4–5 cohort, so more starts are planned starts.
5. **Execute the Veradigm EMR integration and billing-capture workflow.** Veradigm is the confirmed EMR (exact product and version to be confirmed in contracting); the practice adds no headcount — enrollment and engagement staffing is CoachCare-funded.
6. **Validate the panel estimate in discovery** with chart counts (Medicare patients by CKD stage), then re-run the Value Analysis; the 24-month forecast scales roughly linearly with the panel.

# 1. Footprint & Operating Model

Charleston Nephrology Associates is a quiet, stable, independent group — no acquisition, affiliation, or turnover news in the last two years — with organic growth on the advanced-practice side (two PA hires since 2023). Its operating footprint (practice website and NPI registry, retrieved July 2026):

| Dimension | Detail |
|---|---|
| **Legal entity** | Charleston Nephrology Associates, LLC — independent, physician-owned, single-specialty nephrology (Org NPI 1629054960; taxonomy 207RN0300X). Ownership independence inferred from public records; no health-system or private-equity ownership found. |
| **Providers** | 9 board-certified physicians + 4 nurse practitioners + 6 physician assistants = 19 providers. In-house CLIA-certified laboratory. |
| **Offices** | Main office: 3815 Faber Place Drive, North Charleston, SC 29405. Second office: 149 St. James Ave, Goose Creek, SC 29445. |
| **Hospital coverage** | Rounding at six hospital campuses across the Charleston metro area, spanning acute-care, long-term acute-care, and inpatient-rehabilitation settings — a wide funnel of discharges and at-risk CKD patients. |
| **Dialysis footprint** | 19 affiliated dialysis clinic assignments across the tri-county area, including at least seven home-dialysis programs — an unusually deep home-modality orientation. |
| **Clinical services** | CKD management, hypertension management, transplant evaluation and coordination, in-center and home dialysis oversight, hospital nephrology. |
| **Value model** | Verified CKCC participation via Carolina Kidney Partners, LLC (KCE; CKCC Professional, Cohort 1, GA/SC) — see Section 3. |
| **Digital layer** | Veradigm EMR (confirmed; product/version confirmed in contracting) with the FollowMyHealth patient portal. No RPM, care-management, or telehealth program visible on the public site (July 2026). |

Two structural facts shape the strategy. First, the practice's clinical reach is far wider than its office schedule: nineteen providers cover two offices, six hospitals, and nineteen dialysis clinics, which means the scarce resource is **longitudinal attention between encounters**, not clinical capability. Second, the practice already carries total-cost accountability through its KCE — so infrastructure that improves between-visit control is not just billable service; it is performance on a contract the physicians are already in.

### Design principles for the 2026 operating model

| Principle | What it means here |
|---|---|
| **Longitudinal by default** | CKD is managed as a continuous condition with daily physiologic data and a documented monthly touch — not a sequence of quarterly office encounters. |

| Principle | What it means here |
|---|---|
| **One scorecard** | Clinical (eGFR slope, BP control), model (optimal starts, home persistence, total cost), and financial (census, capture, margin) metrics reviewed together, quarterly. |
| **Hub-and-spoke** | Two offices act as the hub; the monitoring layer follows patients across six hospitals, nineteen dialysis clinics, and home. |
| **One front door** | A single enrollment and consent path into RPM/PCM at office visits, hospital discharge, and dialysis-education touchpoints. |
| **Digital as care, not administration** | Device readings and monthly care-management calls are clinical work products that feed physician decisions — and are billable under the 2026 fee schedule. |

# 2. The Remote Care Service Line — The Spine

## 2.1 What it is: the nephrology remote-care stack

The Remote Care Service Line is a managed clinical program, run with CoachCare as the operating partner, built from three coordinated Medicare care-management families — plus one deliberately excluded one:

| Component | Codes | Role in the nephrology service line |
|---|---|---|
| **RPM — Remote Physiologic Monitoring** | 99453, 99454, 99445 (new 2026), 99457, 99470 (new 2026), 99458 | Connected BP cuffs and weight scales for CKD 3b–5, resistant hypertension, and fluid-status management; 24/7 alert-and-triage with telephonic clinical monitoring. The daily data layer. |
| **PCM — Principal Care Management** | 99424, 99425 (physician); 99426, 99427 (clinical staff) | Monthly, documented management of the single dominant renal condition: medication review, lab follow-up, modality education, care-plan maintenance. The monthly touch layer — and this specialty's care-management vehicle. |
| **TCM — Transitional Care Management** | 99495, 99496 | Two-business-day contact and timely follow-up after discharges from the practice's hospital rounding footprint; hands off into RPM/PCM. The re-entry layer. |
| **CCM — noted, not modeled** | 99490 family | Chronic Care Management applies where the billing practitioner manages 2+ chronic conditions longitudinally. It is structurally set to zero in this forecast — PCM is the modeled vehicle for a single-specialty renal panel — and can be revisited per patient in discovery. |

> **The coordination rules (set as enrollment policy up front, not per claim)**
>
> PCM and CCM cannot both be billed for the same patient in the same month by the same practitioner — for this panel, PCM is the default and CCM stays off. RPM stacks with PCM (discrete time and documentation). TCM owns the 30-day post-discharge window, then monthly PCM resumes. One care plan lives in the Veradigm chart; every program documents against it. For patients co-managed with primary care, set an attribution policy up front: the nephrology practice owns renal PCM + RPM; the PCP owns any primary-care care-management billing.

