COACHCARE | SERVICE LINE STRATEGY

Columbia Nephrology Associates, PA

Columbia, South Carolina. An independent, physician-owned nephrology practice at four offices, rounding at 15 dialysis units across the Midlands: 19 nephrologists and 11 advanced-practice clinicians

Nephrology Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) built as the between-visit layer for a kidney panel the practice already manages and is already accountable for, sized against its own Medicare claims and priced at its own locality, with a margin-positive P&L billed under the practice's own TIN

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the physician owners and administrator of Columbia Nephrology Associates. It starts from the practice's own Medicare claims. In CY2024, 32 billing clinicians carried 15,037 beneficiary records and $5,421,829 of Medicare allowed charges. The average patient is 73 years old with a risk score of 3.54, and kidney disease, hypertension and hyperlipidemia all report at the ceiling CMS publishes to.

The practice already bills chronic care management and already carries total-cost accountability for its late-stage kidney patients through the Kidney Care Choices model. What the same claims do not contain is any remote physiologic monitoring or transitional care management at meaningful scale. Between quarterly visits, no blood pressure and no weight is read.

The forecast in section 6 sizes that gap: $3,768,364 of net reimbursement over 24 months at a 42.2% practice margin, positive from month 2, with no clinical headcount added to the practice's payroll.

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Executive Summary

Columbia Nephrology Associates is an independent, physician-owned nephrology practice with offices in Columbia, West Columbia, Lugoff and Sumter, South Carolina. Its physicians round at 15 dialysis units across the Midlands, operate the market's only vascular access center with a national partner, run an in-house renal laboratory, and have kept a clinical research program open since 2005. CMS registry data resolve **30 clinicians** to the practice's billing entity for the purpose of this analysis: 19 nephrologists and 11 nurse practitioners and physician assistants.[1] In CY2024, 32 clinicians billed **$5,421,829** of Medicare fee-for-service allowed charges on 15,037 beneficiary records.[2]

The panel is the argument. The average patient is **73 years old** and carries a hierarchical condition category risk score of **3.54** against a national average of 1.00. Chronic kidney disease, hypertension and hyperlipidemia all report at 75%, the ceiling CMS publishes chronic-condition prevalence to rather than a measured rate. Diabetes runs 62%, heart failure 48%, ischemic heart disease 51%, atrial fibrillation 33% and COPD 22%.[3]

What is already running

Two things. First, the practice bills chronic care management: in CY2024, 19 clinicians billed the first-20-minute code for 946 beneficiaries, about one established patient in five.[4] The consent conversation and the monthly documented touch, the two hard parts of any care-management program, are already in the practice's habits. The program bills about a quarter of the months it could: 2,802 claims on 946 patients is roughly 3 billed months per patient per year. Second, the practice is a participant in the CMS Kidney Care Choices model through **Carolina Kidney Partners**, a physician-led Kidney Contracting Entity in the Professional option since the model's first performance year, and is measured on the total cost of care, quality and dialysis starts of its aligned patients.[5]

What is absent

Across every clinician, the remote physiologic monitoring and transitional care management code families are absent from the same year's claims.[6] CMS suppresses any line below eleven beneficiaries, so the exact reading is that the practice ran **no such program at meaningful scale in CY2024**. On a panel where three patients in four carry hypertension and one in two carries heart failure, no blood pressure and no weight is being read between visits. And roughly 3,800 beneficiaries were followed in the hospital by the practice's clinicians in the year without a single transitional-care claim behind the discharge.[7]

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[1] CMS Doctors & Clinicians national file, the NPPES registry, the PECOS reassignment list and the Quality Payment Program eligibility interface, retrieved 14 September 2026. 22 physicians bill under the practice's CMS group identifier, of whom 19 are nephrologists; the two access-center surgeons and one internist are excluded from the referring-clinician count. 11 advanced-practice clinicians remain enrolled under the group in 2026 after two moved to other billing organizations. The practice website lists 16 physicians and 7 practitioners.

[2] Medicare Physician & Other Practitioners — by Provider, calendar year 2024, queried per national provider identifier for the 32 clinicians with claims under the practice's CMS group identifier, 14 September 2026. Beneficiary counts are summed across clinicians and are not deduplicated; a patient seen by two clinicians is counted twice.

[3] Medicare Physician & Other Practitioners — by Provider, calendar year 2024, queried per national provider identifier for the 32 clinicians with claims under the practice's CMS group identifier, 14 September 2026. Risk score, average age and chronic-condition prevalence are beneficiary-weighted across clinicians. CMS caps published prevalence at 75.0%, so kidney disease, hypertension and hyperlipidemia report at that ceiling.

[4] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code, 14 September 2026. CMS suppresses any provider and procedure line below eleven beneficiaries. Code 99490 on 19 clinicians: 946 beneficiaries and 2,802 services, $157,616 allowed. Code 99439 (each additional 20 minutes) on 354 beneficiaries. Code 99426 (principal care management, first 30 minutes) on 51 beneficiaries.

[5] CMS Kidney Care Choices model participants and affiliations file, CY2026; the entity's published provider roster and CMS results page, retrieved 14 September 2026; CMS Quality Payment Program eligibility interface, performance year 2026, which carries the Kidney Care Choices alternative payment model flag on 28 of the practice's clinicians.

[6] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code, 14 September 2026. CMS suppresses any provider and procedure line below eleven beneficiaries. Codes 99453, 99454, 99457, 99458, 99091, 99495 and 99496 were searched by exact procedure code for every clinician billing under the group. None appears at eleven or more beneficiaries on any clinician.

[7] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code, 14 September 2026. CMS suppresses any provider and procedure line below eleven beneficiaries. Subsequent hospital care codes 99232 and 99233: about 3,800 beneficiaries and $624,000 allowed across the practice's clinicians,

The finding in one sentence

A practice that already consents and manages about 946 patients three months a year, and is already accountable for what those patients cost, bills nothing for watching them the other nine months and bills nothing for the discharges it already follows.

Why the timing is right

Three facts line up. The Kidney Care Choices model's current performance period ends on 31 December 2026, and CMS has not announced a successor for the entity's cohort; whatever follows will score the same things, fewer unplanned admissions, more planned starts and more home dialysis, and a practice that produces those results as fee-for-service margin today holds a stronger position for that negotiation. CMS created two remote-monitoring codes for CY2026 that pay for exactly the short windows after a discharge, an access placement or a dialysis start. And the practice's care-management habit means the extension is a workflow change, not a new competence.

The forecast

The Value Analysis models a remote care service line across the practice's estimated Medicare panel of 8,540 patients, all in scope for a nephrology service line, enrolled through 30 referring clinicians. Over 24 months it produces **$3,768,364 of net reimbursement** to the practice against $2,177,189 of CoachCare fees, leaving **$1,591,175 retained, a 42.2% practice margin**.[8] Year 1 runs 41.6% and year 2 runs 42.4%. Month 1 runs $1,369 negative, because implementation and integration setup post against a first-month census of 54 patients; the practice is positive from month 2 and stays there.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$936,821	$2,831,543	$3,768,364
CoachCare program and platform fees	$546,742	$1,630,447	$2,177,189
Net to the practice	$390,079	$1,201,096	$1,591,175
Practice margin	41.6%	42.4%	42.2%
Unique patients under management	1,405	2,504	2,504

Value Analysis summary. Unique patients are deduplicated across programs: a patient enrolled in both monitoring and care management is one person and two enrollments, so 2,504 unique patients carry 3,117 active program enrollments at month 24.

