

ADVANCED KIDNEY CARE OF HUDSON VALLEY

Nephrology Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as the interstitial care layer of kidney care — and the practice-owned recurring-revenue infrastructure beneath it.

Purpose of this report

Prepared by CoachCare for the physicians and leadership of Advanced Kidney Care of Hudson Valley, P.C. This report combines public information about the practice and its market (as-of dates noted throughout) with a modeled 24-month Value Analysis of a Remote Care Service Line. **All modeled figures are illustrative, modeled — verify against practice data.** July 2026.

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Executive Summary

Advanced Kidney Care of Hudson Valley, P.C. is the mid-Hudson corridor's independent nephrology group: eight board-certified nephrologists and four nurse practitioners — twelve providers — practicing from offices in Poughkeepsie, Newburgh, and Kingston, with hospital coverage at five regional facilities. Its clinical scope runs the full arc of kidney care: CKD management, hemodialysis and peritoneal dialysis, dialysis access procedures, kidney transplant evaluation and management, acute kidney injury, hypertension, kidney stones, and electrolyte disorders. (Practice website, retrieved July 2026; the site cites nine board-certified physicians and names eight — a headcount to confirm in conversation.)

The starting position is rare: total digital whitespace. Public research (July 2026) finds no patient portal, no remote patient monitoring program, and no care-management program branding anywhere in the practice's public presence — nothing to displace, nothing to migrate, and no incumbent vendor relationship to unwind. Meanwhile the practice's market is moving: across Dutchess, Orange, and Ulster counties, roughly 184,000 Medicare beneficiaries carry Medicare Advantage penetration of 37–41% (2025 data) against a New York statewide share of 53% — and the practice operates against a changing hospital landscape in the Hudson Valley. In that environment, the asset that appreciates is the one the practice already owns: the longitudinal relationship with the region's kidney patients.

The central argument

CKD progression does not happen in the exam room. It happens in the weeks between quarterly nephrology visits — in unmeasured blood pressure, unnoticed weight shifts, missed titrations, and the slow drift that ends in an unplanned, catheter-based dialysis start. A **Remote Care Service Line** — TCM at every hospital discharge, connected BP/weight RPM, and PCM for the kidney-dominant patient — is the **interstitial care layer** that makes those weeks observable and actionable.

It pays for itself twice. It is (1) a **standalone, recurring professional-fee revenue line** — modeled at \$1.76M in net reimbursement and \$759K in practice profit over 24 months (a 43.0% practice margin on net reimbursement), margin-positive from month two with no negative-margin quarter — and (2) **practice-owned infrastructure**: a consented, continuously monitored panel with documented monthly management, which is precisely the readiness substrate for wherever value-based kidney care goes next. Built once. Owned by the practice — not by a hospital, a payer, or a dialysis organization.

The modeled forecast (Section 4) is built on a **Medicare panel estimate of 2,900 patients (range 2,500–3,100), New York locality reimbursement rates, and two programs only — RPM and PCM**. Transitional care management and chronic care management billings are excluded from the model and would be additive. *All modeled figures are illustrative, modeled — verify against practice data.*

2026–2027 Priority Recommendations

1. **Stand up the Remote Care Service Line as a named program.** Connected BP/weight RPM plus PCM across the CKD stage 3b–5 panel, with TCM cadence at every discharge from the five covered hospitals.

2. **Validate the panel.** Confirm the Medicare panel size (working estimate 2,900; range 2,500–3,100) against chart counts in the first discovery conversation, and re-run the Value Analysis on actuals — every modeled figure scales with it.
3. **Confirm the EMR vendor and integration path.** No public evidence establishes the practice's platform today; this is a first-call discovery item (Section 5.2).
4. **Launch enrollment with the CoachCare-funded on-site enrollment specialist.** First billable enrollments in month 1; the modeled RPM census reaches its 761-enrollment ceiling at month 18, while PCM is still climbing at month 24.
5. **Build the crash-start-avoidance pathway.** Route BP/weight alerts, eGFR trajectory, and adherence gaps into nurse triage — with modality education, access planning, and transplant referral triggered ahead of need rather than in the emergency department.
6. **Treat the program as the practice's value-based-care readiness spine.** The consented, continuously monitored panel and its documentation are the entry requirements of any future value-based arrangement — built here under fee-for-service economics, so the practice arrives at any future negotiation holding its own data.