## 2.2 Standalone value: four value layers and the 2026 billing stack

Before any model upside, the service line must stand on its own P&L. Its value arrives in four layers:

1. **Standalone RPM/PCM profit and loss.** Recurring monthly professional-fee revenue on the existing Medicare panel — modeled at $1.05M net reimbursement and $314K practice profit over 24 months (Section 8).

2. **CKCC total-cost performance.** The practice's KCE carries shared accountability for total cost of care on aligned CKD 4–5 and ESRD beneficiaries. Fewer unplanned admissions and better starts flow through the KCE's results — the service line is practice-level machinery for a contract the physicians are already in (Sections 3 and 6).
3. **Delayed dialysis initiation and crash-start avoidance.** Tighter BP and fluid control slows progression for some patients and converts unplanned, catheter-based starts into planned ones for others — the highest-cost failure mode in kidney care (Section 7).
4. **Referral durability with primary care.** A documented monthly touch, shared care plans, and closed-loop reporting back to referring PCPs make the practice the easiest nephrology group in the market to refer to — an independence-preserving asset.

### The 2026 billing stack (South Carolina locality)

| Service / code | Type | 2026 amount | Notes |
|---|---|---|---|
| TCM 99495 / 99496 | Per discharge | ~$200 / ~$280 | Moderate / high complexity; interactive contact within 2 business days; visit within 14 / 7 days. |
| RPM 99453 | One-time setup | ~$20 | Device setup and patient education. |
| RPM 99454 | Monthly | $48.12 | Device supply, 16–30 days of readings. |
| RPM 99445 (new 2026) | Monthly | ~$48 | Device supply, 2–15 days of readings — short transitional and titration windows now billable. |
| RPM 99457 | Monthly | $49.29 | First 20 minutes of treatment management with interactive communication. |
| RPM 99470 (new 2026) | Monthly | ~$26 | First 10 minutes — lighter-touch months now billable. |
| RPM 99458 | Monthly | $39.72 | Each additional 20 minutes. |
| PCM 99426 / 99427 | Monthly | $65.02 / $51.68 | Clinical-staff PCM, first / each additional 30 minutes, directed by the physician. |
| PCM 99424 / 99425 | Monthly | ~$79 / ~$57 | Physician/QHP-personally-provided PCM, first / additional 30 minutes. |

*Dollar-stated rates (99454, 99457, 99458, 99426, 99427) are 2026 Medicare Physician Fee Schedule amounts for the South Carolina statewide locality (Palmetto GBA); tilde-marked figures are illustrative national magnitudes. All rates are illustrative — verify against the current fee schedule and local MAC before financial planning.*

**Recurring-revenue mechanics**

Each enrolled RPM patient generates a predictable monthly claim set (99454 or 99445 + 99457/99470, plus 99458 where time supports it); each PCM patient adds a monthly management claim. At modeled steady state — 333 RPM and 277 PCM enrolled — the service line produces roughly **$54,500 in net reimbursement and $16,900 in practice profit per month**, subscription-like economics layered onto the existing panel with no added practice headcount. Figures are modeled and illustrative — verify against practice data.

## 2.3 Connective tissue: one engine behind every kidney-care lever

The same seven functions — enrollment, connected devices, 24/7 alert-and-triage, telephonic clinical monitoring, care-plan documentation, billing capture, analytics — power every strategic lever the practice cares about. Build them once, reuse them everywhere:

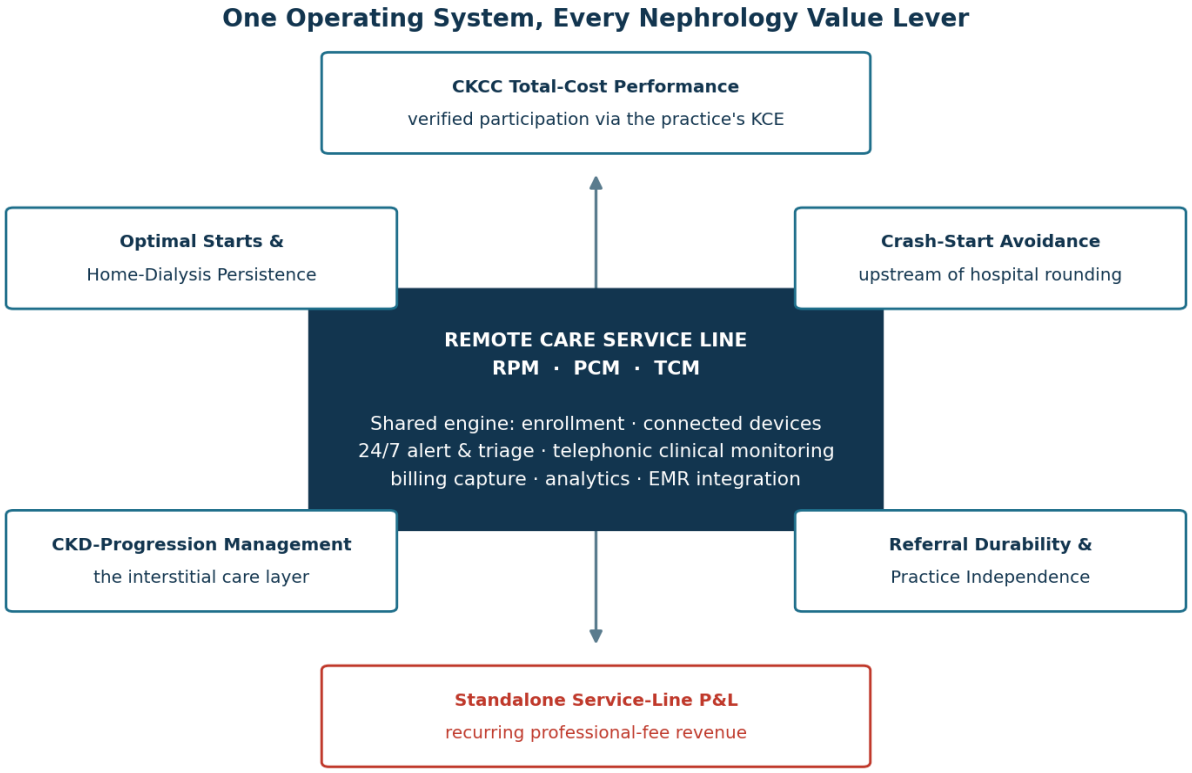


*Figure 1. One shared operating engine powers the standalone P&L and every kidney-care value lever.*

| Value lever | What the shared engine contributes |
|---|---|
| **CKCC total-cost performance** | Daily physiologic surveillance and monthly touch on the aligned CKD 4–5/ESRD cohort → earlier intervention, fewer unplanned admissions, better shared-savings position for the practice's KCE. |

| Value lever | What the shared engine contributes |
|---|---|
| **Optimal starts & home-dialysis persistence** | Modality education delivered through monthly PCM contacts; weight/BP monitoring continues after a home start, catching trouble that would otherwise push patients back to in-center care. |
| **Crash-start avoidance** | Monitoring-triggered escalation on the CKD 4–5 cohort converts emergency starts into planned starts — upstream of the six hospitals where the practice's physicians would otherwise meet those patients. |
| **CKD-progression management** | BP control and fluid management are the two most modifiable progression drivers; the interstitial layer works on them every day between visits. |
| **Referral durability & independence** | Closed-loop reporting to referring PCPs; a differentiated, documented management layer that no competing group in the market shows publicly. |
| **Standalone P&L** | Billing capture across the RPM/PCM/TCM stack, at 2026 rates, with CoachCare-funded enrollment staffing. |

# 3. 2026 Policy & Payment Environment: Kidney Care Choices + the RPM Code Expansion

## 3.1 Kidney Care Choices — the model that bites for nephrology

The CMS Innovation Center's Kidney Care Choices (KCC) model is the value-based framework built specifically for kidney care. Under its Comprehensive Kidney Care Contracting (CKCC) options, Kidney Contracting Entities — partnerships of nephrology practices and other kidney-care providers — take accountability for the total cost and quality of care of their aligned late-stage CKD and ESRD Medicare beneficiaries, with the **Professional option carrying 50% shared savings and losses**, capitated payments for CKD and ESRD management, and model incentives aimed at exactly the outcomes nephrologists control: planned starts, home modality uptake, and transplantation.

> **Verified participation (the gate this report passed)**
>
> Charleston Nephrology Associates participates in CKCC via **Carolina Kidney Partners, LLC** — a Kidney Contracting Entity on the CMS Kidney Care Choices CY2025 and CY2026 participant lists (CKCC Professional option, Cohort 1, GA/SC). One citation caveat, carried honestly: CMS publishes the KCE legal entity, not member-practice rosters; the practice-to-KCE link rests on the KCE's published roster, which lists Charleston Nephrology Associates and all nine of its physicians by name (retrieved July 2026).

The KCE's self-reported 2025 results — **79.23% optimal dialysis starts and 39.5% home-dialysis starts** against national averages it cites of roughly 29% and 14% — put the network in the top tier of kidney-care performance (Section 5). Two implications for the practice. First, every point of unplanned-admission reduction and every additional planned start on the practice's own panel flows through the KCE's shared-savings arithmetic. Second, the KCC model's current performance period runs through CY2026 — and whatever CMS designs next for kidney care, its entry requirements will look like what this service line builds: a consented longitudinal panel, continuous physiologic data, documented monthly management, and a working escalation loop. Building it now under fee-for-service means the practice arrives at the next contract cycle with the machinery already running.