Transitional care management is priced in section 3 and is **not in that forecast**. The forecast contains remote physiologic monitoring and principal care management only, and it claims no shared-savings dollar from the Kidney Care Choices arrangement. About 44% of Medicare beneficiaries across the practice's four counties are in Medicare Advantage, so most of the panel is still traditional Medicare. Advantage plans must reimburse at least the Medicare rate. That is a floor; individual contracts set their own terms for the care-management code families.

The enrollment specialist who drives that census, and the care team behind them, are **carried at CoachCare's expense**. They are not deducted from the margin above and they do not appear on the practice's payroll. At month 24 the service line is carrying about 15.9 full-time equivalents of care-team labor, none of it hired by the practice.

CY2024.

[8] CoachCare Value Analysis for this account, built on the CY2026 physician fee schedule at Palmetto GBA South Carolina locality 01 and recalculated 14 September 2026. Revenue is net of modeled denials, patient coinsurance and coinsurance bad debt.

2026–2027 priority recommendations

1. **Bill transitional care management on the discharges already happening.** Six hospitals, privileges at all of them, roughly 3,800 beneficiaries followed in the hospital, and no 99495 or 99496 in the claims. No device, no new population, no consent hurdle. $209.97 and $284.94 per discharge at this locality, outside the 24-month forecast entirely.
2. **Turn the existing three-month care-management touch into a twelve-month program with a cuff and a scale in it.** The consent and the monthly documented contact already reach about 946 patients. Principal care management and chronic care management cannot both be billed for one patient in one month, so the existing panel migrates or stays, patient by patient, at the practice's direction.
3. **Put the CKD stage 3b to 5, resistant-hypertension and heart-failure cohorts on blood-pressure and weight monitoring first.** Fluid overload and uncontrolled pressure are what turn a stable stage 4 patient into an admission and a crash start. Both are visible days ahead on a cuff and a scale.
4. **Start at the Columbia office and extend to West Columbia, Lugoff and Sumter.** One statewide locality means every office and every dialysis unit prices on the same rail, so sequencing is an operational choice, not a financial one.
5. **Bring the Medicare Advantage plan mix to the first call.** With about 44% of the four counties' beneficiaries in Advantage, the plan mix of the practice's own panel decides how much of this forecast is fee-schedule-certain.
6. **Read the CY2027 final rule when it lands in early November.** The proposed rule cuts the device-supply codes by 20.6% at this locality, which flows through to −7.2% on the service line. Principal care management is not in the proposal. The final rule is effective 1 January 2027.

1. Where the Practice Is Today

1.1 The panel: what the claims say

CMS publishes, per clinician, the beneficiaries seen, the allowed charges, the average risk score and the share of beneficiaries carrying each chronic condition. Read across the 32 clinicians with CY2024 claims, the file describes one of the highest-acuity outpatient panels in the state.

Panel measure	Value	What it means here
Beneficiary records, 32 clinicians	15,037	Summed across clinicians, not deduplicated across them
Established-visit beneficiaries	6,805	Patients who return to the office (99213 to 99215), summed; about 4,764 unique patients after cross-clinician deduplication
Medicare allowed, CY2024	$5,421,829	Professional, laboratory and access-center services across the group
Average risk score	3.54	Beneficiary-weighted; more than three times the national 1.00 benchmark
Average beneficiary age	73	A panel in the highest-utilization Medicare decade
Chronic kidney disease	75%	The ceiling CMS publishes prevalence to; the true figure is higher
Hypertension	75%	At the ceiling. The condition a cuff at home is for
Hyperlipidemia	75%	At the ceiling
Diabetes	62%	Two patients in three; the leading cause of the kidney disease

Panel measure	Value	What it means here
Heart failure	48%	Roughly one patient in two. The cohort that drives fluid admissions
Ischemic heart disease	51%	One patient in two
Atrial fibrillation	33%	One patient in three
COPD	22%	About one patient in five

CY2024 Medicare Physician & Other Practitioners data, by provider, beneficiary-weighted across the practice's clinicians. CMS publishes chronic-condition prevalence to a ceiling of 75.0%, so kidney disease, hypertension and hyperlipidemia report at that ceiling rather than at a measured rate.

Two readings follow. First, this is an established panel that comes back: about 6,805 established-visit beneficiary records against a far smaller new-patient volume, so a monthly care-management program enrolls from patients the practice already sees on a schedule.[9] Second, the dialysis book is large and already includes a home population. Monthly capitation was billed for 684 in-center beneficiary-lines and 283 home-dialysis beneficiary-lines, about 19% of the total on home therapy.[10] The patients who matter most to this report sit between those two groups: the stage 3b to 5 patients who have not started dialysis yet, whose progression happens between quarterly visits.

1.2 The care-management program the practice already bills

Most remote care proposals to an independent practice have to argue the concept first. This one does not. The practice bills chronic care management across 19 clinicians, and the claims show the shape of the program.

Care management, CY2024	Clinicians	Beneficiaries	Services	Allowed
Chronic care management, first 20 minutes (99490)	19	946	2,802	$157,616
Chronic care management, each additional 20 minutes (99439)	18	354	807	$36,542
Principal care management, first 30 minutes (99426)	4	51	reported	reported

CY2024 Medicare claims, care-management codes only. The complex and physician-time chronic care management codes (99487, 99489, 99491, 99437) and the remaining principal care management codes (99424, 99425, 99427) do not appear at eleven or more beneficiaries on any clinician.

Three readings matter. The program is real: 19 clinicians, 946 patients, and the consent and monthly-touch discipline that implies. It is under-run: 2,802 claims on 946 patients is about 3 billed months per patient per year against twelve for a fully run program, so the existing program bills about a quarter of the months it could. And it reaches about one established patient in five, on a panel where two-condition eligibility is close to universal.

[9] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code, 14 September 2026. CMS suppresses any provider and procedure line below eleven beneficiaries. Established codes 99213, 99214 and 99215 report 6,805 beneficiaries summed across clinicians; new-patient code 99204 reports 1,071 beneficiaries across 28 clinicians.

[10] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code, 14 September 2026. CMS suppresses any provider and procedure line below eleven beneficiaries. Codes 90960 (in-center, four or more visits) on 684 beneficiaries and 90966 (home dialysis) on 283 beneficiaries; the home share is of monthly-capitation beneficiary-lines, not unique patients. A home dialysis unit operates inside the practice's own building.

What this changes about the proposal

The hard parts of care management are the parts that need a person doing them every month: someone consents the patient, makes the contact, documents it and gets it billed. This practice already does those four things for about 946 patients, three months a year.

What follows is the extension of a workflow the practice already runs, from three months a year to twelve, from a phone call to a cuff and a scale, and from about 946 patients to the rest of the 4,764 established patients with the same diagnoses.