1. Practice Footprint & Market Position

1.1 The Practice

Advanced Kidney Care of Hudson Valley is an independent, physician-owned professional corporation — a structure that has become the exception in the Hudson Valley as physician groups consolidate. That independence is a strategic asset in this report's argument: every capability described here is built under the practice's own brand, on the practice's own panel, with the revenue and the data accruing to the practice.

Dimension	Profile (public sources; as-of dates noted)
Organization	Independent physician-owned professional corporation (P.C.); Medicare-enrolled medical group
Providers	8 board-certified nephrologists + 4 nurse practitioners (12 providers). Website cites nine physicians and names eight — confirm; a Medicare-derived directory lists the same eight physicians.
Offices	Poughkeepsie (Dutchess Co.) · Newburgh (Orange Co.) · Kingston (Ulster Co.) — all M–F 9–5
Hospital coverage	Five regional facilities across the mid-Hudson corridor (per the practice website and physician Medicare profiles; affiliations to confirm)
Clinical scope	CKD management; hemodialysis & peritoneal dialysis; ESRD care; dialysis access procedures; transplant evaluation & management; AKI; hypertension; kidney stones; electrolyte disorders
Payer mix	Medicare, Medicare Advantage, Medicaid, and a broad commercial panel (per website payer list, retrieved July 2026)
Digital programs	None found publicly — no patient portal, no RPM/CCM program branding (July 2026; Section 5)

1.2 The Tri-County Medicare Market

The practice's three counties hold a large, aging Medicare population with Medicare Advantage penetration climbing toward the New York statewide share:

County (office)	Medicare beneficiaries (2025)	Medicare Advantage share (2025)
Dutchess (Poughkeepsie)	67,711	41.2%
Orange (Newburgh)	71,549	37.2%
Ulster (Kingston)	44,897	41.1%
Tri-county total	≈184,000	≈39% blended · NY statewide: 53%

Source: compilation of 2025 CMS enrollment data (secondary source, retrieved July 2026) — verify against current CMS Medicare Advantage penetration files.

Three readings of the same table. **First**, roughly six in ten of those beneficiaries remain in Original Medicare — a fee-for-service base on which RPM, PCM, and TCM are billable today, no contract negotiation required. **Second**, Medicare Advantage at 37–41% and rising means an ever-larger share of the practice's panel is managed by payers accountable for total cost of care. Plans direct patients toward nephrology practices that can demonstrate continuous management and fewer avoidable admissions — and the practice that holds continuous physiologic data on its panel holds the evidence. **Third**, public search surfaces no comparable independent nephrology group in the Poughkeepsie–Newburgh–Kingston corridor (an inference to validate, not a verified fact) — making this practice the natural owner of the region's kidney-care panel and its data.

1.3 Design Principles for the Next Operating Model

Principle	What it means in practice
Longitudinal by default	Every CKD 3b–5 patient leaves the office enrolled in monitoring — the program is the standard of care, not an add-on for the motivated few.
The interstitial period is owned	The weeks between visits produce data that someone is watching and acting on — not a gap the practice hopes goes quietly.
One front door	The same care layer spans all three offices and all five covered hospitals: one enrollment path, one alert protocol, one scorecard.
Digital as care, not administration	Devices and the patient app are clinical touchpoints under the practice's brand — the patient's daily experience of their nephrologist.
Independence preserved	The infrastructure, the revenue, and the data belong to the practice — not to a hospital program, a payer platform, or a dialysis organization.

2. The Remote Care Service Line: The Interstitial Care Layer

A nephrology panel is managed, at best, in quarterly increments — four hours a year of direct contact for the sickest patients, and the disease does its work in the other 8,760. The Remote Care Service Line is the layer that occupies that interval: **TCM** bridges every hospital discharge back to the practice; **connected BP/weight RPM** turns the interstitial period into monitored clinical time; **PCM** funds the disciplined monthly management of the kidney-dominant patient. One enrollment, one device kit, one triage protocol — three coordinated billing programs.