## 3.2 The CY2026 fee-schedule tailwind

Separately from any model, the CY2026 Medicare Physician Fee Schedule made remote monitoring materially more billable:

- **99445 — device supply, 2–15 days of readings.** Previously, a month with fewer than 16 days of transmissions produced no supply revenue. Short windows — post-discharge stabilization, diuretic or antihypertensive titration bursts, pre-start observation — now bill at approximately the full supply amount.
- **99470 — first 10 minutes of treatment management.** Months with real but lighter clinical engagement, previously below the 20-minute threshold of 99457, now carry revenue.

For a nephrology panel — where clinically meaningful monitoring often comes in bursts around titration, intercurrent illness, and modality transitions — these two codes convert previously unbillable clinical work into revenue, and they are reflected in the modeled economics of Section 8.

## 4. Operating System for Service Line Performance

A service line is managed by a scorecard, not a code list. The recommended quarterly scorecard integrates clinical, model, and financial views — one meeting, one document, physician-led:

| Domain | Measures | Cadence |
|---|---|---|
| **CKD population health** | eGFR slope on enrolled vs. non-enrolled CKD 3b–5; BP control rate; weight/fluid alert resolution time | Quarterly |
| **Modality & starts** | Optimal-start rate; home-dialysis start rate; unplanned (crash) start count; modality-education completion in PCM | Quarterly |
| **Utilization** | Hospitalizations per 1,000 enrolled; 30-day readmissions after nephrology-related discharges; ED visits avoided via triage | Quarterly |
| **Remote care service line** | Enrolled census (RPM / PCM); time-to-first-billable-enrollment; monthly claim-capture rate; revenue per enrolled patient per month | Monthly |
| **Patient experience** | Device adherence (days transmitting); care-manager contact completion; portal activation | Monthly |
| **Financial** | Net reimbursement; CoachCare fees; practice profit; margin vs. the 42.85% modeled 24-month benchmark | Monthly |

### CKCC-performance readiness checklist

The practice's KCE brings network-level analytics and care coordinators; the practice-level readiness items below are what the Remote Care Service Line supplies:

| Readiness item | Status today (public evidence, July 2026) | Service-line answer |
|---|---|---|
| Consented, risk-stratified CKD panel | No public program evidence | Enrollment workflow with consent capture; CKD-stage stratification at intake |
| Continuous physiologic data on the high-risk cohort | None — no RPM program visible | Connected BP/weight devices; 24/7 monitored data feed |
| Documented monthly management touch | None visible between office visits | PCM contact + care-plan update, every month, documented in Veradigm |
| Escalation loop before the ED | Office phone line only | Alert thresholds → telephonic triage → same-day nephrologist escalation path |
| Modality-education pipeline | Static booklets on the website | Structured education milestones inside PCM contacts for CKD 4–5 |
| Quarterly metric reporting | KCE-level only | Practice-level scorecard (above) feeding the KCE's quarterly cycle |

# 5. Performance Snapshot: Verified Network Results, Practice-Level Whitespace

## 5.1 What is already working — the network layer

The practice's KCE publicly reports 2025 performance that most kidney-care networks cannot match. Optimal starts (patients beginning dialysis with a mature access, at home, or receiving a preemptive transplant) run at nearly three times the national average it cites; home-dialysis starts at nearly three times as well:

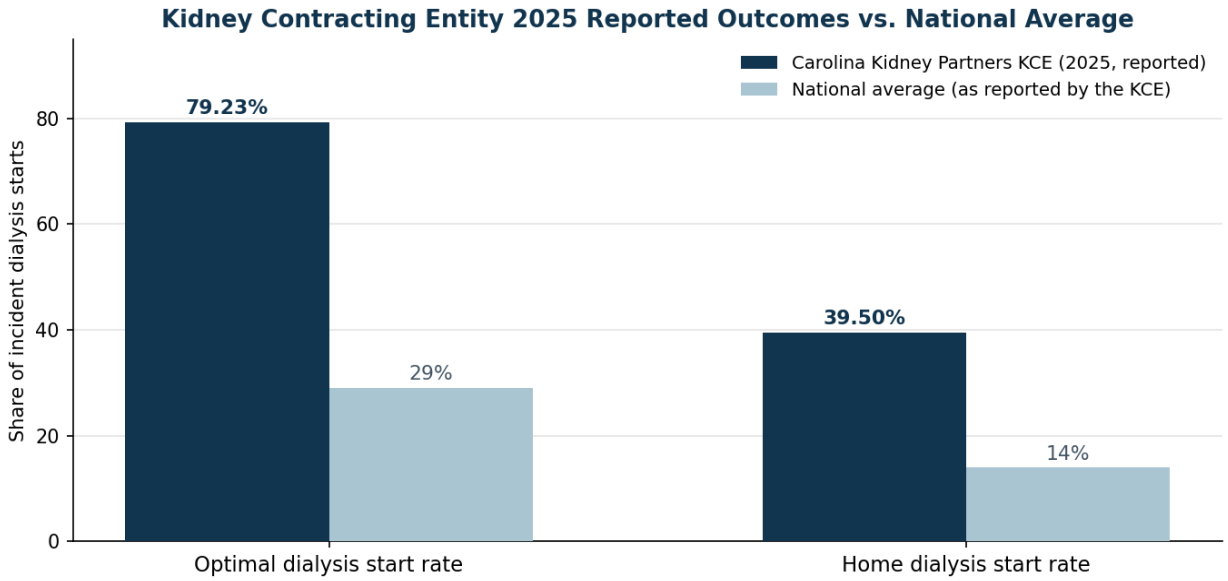


*Figure 2. Carolina Kidney Partners, LLC — publicly reported 2025 outcomes vs. the national averages it cites (carolinakidneypartners.com, retrieved July 2026). KCE-reported figures; directional snapshot — validate current values in discovery.*

These are network-level numbers, produced across the KCE's participating practices — and Charleston Nephrology Associates' nine physicians and deep home-dialysis footprint (seven-plus home programs among its nineteen clinic assignments) are part of the machinery producing them. The strategic question is not whether the practice can perform; it is what sustains and extends that performance as the panel grows and the contract cycle turns.

## 5.2 The practice-level whitespace

| Capability | Public evidence (site review, July 2026) | Assessment |
|---|---|---|
| **Remote physiologic monitoring** | No mention anywhere on the practice site | Whitespace |
| **Care management (PCM/CCM)** | No program mentioned | Whitespace |
| **Telehealth** | No offering mentioned | Whitespace |
| **CKD education** | Static PDF booklets and diet guides | Upgrade path — no classes, dietitian program, or app |

| Capability | Public evidence (site review, July 2026) | Assessment |
|---|---|---|
| **Patient-facing digital** | FollowMyHealth patient portal only | Portal ≠ monitoring; no physiologic data flows |

The diagnosis, stated plainly: **network-level excellence sitting on practice-level whitespace.** The KCE's analytics identify risk; its coordinators work at network scale. But between a patient's quarterly visits, nothing at the practice level is watching daily blood pressure or weight, nobody is billing for a monthly documented touch, and the education pipeline is paper. Every element of that gap is a billable, staffed, managed service under the 2026 fee schedule — which is precisely what the Remote Care Service Line is.

## 6. Powering CKCC: The Interstitial Care Layer

CKD progression is not made at office visits; it is made in the weeks between them — the missed diuretic dose that becomes a fluid overload admission, the creeping blood pressure that accelerates eGFR decline, the patient who reaches CKD 5 without ever completing modality education. The KCE's reported results show what the network achieves when patients reach the decision point prepared. The Remote Care Service Line is the practice-level engine that prepares them:

| CKCC lever | How the service line drives it |
|---|---|
| **Total cost of care** | Daily BP/weight surveillance on the aligned CKD 4–5/ESRD cohort catches decompensation days earlier; telephonic triage resolves what would otherwise become ED visits. The model attributes 45.4 avoided hospitalizations over 24 months (Section 8) — avoided cost that lands on the KCE's shared-savings ledger as well as the community's patients. |
| **Optimal starts (sustain the 79.23%)** | Monitoring identifies acceleration toward ESRD early enough for access placement and planned initiation; PCM documents the preparation path month by month. |
| **Home-dialysis starts (extend the 39.5%)** | Structured modality education inside monthly PCM contacts moves patients toward home candidacy — and RPM continues after the home start, supporting persistence rather than drift back to in-center care. |
| **Quality & patient experience** | A monthly documented touch and a monitored device at home are, to the patient, the visible difference between being watched over and being scheduled. |

Note the division of labor: the KCE supplies predictive analytics and network care coordination; the practice supplies the daily data and the monthly touch that make those analytics actionable on its own panel. The two layers are complementary, not duplicative — and only the practice-level layer generates fee-for-service revenue while it works.

## 7. Crash-Start Avoidance & CKD-Progression Economics

An unplanned, or crash, dialysis start — typically an emergency, catheter-based, in-hospital initiation — is the most expensive single failure mode in kidney care: published literature consistently associates unplanned starts with substantially higher first-year costs, longer index admissions, catheter-related complications, and lower home-modality uptake than planned starts. Nationally, the majority of dialysis starts are still suboptimal; the practice's KCE reports it has driven optimal starts to 79.23% — meaning roughly one start in five in the network remains addressable.

The practice's six-facility hospital rounding footprint is where crash starts surface today: a physician meets the patient in the hospital, after the emergency has happened. The service line moves that encounter upstream:

- **Detection:** rising BP and weight trends on the monitored CKD 4–5 cohort flag decompensation and progression acceleration days to weeks before symptoms drive an ED visit.
- **Escalation:** 24/7 alert-and-triage routes the flag to a same-day clinical response — medication adjustment, expedited labs, an urgent visit — instead of an admission.