1.3 The codes that are absent

Every remote physiologic monitoring and transitional care management code was searched by exact procedure code across every clinician in the CY2024 file. None is present at meaningful scale.[11]

Code family	Codes searched	CY2024 result
Remote physiologic monitoring	99453, 99454, 99457, 99458, 99091	None at meaningful scale
Transitional care management	99495, 99496	None at meaningful scale
Chronic care management	99490, 99439	Present, 19 clinicians, 946 beneficiaries
Principal care management	99424, 99425, 99426, 99427	99426 only, 51 beneficiaries

CMS suppresses any provider and procedure line below eleven beneficiaries, so the defensible reading is that no remote monitoring or transitional care program ran at meaningful scale in CY2024.

The transitional care absence is the loudest of the two. The practice's physicians hold privileges at Lexington Medical Center, MUSC Health Columbia Medical Center Downtown, MUSC Health Columbia Medical Center Northeast, Prisma Health Baptist, Prisma Health Baptist Parkridge and Prisma Health Richland. Their patients are admitted, discharged and seen back in the office, and the claims show about 3,800 beneficiaries of subsequent hospital care in the year. The clinical work of a transition is being done. The payment attached to it is not being captured.[12]

2. Kidney Care Choices: The Second Ledger

Columbia Nephrology Associates is a participant in the CMS Kidney Care Choices model through **Carolina Kidney Partners**, a physician-led Kidney Contracting Entity in the Professional option, in the model's first cohort with a 2022 start. The entity's own roster lists the practice's 19 nephrologists and 11 advanced-practice clinicians; CMS lists the entity in the CY2026 participant file; and 28 of the practice's clinicians carry the model's alternative payment model flag in the CMS Quality Payment Program record for 2026.[13] Under the Professional option the practice's physicians share in savings and losses on the total cost of care for aligned late-stage kidney disease and dialysis patients, are scored on quality, and are paid on optimal dialysis starts.

[11] As the by-Provider-and-Service source above. Codes 99453, 99454, 99457, 99458, 99091, 99495 and 99496 were searched, plus the CY2026 codes 99445 and 99470, which could not appear in a CY2024 file. The remote blood-pressure codes 99473 and 99474 are also absent.

[12] Practice website, hospital affiliations, retrieved 14 September 2026. The physician login page links to the patient-access portals of two of the systems, consistent with active privileges.

[13] CMS Kidney Care Choices model participants and affiliations file, CY2026; the entity's published provider roster and CMS results page, retrieved 14 September 2026; CMS Quality Payment Program eligibility interface, performance year 2026, which carries the Kidney Care Choices alternative payment model flag on 28 of the practice's clinicians. The entity's roster uses the practice's trade name; the clinician-level match through the Quality Payment Program resolves it to the legal entity.

Measure	Value	Basis
Participation	Verified	CMS CY2026 participant file; the entity's published roster; CMS alternative payment model flag on 28 clinicians
Total quality score, performance year 2024	92.5%	CMS-scored, as published by the entity from its CMS results; multi-year average 89.2%
Optimal end-stage kidney disease starts	55.8%	The CMS-measured rate for the entity: patients who start dialysis with a planned access, at home, or with a pre-emptive transplant
Savings distribution	Half reinvested, half to practices	The entity's published policy
Current performance period ends	31 December 2026	CMS-published; no successor announced for this cohort as of 14 September 2026

Kidney Care Choices position. The quality score and the optimal-start rate are the CMS-scored figures; the entity's own interim rates for 2025 are not used here.

What the entity supplies, and what it cannot

The entity supplies analytics, care coordination and the contract itself at the network level. What it cannot produce is a daily physiologic signal from each practice's own panel between visits. That layer belongs to the practice, and it is the instrument the contract's economics reward. Fluid overload and uncontrolled pressure are what turn a stable stage 4 patient into an admission and a crash start. Both are visible days ahead on a cuff and a scale, and invisible between quarterly visits.

The model's current performance period ends on 31 December 2026. Whatever follows it, and CMS has said the destination is risk-based, per-member payment reconciled against outcomes, will score the same things: fewer unplanned admissions, more planned starts, more home dialysis, and documented monthly management of the patients most likely to crash into the hospital. A service line that produces those results as fee-for-service margin today is the practice's position for that negotiation.

Avoided admissions write to both ledgers

A kidney admission that does not happen is fee-for-service margin for the service line and, for an aligned patient, a dollar that stays under the entity's benchmark. The same program writes to both. The Value Analysis in section 6 counts 204 avoided hospitalizations over 24 months at the model's generic 20% annual admission rate. A stage 3b to 5 cohort with heart failure at 48% of the panel admits well above that.

Annual admission rate in the enrolled cohort	Hospitalizations avoided, 24 months	Acute-care spend that never occurs
20%, the modeled base	**204**	**$3.06M**
30%	306	$4.59M
40%, realistic for this cohort	408	$6.12M
50%	510	$7.64M

Avoided admissions scale with the cohort's baseline admission rate, holding the enrolled census and the model's reduction rate constant. Spend avoided is priced at $15,000 per admission, before any shared-savings split. None of it is in the Value Analysis, which prices the fee-for-service codes only.

Worth saying plainly

No shared-savings dollars are in the forecast. The service line is margin-positive on Part B professional fees billed under the practice's own TIN before any value-based dollar is counted. What the Kidney Care Choices position adds is a second reason to run the program, and an organization that is measured on exactly the outcomes the program produces.

3. The Service Line: TCM, RPM, PCM

3.1 Transitional care: the fastest first dollar

Transitional care management is the entry point on this account, for reasons that have nothing to do with the forecast. It requires no device, no new patient population, no consent conversation and no enrollment funnel. It requires a contact within two business days of discharge, medication reconciliation, and a face-to-face visit inside 14 days for moderate complexity or 7 days for high complexity, on patients the practice already discharges from six hospitals and already sees. The practice does this work today and bills the office visit for it.

Code	Service	CY2026 rate at this locality
99495	Transitional care management, moderate medical decision complexity, face-to-face within 14 days	$209.97
99496	Transitional care management, high medical decision complexity, face-to-face within 7 days	$284.94

CY2026 physician fee schedule, non-facility, Palmetto GBA South Carolina locality 01, the statewide locality resolved from ZIP 29203. All four offices and every dialysis unit bill at the same locality.

Worth saying plainly

Transitional care management is not in the 24-month forecast. The Value Analysis in section 6 contains remote physiologic monitoring and principal care management only. Every dollar of transitional care revenue sits outside those numbers.

It also does more than pay. The 30-day window it covers is the window in which a kidney or heart-failure discharge comes back, the window the Kidney Care Choices benchmark absorbs, and the window in which the post-discharge cadence in section 5 does its work.

3.2 The clinical and billing stack

Three programs, one infrastructure, one patient record. A patient enters wherever they are: coming out of the hospital, newly overloaded, freshly cannulated, or overdue for real between-visit management. They stay on the same pathway through progression, access placement and the transition to dialysis or transplant.