- **Preparation:** for patients whose trajectory is unmistakably toward ESRD, monthly PCM contacts drive access planning and modality education on a schedule, so initiation happens on the practice's terms.

The economics are directionally large even at conservative assumptions. The Value Analysis attributes **45.4 avoided hospitalizations over 24 months — roughly $682K of avoided cost at a modeled $15,000 per admission** — before counting the difference between planned and unplanned start costs. Under the KCE's shared-accountability arrangement, a meaningful share of such avoided cost returns to the network's participants; the rest is capacity handed back to the practice's rounding physicians. (Illustrative, modeled — verify against practice data.)

On the progression side, the mechanism is slower but compounds: sustained BP control and fluid management are the two most modifiable levers on eGFR decline. Every quarter of delayed initiation on a late-stage panel is deferred dialysis cost for the model's aligned population — and, for the patient, time on their own kidneys. A service line that touches the panel monthly and measures it daily is the only practice-scale instrument that works on those levers continuously.

# 8. The Value Analysis: Modeled 24-Month Economics

The forecast below comes from the CoachCare Value Analysis workbook built for this practice (July 2026), at 2026 Medicare rates for the South Carolina statewide locality (Palmetto GBA). It models **RPM + PCM only**: CCM is structurally zero for a nephrology panel in this model, with PCM serving as the care-management vehicle. **All figures are illustrative, modeled — verify against practice data.**

## 8.1 Inputs and method

| Input | Value | Basis |
|---|---|---|
| **Medicare panel** | 1,850 (estimate; range 1,500–1,950) | Medicare allowed-amount triangulation: ~$2.53M practice Medicare allowed (Definitive Healthcare) ÷ a $1,300 per-beneficiary divisor gives a 1,949 upper bound; shaded down because nephrology per-beneficiary allowed runs higher than the divisor's calibration. Cross-check: ≈205 Medicare patients per physician across 9 physicians. An estimate for discovery validation — not a chart count. |
| **Program eligibility** | RPM 60% · PCM 60% · CCM 0% | Model's nephrology eligibility profile; CCM structurally zero for this specialty. |
| **Enrollment conversion** | RPM 30% · PCM 25% | Standard modeled conversion of the eligible population. |
| **Enrollment staffing** | 1 on-site enrollment specialist, 80 enrollments/month | CoachCare-funded — CoachCare's expense, embedded in its fees, never subtracted from practice margin. |
| **Pricing** | 3% program discount | Applied against CoachCare list pricing; at list, the 24-month margin is 38.72%. |
| **Rates** | 2026 SC locality | Palmetto GBA, South Carolina statewide locality (e.g., 99454 $48.12, 99457 $49.29, 99426 $65.02). |

## 8.2 Headline results

| | Year 1 | Year 2 | 24-Month |
|---|---|---|---|
| **Net reimbursement — RPM** | $262,829 | $363,897 | $626,726 |
| **Net reimbursement — PCM** | $130,112 | $289,938 | $420,050 |
| **Net reimbursement — Total** | **$392,941** | **$653,835** | **$1,046,776** |
| CoachCare fees (all-in, incl. one-time) | $281,389 | $451,409 | $732,798 |
| **Practice profit** | **$111,552** | **$202,426** | **$313,978** |
| **24-month margin (workbook basis)** | — | — | **42.85%** |

*Modeled at a 3% discount to list; at list pricing the 24-month margin is 38.72%. Workbook margin basis: practice profit as a share of CoachCare program fees; equivalently, profit is 30.0% of 24-month net reimbursement. Illustrative, modeled — verify against practice data.*

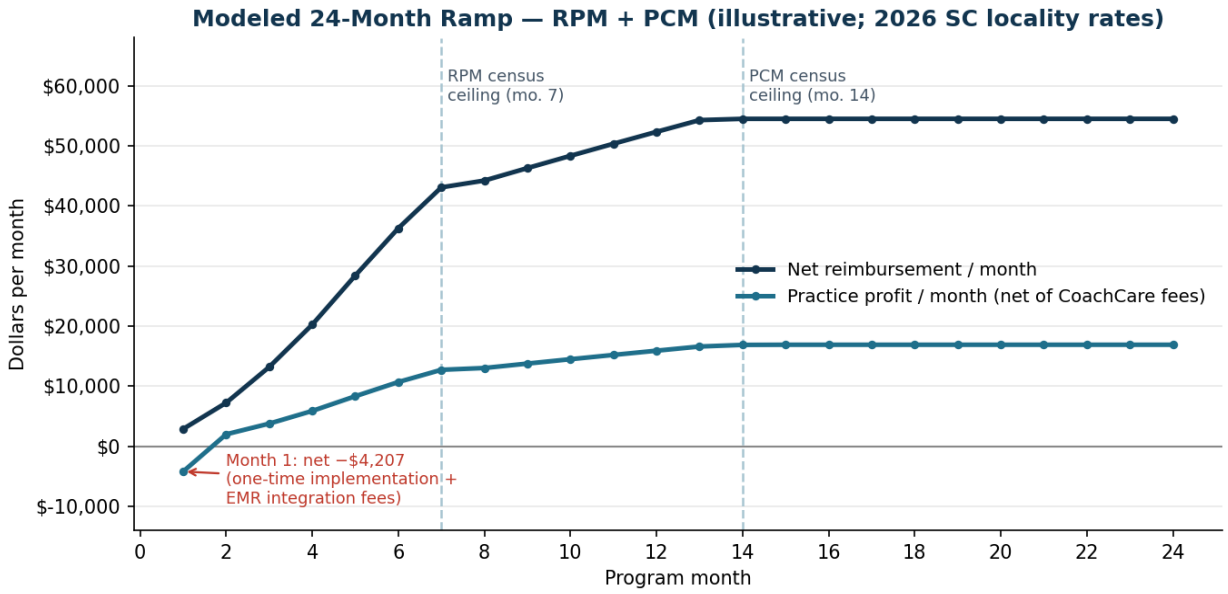


*Figure 3. Modeled monthly ramp. RPM census saturates at 333 in month 7; PCM at 277.5 in month 14; steady state runs ≈$54,500/month net reimbursement and ≈$16,900/month practice profit.*

**Month-one economics — read this before quoting the forecast**

Month 1 is modeled at **−$4,207**: $2,873 of net reimbursement against $7,080 of fees, because the one-time implementation fee and the Veradigm integration setup land in the first month. The program is **margin-positive from month two** and reaches **cumulative breakeven in month three**, staying positive every month thereafter.

### 8.3 What constrains the number — and what doesn't

This account is **ceiling-limited, not outreach-limited**. At 80 enrollments per month, the enrollment specialist fills the RPM ceiling (333 = 1,850 × 60% eligible × 30% conversion) by month 7 and the PCM ceiling (277.5) by month 14. Adding enrollment capacity would not raise the 24-month total; the binding constraint is panel size × eligibility × conversion. Consequently the forecast scales roughly linearly with the panel — which is why validating the 1,850 estimate against chart counts, then re-running the Value Analysis, is a priority recommendation rather than a formality. At the range bounds (1,500–1,950), the 24-month profit moves roughly proportionally.

### 8.4 Clinical and operational value alongside the P&L

| Measure (24-month, modeled) | Value |
|---|---|
| Claims/units generated and captured | 20,120 |
| Physiologic readings collected | 71,562 |

| Measure (24-month, modeled) | Value |
|---|---|
| Hospitalizations avoided | 45.4 (≈$682K at a modeled $15,000/admission) |
| Care-team hours saved | 9,918 (≈4.8 FTE-years of clinical capacity) |
| Care-management tasks completed | 40,241 |
| Patient–care-manager conversations | 6,036 |
| Inbound call time saved | 335 hours |

*From the Value Analysis clinical-operations model. The staffing behind these outputs — enrollment, telephonic monitoring, care management — is CoachCare's expense within its fees: embedded value, not a practice cost line.*

# 9. Implementation Playbook: Building the Remote Care Service Line

## 9.1 Scope, populations, and staffing

**Goal:** a fully operating, physician-governed Remote Care Service Line within 12 months — RPM census at ceiling by month 7, PCM approaching ceiling by month 12–14, wired into the practice's CKCC scorecard from the first quarter.

| Target population | Primary programs | Priority |
|---|---|---|
| CKD 3b–5 with hypertension and/or fluid-management needs | RPM (BP + weight) + PCM | Wave 1 (months 1–6) |
| Post-discharge patients from the six-facility rounding footprint | TCM → RPM short-window (99445) → PCM | Wave 1 |
| CKD 4–5 pre-dialysis cohort (modality education & access planning) | PCM with education milestones + RPM | Wave 1–2 |
| Home-dialysis patients (persistence support) | RPM (weight/BP) + PCM | Wave 2 (months 6–12) |
| Transplant-evaluation and waitlist patients (stability) | RPM + PCM | Wave 2 |

Staffing follows the full-service model: CoachCare funds and manages the on-site enrollment specialist (80 enrollments/month modeled), telephonic clinical monitoring, 24/7 alert-and-triage, and billing-capture operations. The practice contributes physician governance, alert-escalation coverage during clinic hours, and standing orders. **No practice headcount is added**; the practice's 10 advanced-practice providers are leverage for escalations, not program labor.

## 9.2 Technology, data, and billing architecture

Veradigm is the practice's confirmed EMR, corroborated by its FollowMyHealth patient portal; the exact product and version are confirmed in contracting. The integration pattern is standard for CoachCare's Veradigm deployments:

- Device data (BP, weight) flows into the CoachCare platform; summarized vitals, alerts, and monthly care-management documentation write back to the Veradigm chart against the shared care plan.
- Billing capture runs as a monthly closed loop: eligibility check → enrollment/consent record → time and data-day accumulation → claim-ready output for 99445/99454, 99457/99470, 99458, and 99426/99427 → capture-rate reporting on the scorecard.
- Portal continuity: FollowMyHealth remains the patient's records front door; the monitoring app and connected devices add the daily physiologic layer the portal does not carry.