Stage	Program	What happens	Cadence
At discharge	Transitional care management	Contact within two business days, medications and the fluid and potassium plan reconciled against the discharge summary, face-to-face visit booked and confirmed	Once per discharge
Days 1–30	Remote physiologic monitoring, short window	Blood pressure and weight from the patient's home, daily review, escalation on critical values and established trends. The same window follows an access placement or a dialysis start	Monthly, from 2 days of data

Stage	Program	What happens	Cadence
Month 2 onward	Remote physiologic monitoring, longitudinal	Continuous physiologic data with treatment-management time logged against it	Monthly
Month 2 onward	Principal care management	One serious condition, chronic kidney disease, managed against a written care plan with monthly clinical staff time: progression, blood-pressure targets, access readiness and modality education	Monthly

Remote monitoring and principal care management may be billed together for the same patient in the same month, on discrete documented time. That is what makes a single enrollment carry two revenue lines and one care plan. Principal care management is the monthly care-management code for a patient whose care centers on one serious condition, and chronic kidney disease is the textbook case.

Principal care management and the existing chronic care management panel

Principal care management and chronic care management cannot both be billed for one patient in one month. The forecast models principal care management as the monthly vehicle and leaves chronic care management out of the workbook. The practice's existing chronic care management panel of about 946 patients is credited, not replaced: each patient migrates to principal care management or stays on chronic care management, patient by patient, at the practice's direction.

Either way, the consent already exists, and the program the practice already runs three months a year becomes a twelve-month program with a cuff and a scale in it.

3.3 CY2026 rates at South Carolina locality 01

Code	Service	CY2026 rate
99453	Remote monitoring setup and patient education, once per enrollment	$20.01
99454	Device supply with daily recording, 16–30 days	$48.12
99445	**Device supply with daily recording, 2–15 days, new for CY2026**	**$48.12**
99457	Treatment management, first 20 minutes	$49.29
99470	**Treatment management, first 10 minutes, new for CY2026**	**$24.81**
99458	Treatment management, each additional 20 minutes	$39.72
99426	Principal care management, clinical staff, first 30 minutes	$65.02
99427	Principal care management, clinical staff, each additional 30 minutes	$51.68
99424	Principal care management, physician or qualified professional, first 30 minutes	$84.27
99425	Principal care management, physician or qualified professional, each additional 30 minutes	$59.15
99495	Transitional care management, moderate complexity	$209.97
99496	Transitional care management, high complexity	$284.94

CY2026 physician fee schedule, non-facility, Palmetto GBA South Carolina locality 01, resolved from ZIP 29203 by the model's locality crosswalk. The forecast bills principal care management on the clinical-staff codes 99426 and 99427; the physician codes and the transitional care codes are shown for completeness and are not in the forecast.

The two codes new for CY2026 change the shape of a nephrology program. 99445 pays the device-supply rate for a 2-to-15-day window instead of requiring sixteen days of data, which makes the first two weeks after a discharge, an access placement or a dialysis start billable on their own terms. 99470 pays for the first ten minutes of treatment management instead of requiring twenty, which makes a stable patient's month billable without inflating the time spent. Across the 24-month forecast the two together carry **$517,303** of gross remote-monitoring reimbursement, 17% of the monitoring arm's gross, or about $479K net, roughly 12.7% of the whole service line's net reimbursement. That is revenue that did not exist under the CY2025 schedule.[14]

3.4 Who does the work

The practice's clinicians order, review escalations that need a nephrologist, and see the patient. Everything else is done by CoachCare's care team under the practice's protocols: outreach and consent, device shipment and setup, daily reading review, monthly care-management contact, time capture, documentation into the chart, and claim generation. The on-site enrollment specialist who drives the census is CoachCare's employee and CoachCare's expense.

Function	Practice	CoachCare
Eligibility and ordering	Nephrologist or advanced-practice clinician orders by program	Screens the panel by diagnosis and flags candidates in the chart
Enrollment and consent	Introduces the program at the visit or the dialysis round where useful	On-site enrollment specialist consents, educates and ships the cuff and scale
Daily monitoring	Receives only what needs a clinical decision	Reviews every reading against patient-specific thresholds
Escalation	Named clinical contact decides on non-critical findings	Runs the escalation engine, calls the patient, activates 911 where indicated
Monthly care management	Reviews and signs the care plan	Delivers the monthly contact, diuretic and antihypertensive prompts, modality and access education, and documentation
Billing	Submits claims under its own TIN	Captures time, attaches monthly documents, creates the claim in athenahealth

4. Inside athenahealth

The practice runs athenahealth. Its patient portal resolves to an athenahealth practice instance and its physician login page links directly to athenaNet single sign-on; both returned live pages on 14 September 2026.[15] That settles the integration question before the first call. CoachCare is an athenahealth integration partner, and the integration uses athenahealth's built-in workflows, so the practice's clinicians and billing staff enroll and monitor patients without learning a new system. The care team works inside the practice's chart, not beside it.

What the integration does	What it means in this office
Bidirectional enrollment by service	Enrollment flags and ordering by service inside the athenahealth workflow; the practice sees enrollment status in real time in the existing clinical workflow, and patients begin receiving services in under five days
Exchange of health history	The care team starts from the practice's problem list, medications and allergies rather than re-collecting them

[14] As the Value Analysis source. 99445 carries $441,437 and 99470 carries $75,866 of gross remote-monitoring reimbursement across the 24-month horizon, against $3,050,584 of gross for the monitoring arm, read from the model's per-code rows and verified on 14 September 2026.

[15] Practice website, Patient Log-in and Physicians Login pages, retrieved 14 September 2026; the portal resolves to an athenahealth-hosted instance and returned HTTP 200.

What the integration does	What it means in this office
Integrated discrete vitals	Home blood pressure and weight land in the patient's chart as structured vitals, reviewable by any clinician at any of the four offices
Escalation tasks	Non-critical findings arrive as tasks for the clinician the practice designates, with the readings and the symptom check attached
Compliance documentation and integrated care summary	Evidence of care, the vitals summary and the care plan are attached to the chart every month, so the record supports the time-based claim without a second system
Automated claim generation	Claims are created by the CoachCare billing engine for every enrolled patient every month, which removes the manual claim step. CoachCare is the only care-management partner integrated with athenahealth that does this

CoachCare athenahealth integration overview.

The last row is the one that matters most here. A practice billing team cannot absorb 1,559 or more new claim lines a month by hand. The integration means the monthly claim for every enrolled patient is created from captured time and attached documentation, and the billing team reviews rather than keys.

Integration economics carried in the model are $1,000 of one-time setup, $150 per month, and $1.50 per enrolled patient per month, confirmed in contracting.

5. Clinical Governance and Escalation

The economics establish that the service line pays. This section establishes that it is safe and disciplined, which is the question a physician-owned group asks first, and that 19 nephrologists see signal rather than a thousand readings a day. Every reading generated by the program routes through one escalation engine before it reaches the practice. The engine, the emergent pathway, the routing and the post-discharge cadence below are drawn from CoachCare's Care Management Standard Operating Procedures and the SOP process maps derived from them.[16]

5.1 The escalation engine

- **Reading received.** Values are evaluated against the patient's own thresholds, set by the nephrologist at enrollment, not a generic band. A dialysis patient's dry weight and a stage 4 patient's pressure target are different numbers.
- **Critical value.** Escalates regardless of whether the patient reports symptoms. There is no symptom gate on a critical value and no waiting for a confirmatory reading.
- **Out of range, not critical.** A retake, then a structured symptom check, before anything is routed to the practice.
- **Trend, defined objectively.** Three consecutive blood-pressure readings at least one hour apart, or a weight gain of three pounds in a day or five pounds in a week, the fluid signature that precedes an admission. An established trend escalates on the same footing as a single critical value.
- **Patient unreachable.** Voicemail and a scheduled callback; if the value is critical or the trend is established, the escalation proceeds regardless.
- **Documentation.** Every escalation records the vital, the findings, the contact method, who was reached, the outcome and the follow-up, written to the athenahealth chart, so the record supports the clinical decision and the billing equally.