CoachCare operates this pattern at scale: 500,000+ patients managed across 400+ conditions, 10,000+ providers, 1,000+ implementations, over 5 million claims generated through care-plan coding and billing, and more than 100 million vitals recorded (coachcare.com, July 2026).

## 9.3 Clinical workflow

Enroll (office visit, discharge, or dialysis-education touchpoint) → connect devices and set patient-specific thresholds → monitor daily with 24/7 alert-and-triage → escalate per standing orders (medication adjustment, expedited labs, urgent visit) → document the monthly PCM touch against the care plan → prepare a physician-facing summary before each office visit, so the quarterly encounter starts from ninety days of data rather than a blood-pressure cuff reading in the room.

## 9.4 KPI dashboard and 12-month roadmap

| Phase | Months | Milestones |
|---|---|---|
| **Contract & integrate** | 1 | Contracting (EMR product/version confirmation, BAA); Veradigm integration; standing orders; alert thresholds; enrollment specialist onboarded. Note: the one-time fees land here — month 1 is the forecast's only negative month. |
| **Launch Wave 1** | 2–4 | First cohort enrolled (modeled census 53 by month 2, 153 by month 4); margin-positive from month two; cumulative breakeven in month three; first monthly scorecard. |
| **Scale to RPM ceiling** | 5–7 | RPM census reaches its 333 ceiling (month 7); TCM handoff live at all six rounding facilities; first quarterly CKCC-aligned report to the practice's KCE cycle. |
| **Deepen PCM & Wave 2** | 8–12 | PCM census 207+ by month 10 and 253 by month 12 (ceiling 277.5 reached in month 14); home-dialysis persistence and transplant-stability cohorts enrolled; panel-estimate validation complete and Value Analysis re-run on chart counts. |

KPIs for the monthly dashboard: enrolled census by program; time-to-first-billable-enrollment; data-day adherence; alert-resolution time; monthly claim-capture rate; revenue per enrolled patient per month; hospitalizations per 1,000 enrolled; unplanned-start count; and margin against the modeled benchmark. Expected 24-month impact at the modeled panel: **$1.05M net reimbursement, $314K practice profit, 71,562 readings, 45.4 avoided hospitalizations** — and a practice that arrives at the next kidney-model contract cycle with its interstitial care layer already built, staffed, and paying for itself. (Illustrative, modeled — verify against practice data.)

## References & Data Sources


- Charleston Nephrology Associates website — home, providers, locations, contact, and resources pages (charlestonnephrology.com; retrieved July 2026). Provider counts, office and facility footprint, dialysis clinic assignments, portal, and services.
- NPPES / NPI Registry — Charleston Nephrology Associates, LLC, Org NPI 1629054960 (nephrology taxonomy 207RN0300X); organizational details and CLIA laboratory certification.
- CMS, Kidney Care Choices (KCC) Model — Model Participants CY2025 (cms.gov/files/document/kcc-model-participants-cy2025.pdf) and Model Participants & Affiliations CY2026 (cms.gov/priorities/innovation/files/kcc-model-participants-affiliations-cy2026.pdf): Carolina Kidney Partners, LLC — CKCC Professional option, Cohort 1, GA/SC.
- Carolina Kidney Partners, LLC — public website including the participating-provider roster naming Charleston Nephrology Associates and its nine physicians, and self-reported 2025 outcomes (79.23% optimal dialysis starts; 39.5% home-dialysis starts, with the national averages it cites) (carolinakidneypartners.com; retrieved July 2026).
- CMS CY2026 Medicare Physician Fee Schedule — RPM/PCM/TCM payment amounts; South Carolina statewide locality (Palmetto GBA). Dollar-stated rates per the locality fee schedule; other figures illustrative national magnitudes.
- Definitive Healthcare — practice-level Medicare allowed-amount and technology-installation intelligence (2026 vintage), used for the panel-size estimate and EMR confirmation.
- CoachCare Value Analysis workbook — Charleston_Nephrology_CoachCare_Value_Analysis_2026.xlsx (July 2026): all modeled census, reimbursement, fee, profit, and clinical-operations figures.
- CoachCare corporate statistics — coachcare.com (July 2026).


**Global caveat**

This report is a strategy document prepared from public sources (retrieved July 2026) and a modeled financial forecast. All modeled figures are illustrative, modeled — verify against practice data. The Medicare panel size is an estimate with a stated method and range, to be validated with chart counts in discovery. Payment rates are 2026 amounts for the South Carolina locality where stated and illustrative national magnitudes otherwise — verify against the current fee schedule and the practice's MAC. Confirm current model-participation status, KCE-reported outcomes, and EMR product/version in contracting. Nothing in this document is billing, coding, legal, or compliance advice.