[16] CoachCare Care Management Programs Standard Operating Procedures, version March 2026, and the Care Management Process Maps derived from sections 4, 5, 7 and 11.

5.2 The emergent pathway

Chest pain, new shortness of breath, stroke signs, syncope, sudden swelling, or a bleeding or non-thrilling access trigger an immediate emergency activation: the care manager calls emergency services with the patient still on the line. If the patient declines, they are directed to the clinic; if they decline that, emergency services are activated regardless.

> **The rule that makes delegation possible**
>
> **CoachCare's urgent and emergent policy supersedes any practice-specific escalation preference.** It is not a configurable setting. It is the reason a practice whose physicians round at 15 dialysis units and six hospitals can delegate the overnight and weekend watch without inheriting the risk of having done so.

5.3 Routing, so the practice sees signal rather than noise

Escalations route three ways. Emergencies go to emergency services. Non-critical findings that require a clinical decision go to a named member of the practice's team, agreed during protocol design, with the readings, the symptom check and the recommended next step attached. Stable, resolved events post to the chart as a notification and no one is paged. The volume that reaches a nephrologist is the volume that requires a nephrologist. In a practice whose physicians split their days between four offices, 15 dialysis units, an access center and six hospitals, that distinction is the difference between a program that gets adopted and one that gets ignored.

5.4 The post-discharge cadence

Touch	Timing	Content
First	Day 1–2	Medications and the fluid and potassium plan reconciled against the discharge instructions; symptom and red-flag screen; confirm the follow-up appointment is booked; cuff and scale set up or re-verified
Second	Day 5–8	Weight and blood-pressure trend reviewed; diuretic or antihypertensive plan confirmed with the nephrologist; barriers surfaced: transport, cost, comprehension
Third	Day 12–14	Confirm the follow-up visit happened; close the episode or extend it; anything trending is escalated through the engine above; hand off to the longitudinal cadence

Post-discharge follow-up sequence, triggered by any emergency-room visit or hospitalization reported in the previous 60 days. The same cadence follows an access placement and the first weeks of a dialysis start.

That sequence is where the 204 avoided hospitalizations in the forecast come from. It runs inside the same 30-day window transitional care management pays for and the Kidney Care Choices benchmark absorbs. One cadence, three separate reasons to run it.

Discharge from the program is governed the same way. A patient who cannot be reached is escalated to the clinic and re-escalated on a fixed cadence rather than dropped, the practice is notified at every decision point, and a patient who stops transmitting is worked before a billing month is lost.

6. The Value Analysis

6.1 Model inputs and how the panel was sized

Input	Value
Medicare panel	8,540 patients
In-scope for year 1	8,540, 100% of the panel
Referring clinicians	30: 19 nephrologists and 11 advanced-practice clinicians
On-site enrollment specialists	1, funded by CoachCare
Programs modeled	Remote physiologic monitoring and principal care management
MAC and locality	Palmetto GBA (JM), South Carolina locality 01, statewide, resolved from ZIP 29203
Electronic health record	athenahealth, native integration
Medicare Advantage penetration	43.0% Richland County, 42.4% Lexington County, 50.1% Sumter County, 48.3% Kershaw County; 44.2% weighted by eligibles. Advantage plans must reimburse at least the Medicare rate. That is a floor; individual contracts set their own terms for the care-management code families.
Forecast horizon	24 months

The panel figure is built from the established-visit population rather than from total beneficiary counts. CMS reports beneficiaries per rendering clinician, and in a group of 32 clinicians the same patient is routinely seen by more than one of them, so the 15,037 beneficiary records in the file overstate the unique panel. The 6,805 established-visit records are deduplicated across clinicians to about 4,764 unique patients and then grossed up for the Medicare Advantage share of the four counties, because the claims file covers fee-for-service only and the practice's Advantage patients are not in it. The result is a 8,540-patient Medicare panel. For a nephrology practice the whole panel is in scope: every patient the practice follows has the kidney disease or the hypertension that qualifies.[17]

The forecast contains two programs. Principal care management is the care-management family for a single serious condition, which is the nephrology case, and the model bills it on the clinical-staff codes. Chronic care management is off in the workbook, because a patient cannot be on both in the same month; the existing panel's migration is the practice's decision and section 3 sets out the choice. The 30 referring clinicians are the 19 nephrologists and 11 advanced-practice clinicians who resolve to the practice in CMS data; the website lists fewer, and section 11 carries the roster as an open item.

[17] Panel derivation: 6,805 established-visit beneficiary records across the practice's clinicians, deduplicated at 70% to account for patients seen by more than one clinician, then divided by the fee-for-service share of the four counties (1 less 44.19% eligible-weighted Advantage penetration, July 2026 CMS file) to restore the Advantage patients the claims file does not contain. In-scope is 100% of the resulting panel.

6.2 The 24-month forecast

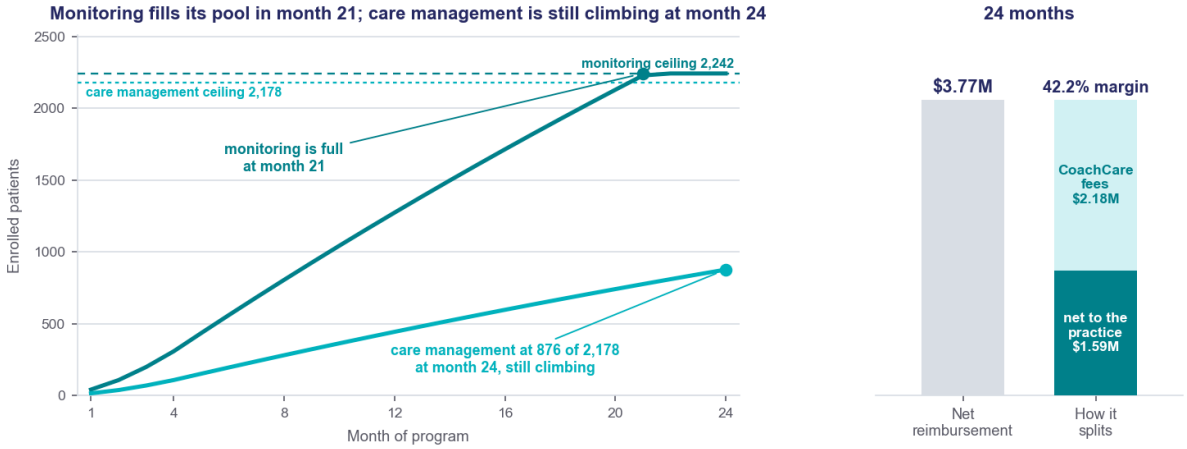


Figure 1. Enrollment against the modeled ceilings, and how 24 months of net reimbursement splits between the practice and CoachCare.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$936,821	$2,831,543	$3,768,364
CoachCare program and platform fees	$546,742	$1,630,447	$2,177,189
Net to the practice	**$390,079**	**$1,201,096**	**$1,591,175**
Practice margin	**41.6%**	**42.4%**	**42.2% (42.22%)**

By program	Year 1 net	Year 2 net	24-month net	24-month fees	Ceiling	Month 24 census
Remote physiologic monitoring	$708,840	$2,116,764	$2,825,604	$1,591,364	2,242	2,242, at ceiling from month 21
Principal care management	$227,981	$714,779	$942,760	$491,070	2,178	876, still climbing
Implementation, integration and outreach				$94,754		

Per-program year splits are read from the workbook's summary, not allocated from the ramp, and reconcile to the annual totals above. Enrollment outreach, care management and device logistics are CoachCare's expense, embedded in the fee and never deducted from the practice's margin.

The two programs are constrained by different things, and the copy has to say both. Remote monitoring is ceiling-limited: it reaches its eligibility ceiling of 2,242 patients in month 21 and holds there, because the model has run out of patients it counts as eligible, not because it has run out of outreach. Principal care management is pace-limited: at month 24 it holds 876 of a 2,178 ceiling and is still climbing, so its constraint is enrollment pace, and every unit of enrollment capacity keeps moving it. Monitoring fills its pool inside the forecast. Care management does not.

6.3 Month by month

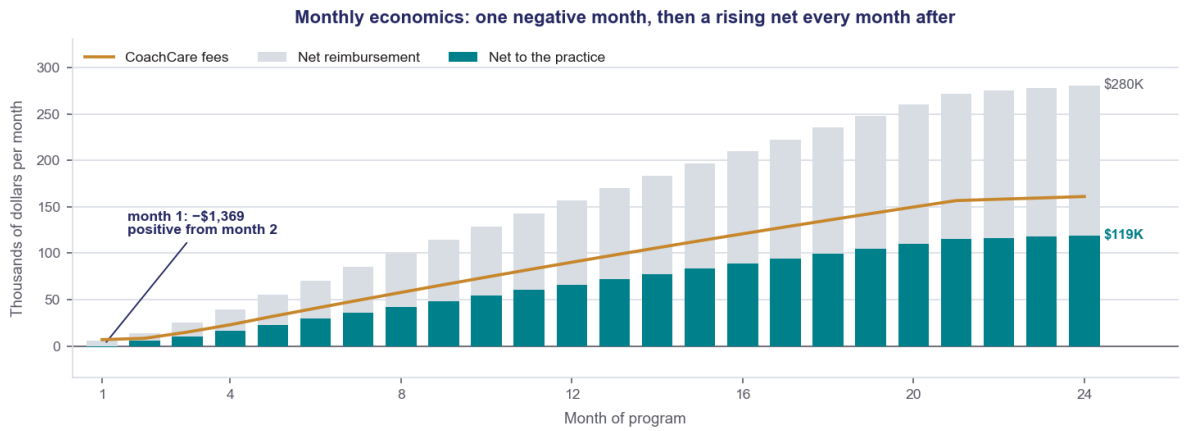


Figure 2. Net reimbursement, CoachCare fees and net to the practice by month. Month 1 is the only negative month.

Month 1 runs **$1,369 negative**. Implementation and the athenahealth integration setup both post in the first month against a 54-patient census. The practice is positive from **month 2** onward and stays there. By month 12 the practice nets $66,180 a month; by month 24, $119,340.

6.4 Patients, readings and avoided admissions

What the service line produces over 24 months	Value
Unique patients under management at month 12	1,405
Unique patients under management at month 24	2,504
Active program enrollments at month 24	3,117
Physiologic readings reviewed	321,078
Claims generated	73,986
Hospitalizations avoided	204
Care-team hours delivered	33,148, about 15.9 full-time equivalents

Unique patients are deduplicated across programs. A patient enrolled in both monitoring and care management is one person and two enrollments, which is why 2,504 unique patients carry 3,117 active enrollments at month 24. Care-team hours describe labor supplied by CoachCare, not headcount the practice hires.

The avoided-admission figure is built on a generic 20% annual admission rate. A stage 3b to 5 cohort with heart failure at 48% of the panel runs well above that; section 2 shows what the same enrolled population avoids at higher baselines, and 40% is the realistic figure for this cohort, about 408 avoided admissions.

Those hours are the number to hold against the practice's own staffing. About 15.9 full-time equivalents of care-management labor, supplied by CoachCare, against a practice whose 11 advanced-practice clinicians already carry office and dialysis-round schedules. Any version of this program that assumes existing headcount absorbs the work is a proposal that the advanced-practice clinicians stop seeing patients.

7. What Moves the Forecast

Four inputs move the 24-month answer, and each can be settled on the first call or in the first fortnight. The table holds every other input at the modeled base.

Input	Setting	24-month net	Net to the practice	Unique patients, month 24
Modeled base	**1 enrollment specialist, 100% in scope, 30 clinicians**	**$3,768,364**	**$1,591,175**	**2,504**
Enrollment specialists	0, practice referrals only	$2,795,697	$1,174,365	2,078
	2	$4,498,667	$1,908,211	2,596
	3	$5,089,765	$2,168,116	2,688
In-scope share of the panel	80%	$3,519,758	$1,488,499	2,055
	60%	$3,103,939	$1,317,196	1,604
Panel	Fee-for-service patients only, 4,764	$2,997,826	$1,273,512	1,511
Referring clinicians	22	$3,106,315	$1,310,960	2,248
	33	$3,968,279	$1,676,338	2,521

Sensitivities recalculated from the same workbook, one input at a time. The fee-for-service-only panel drops the Advantage gross-up and models the 4,764 deduplicated established patients in the claims file alone.

Read the enrollment rows carefully

Going from zero enrollment specialists to one is worth $972,666 over 24 months. That is the single largest lever in the model, and it is the answer to the staffing objection: the enrollment function is the program, and CoachCare funds it. Without a funded specialist the practice's own referral flow reaches 2,078 unique patients at month 24 against 2,504.

A second specialist moves both revenue and the month-24 unique count on this account, to $4,498,667 and 2,596 patients, where it would not on a panel that fills in a year. That is the split regime at work: monitoring reaches its ceiling months sooner, and care management, which is still climbing at month 24, keeps lifting. A third adds $591,098 more and 2,688 patients.

The in-scope share and the panel move the ceiling. The enrollment specialist count moves the pace, and on this account the pace is still binding on care management at month 24. Both matter, and they are different conversations.

The objection this table answers is the one the practice will raise first: our people already do care management. They do, for about 946 patients, about three months a year each. The gap between that and 2,504 patients twelve months a year is about 15.9 full-time care managers and an enrollment function, and the row without a specialist shows what the practice's own outreach produces on its own.

8. Medicare Advantage in This Market

County	Medicare eligibles	Advantage penetration	Population 65 and over
Richland	80,109	43.0%	59,468 (14.1%)
Lexington	66,283	42.4%	52,089 (17.1%)
Sumter	24,604	50.1%	reported
Kershaw	17,066	48.3%	reported
Four counties, weighted by eligibles		**44.2%**	

CMS State and County Medicare Advantage penetration file, July 2026; American Community Survey 2020–2024 five-year estimates for the two core counties.

This market is close to the national midpoint for Advantage. 43.0% of Richland County's Medicare eligibles and 42.4% of Lexington County's are in Advantage plans, with Sumter at 50.1% and Kershaw at 48.3%. Across the four counties, weighted by eligibles, that is 44.2%, which leaves about 83,859 fee-for-service beneficiaries in the two core counties alone.[18] The practice's claims profile in section 1 describes only the fee-for-service majority of its panel. The Value Analysis grosses the panel up to include the Advantage patients, because they are enrolled in the same programs and consented the same way. Advantage plans must reimburse at least the Medicare rate. That is a floor; individual contracts set their own terms for the care-management code families.

Richland County is younger than the state, with 14.1% of its population 65 and over against 17.1% in Lexington, and it carries a disproportionate share of the state's kidney disease burden. The practice's own dual-eligible share is moderate for the market. Cost-sharing on a monthly care-management program is an ordinary conversation on this panel, and the enrollment specialist has it in person.[19]

What this means for the business case

A little more than half of the panel's reimbursement is fee-schedule-set and a little less than half is contract-dependent. The practice's own Advantage plan mix, plan by plan, is therefore one of the most useful pieces of information it can bring to the first call, along with whether any payer arrangement held through the Kidney Contracting Entity covers those lives.

The fee-for-service majority is where the rates in section 3 apply exactly as printed. The Advantage share is where the practice's existing plan contracts decide the answer, and those contracts already exist.

[18] CMS State and County Penetration, Medicare Advantage, July 2026 file: Richland County 80,109 eligibles, Lexington County 66,283, Sumter County 24,604, Kershaw County 17,066. The fee-for-service figure is eligibles less enrolled for Richland and Lexington.

[19] American Community Survey 2020–2024 five-year estimates, table DP05, Richland and Lexington counties. Dual-eligible counts per clinician from the by-Provider source.

9. The CY2027 Proposed Rule

CMS published the CY2027 physician fee schedule proposed rule on 16 July 2026. The comment period closed on 14 September 2026; the final rule is expected in early November 2026 and takes effect on 1 January 2027.[20] Two things in it bear directly on this forecast: the conversion factor moves from $33.4009 to $32.8409, and the remote-monitoring device-supply codes take a large cut in practice-expense value. The proposal reaches the remote-monitoring family only; principal care management is not in it. Every code in the forecast was repriced on the practice's own billing mix at South Carolina locality 01.

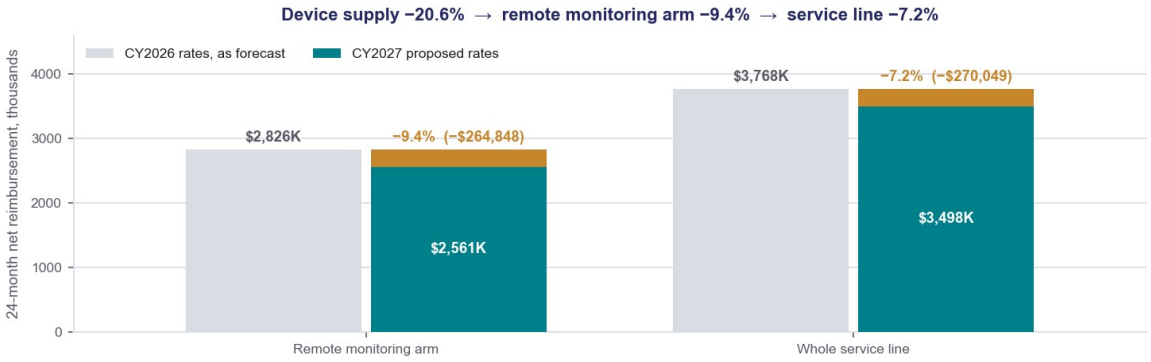


Figure 3. The CY2027 cascade on one dollar scale: the device-supply cut flows through the remote-monitoring arm to the whole service line, each percentage smaller only because its base is larger.

Device supply (99454 and 99445) falls −20.6% at this locality, from $48.12 to $38.21 per patient-month. Device supply is 31% of the remote-monitoring basket on the practice's mix, so the monitoring arm falls −9.4%, or −$264,848 over 24 months. The monitoring arm is 75% of the service line, so the whole line falls −7.2%, or −$270,049 of $3,768,364. Principal care management moves −0.55%, through the conversion factor and practice-expense churn rather than any targeted change, so $5,201 of the total sits outside the remote-monitoring arm.

Code	Service	Locality 01, CY2026	Locality 01, CY2027 proposed	Change	National, CY2026	National, CY2027 proposed
99453	Remote monitoring setup	$20.01	$18.49	−7.6%	$21.71	$20.03
99454	Device supply, 16–30 days	$48.12	$38.21	−20.6%	$52.11	$41.38
99445	Device supply, 2–15 days	$48.12	$38.21	−20.6%	$52.11	$41.38
99457	Treatment management, first 20 min	$49.29	$47.22	−4.2%	$51.77	$49.59
99470	Treatment management, first 10 min	$24.81	$19.84	−20.0%	$26.05	$20.69
99458	Treatment management, additional 20 min	$39.72	$38.73	−2.5%	$41.42	$40.39
99426	Principal care management, staff, first 30 min	$65.02	$64.25	−1.2%	$67.80	$67.00
99427	Principal care management, staff, additional 30 min	$51.68	$52.02	+0.7%	$54.11	$54.52

[20] CY2027 Physician Fee Schedule proposed rule (CMS-1848-P), published 16 July 2026, with the accompanying RVU and conversion-factor public use files. Comments closed 14 September 2026.

Code	Service	Locality 01, CY2026	Locality 01, CY2027 proposed	Change	National, CY2026	National, CY2027 proposed
99424	Principal care management, physician, first 30 min	$84.27	$81.31	−3.5%	$87.51	$84.40
99425	Principal care management, physician, additional 30 min	$59.15	$56.97	−3.7%	$61.46	$59.11

Locality amounts are used for the cascade and the repricing; national Addendum B amounts are shown side by side for reference. The two bases do not reconcile to the dollar, by design. The device-supply and short-treatment codes are held to a one-year maximum reduction by section 1848(c)(7) of the Act, which phases any decrease of 20 percent or more over two years; CY2027 is the capped year.

The proposal does not change the case. The service line at CY2027 proposed rates still produces $3,498,314 of net reimbursement over 24 months on the same census. Two contingencies are already in build at CoachCare: an unbundled arrangement, with the software platform, device logistics and program enablement priced separately, and an arrangement in which CoachCare manages the staffing while the practice owns the clinical program and the billing. Whichever way the final rule lands, the program does not have to be rebuilt, and CoachCare will rerun this forecast against the final rates the week they publish.

10. Implementation Roadmap

CoachCare operates as the service line's engine while the practice's nephrologists govern protocols and every clinical decision. Launch needs no new hires, the athenahealth integration is native, and the transitional-care path produces cash before any device ships. The first 90 days, modeled: 54 active program enrollments by month 1, 143 by month 2, 266 by month 3, led by the stage 3b to 5 and resistant-hypertension cohorts, the existing care-management panel, and the post-discharge list from the six hospitals.

Phase	Window	What happens
Charter and cohort	Days 1–14	Agree the escalation routing and who receives non-critical alerts. Pull the stage 3b to 5, resistant-hypertension and heart-failure cohorts out of athenahealth, reconcile them against the existing care-management panel, and confirm the enrollable list against the panel estimate in this analysis
Integration and billing	Days 15–30	Turn on the athenahealth integration, configure the time-capture and code mapping, and run a claims test on the transitional care management path first, on current discharges from all six hospitals
Enrollment specialist on site	Days 31–45	The funded specialist starts at the Columbia office, working from the confirmed cohort list, then extends to West Columbia, Lugoff and Sumter. Cuffs and scales ship to enrolled patients. First readings arrive and the escalation engine goes live with the practice watching every route
Ramp	Months 2–21	Monitoring census climbs to its ceiling of 2,242; monthly billing cadence established; first read of readmissions in the post-discharge cohort
Steady state	Month 22 onward	Monitoring holds at ceiling; principal care management keeps climbing toward 2,178 and reaches 876 by month 24. Blood-pressure control, fluid management, post-discharge touches and planned-start documentation accumulate as retrievable reports, which is what the Kidney Care Choices quality measures and any successor model both need

The dashboard the practice should hold CoachCare to

Domain	Measures
Clinical	Blood-pressure control and weight stability in the monitored cohort; diuretic and antihypertensive changes prompted and completed; 30-day readmissions in the post-discharge cohort; escalations by severity and outcome
Operational	Enrolled census against ceiling by program; time to first billable enrollment; monthly reading adherence; escalation response times; unreachable-patient resolution
Financial	Net reimbursement per enrolled patient per month; capture rate against eligible patient-months; denial rate by code and by payer; transitional care management capture against discharges
Kidney Care Choices	Unplanned admissions in the enrolled cohort against the prior year; planned and home dialysis starts among monitored patients; documented monthly management of aligned patients, reported to the entity on its own cadence

About CoachCare

The service line in this report runs on infrastructure already operating at national scale: over 400 managed conditions for 500,000+ patients; 10,000+ providers running remote care programs day to day; 1,000+ programs stood up and running in market; care-plan coding and billing behind more than 5 million claims; over 100 million vitals recorded and 4 million+ care actions enabled.

The billing path is not an afterthought here. It is the part most remote-care programs get wrong.

11. Open Items for the First Call

Eight questions decide how much of this report's forecast survives contact with the practice's own data, and all eight can be answered on the first call.

1. **The chart count.** The 8,540-patient Medicare panel is built from established-visit beneficiaries in the CMS file, grossed up for the Advantage share. A unique-patient count from athenahealth replaces the estimate outright, and section 7 shows what it moves.
2. **How the existing care-management panel migrates.** About 946 patients are on chronic care management today. Principal care management and chronic care management cannot both be billed for one patient in one month, so the practice decides, patient by patient, who migrates and who stays.
3. **Who runs care management today.** Whether the existing program is staffed in-house or by a vendor is not public, and it decides how the twelve-month program is stood up.
4. **The clinician roster.** The website lists 16 physicians and 7 practitioners; CMS data resolve 22 physicians and 11 advanced-practice clinicians to the practice. The forecast uses 30 referring clinicians, and section 7 shows the answer at 22 and at 33.
5. **The Medicare Advantage plan mix, and any payer arrangement through the Kidney Contracting Entity.** About 44% of the four counties' beneficiaries are in Advantage, and the panel is priced at the fee schedule. Which plans, in what proportion, and whether any value-based arrangement the entity holds covers the practice's Advantage lives, is the question.
6. **Ownership in the dialysis and access-center entities.** Whether the practice holds equity in any of the 15 dialysis units or in the access center is not public. It changes nothing in the forecast; it changes how avoided admissions and optimal starts are attributed across the practice's ledgers.
7. **The path after 2026.** The Kidney Care Choices performance period ends 31 December 2026 with no successor announced for the entity's cohort. What the practice expects to be measured on in 2027 decides which reports this program should be producing from day one.

8. **The practice administrator.** The role that owns the billing path, the staffing decision and the integration calendar is not identified in public sources, and that person belongs in the working session.

The case in three sentences

A remote care service line built on the panel this practice already manages produces $3,768,364 of net reimbursement and $1,591,175 of retained margin over 24 months, at a 42.2% practice margin, billed under the practice's own TIN.

It does that while producing the between-visit signal a Kidney Contracting Entity cannot produce on its own, on a panel where three patients in four carry hypertension and one in two carries heart failure.

The consent and the monthly touch are already running for about 946 patients. What is missing is the other nine months, the cuff and the scale, and the rest of the panel.

To take any of this further, the next step is a working session with the practice's physician leadership and administrator to validate the cohort against the chart, decide how the existing care-management panel migrates, confirm the clinician roster the forecast is built on, and set the go-live at the Columbia office. Connor Knapp · Head of Sales · CoachCare · connor.k@coachcare.com.

References & Data Sources

Every figure in this report traces to one of the sources below. CMS files were queried directly rather than through an aggregator, and each query date is recorded in the numbered notes throughout.

Source	Used for	Vintage
Medicare Physician & Other Practitioners — by Provider	Allowed charges, beneficiary counts, risk score, age, dual-eligible share, chronic-condition prevalence for the practice's clinicians	CY2024, queried 14 September 2026
Medicare Physician & Other Practitioners — by Provider and Service	Procedure-level claims: office visits, dialysis capitation, subsequent hospital care, the existing care-management codes, and the absent remote-monitoring and transitional-care families	CY2024, queried 14 September 2026
CMS Doctors & Clinicians national file; NPPES registry; PECOS reassignment list; Quality Payment Program eligibility interface	Clinician roster, group identifier, billing-entity attribution, alternative payment model status	Current files / PY2026, retrieved 14 September 2026
CMS Kidney Care Choices model participants and affiliations file; the Kidney Contracting Entity's published roster and CMS results	Section 2: participation, option, cohort, CMS-scored quality score and optimal-start rate, performance period end	CY2026 file; results as published, retrieved 14 September 2026
CMS State and County Medicare Advantage penetration file	County Advantage penetration and eligibles, four counties	July 2026
American Community Survey five-year estimates, Richland and Lexington counties, South Carolina	Population 65 and over	2020–2024
Practice website: locations, hospital affiliations, services, patient and physician portals	Offices, dialysis-unit count, access center, laboratory, research program, hospital privileges, electronic health record	Retrieved 14 September 2026
CY2026 physician fee schedule, Palmetto GBA South Carolina locality 01	Every CY2026 rate quoted in section 3	CY2026, conversion factor $33.4009
CY2027 physician fee schedule proposed rule (CMS-1848-P) and public use files	Repricing in section 9, locality and national	Published 16 July 2026
CoachCare athenahealth integration overview	Section 4	Current
CoachCare Care Management Standard Operating Procedures and SOP process maps	Section 5: escalation engine, emergent pathway, routing, post-discharge cadence, discharge flow	Version March 2026
CoachCare Value Analysis for this account	The 24-month forecast, per-program detail, sensitivities and clinical outputs	Recalculated 14 September 2026