2.1 What It Is — The Nephrology Billing Stack

Program	CPT codes	Cadence	What it is for this practice
TCM	99495 / 99496	Per discharge	Contact within 2 business days of discharge; face-to-face within 14 / 7 days. The bridge home from any of the five covered hospitals. Not in the modeled forecast — additive.
RPM	99453, 99454 (99445), 99457 (99470), 99458	Monthly	Connected BP cuff + scale; 16+ days of readings (99454) — with the new CY2026 2–15-day code (99445) covering short transitional windows; ≥20 minutes of management (99457) plus additional time (99458).
PCM	99424–99427	Monthly	Principal care management of the single dominant condition — CKD — expected to last ≥3 months; the monthly management discipline for the specialty panel.

The coordination rules (set the policy on day of launch)

RPM stacks. RPM may be billed alongside PCM — or alongside a primary-care physician's chronic care management — for the same patient in the same month, with discrete time and documentation.

PCM and CCM do not stack for the same practitioner. The same practitioner cannot bill both for the same patient in the same month — the forecast therefore conservatively models PCM only for this specialty panel.

TCM months need clean separation. Care-management time in a TCM month must be documented separately; TCM billings sit on top of the modeled forecast, not inside it.

Attribution with referring PCPs. Nephrology owns the kidney-dominant patient's PCM and RPM; the referring PCP may continue CCM on their comprehensive panel; one shared care plan documents who owns what. This is a one-page policy — write it before the first enrollment.

2.2 Standalone Value — Four Layers

1. **Direct recurring professional-fee revenue.** Modeled at \$1.76M in 24-month net reimbursement to the practice, \$759K of it profit after CoachCare fees (Section 4) — subscription-like monthly revenue on a panel the practice already manages.

2. **Avoided-cost value.** The model projects ~78 avoided hospitalizations over 24 months, and Section 3.3 describes the largest single avoidable cost in kidney care — the unplanned, catheter-based dialysis start. These dollars land on patients, hospital partners, and payers today, and on the practice under any risk-bearing arrangement it may later choose.
3. **Referral durability with primary care.** A monthly documented touch plus a data-sharing loop back to referring PCPs makes the practice the most informative consultant in the corridor — the nephrology group that tells the PCP what happened between visits, not just what happened at the last one.
4. **Strategic readiness.** A consented panel, a deployed device fleet, 24/7 monitoring, documented monthly management, and clean billing capture are the entry requirements of value-based kidney-care arrangements. The service line builds them under fee-for-service economics — readiness as a by-product of a profitable program, not a speculative investment.

The CY2026 billing stack (illustrative magnitudes)

Service / code	Type	~CY2026 magnitude	Notes
TCM 99495 / 99496	Per discharge	~\$200 / ~\$280	Moderate / high complexity; 2-business-day contact; face-to-face 14 / 7 days
RPM 99453	One-time setup	~\$20	Requires ≥2 days of data
RPM 99454 / 99445	Monthly	~\$52	16–30 days of readings; 99445 = new CY2026 2–15-day code, same value
RPM 99457 / 99470	Monthly	~\$52 / ~\$26	First 20 minutes / new CY2026 first-10-minute code
RPM 99458	Monthly	~\$41	Each additional 20 minutes
PCM 99424/99425 (physician); 99426/99427 (clinical staff)	Monthly	~\$60 + ~\$50 addl	Single high-risk condition (CKD) expected ≥3 months

Rates caveat

Values above are **illustrative national non-facility magnitudes**. Actual payment is locality-adjusted and set by the regional Medicare Administrative Contractor. The Section 4 forecast uses the practice's actual New York locality rates (e.g., 99457 ≈ \$55.82 and 99426 ≈ \$72.84 in the Poughkeepsie-area locality). Verify against the current-year Physician Fee Schedule.

2.3 One Care Layer, Every Kidney-Care Lever

The same infrastructure — enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, titration support, billing capture, analytics — powers every clinical and financial lever the practice cares about. Build it once; every program below reuses it.

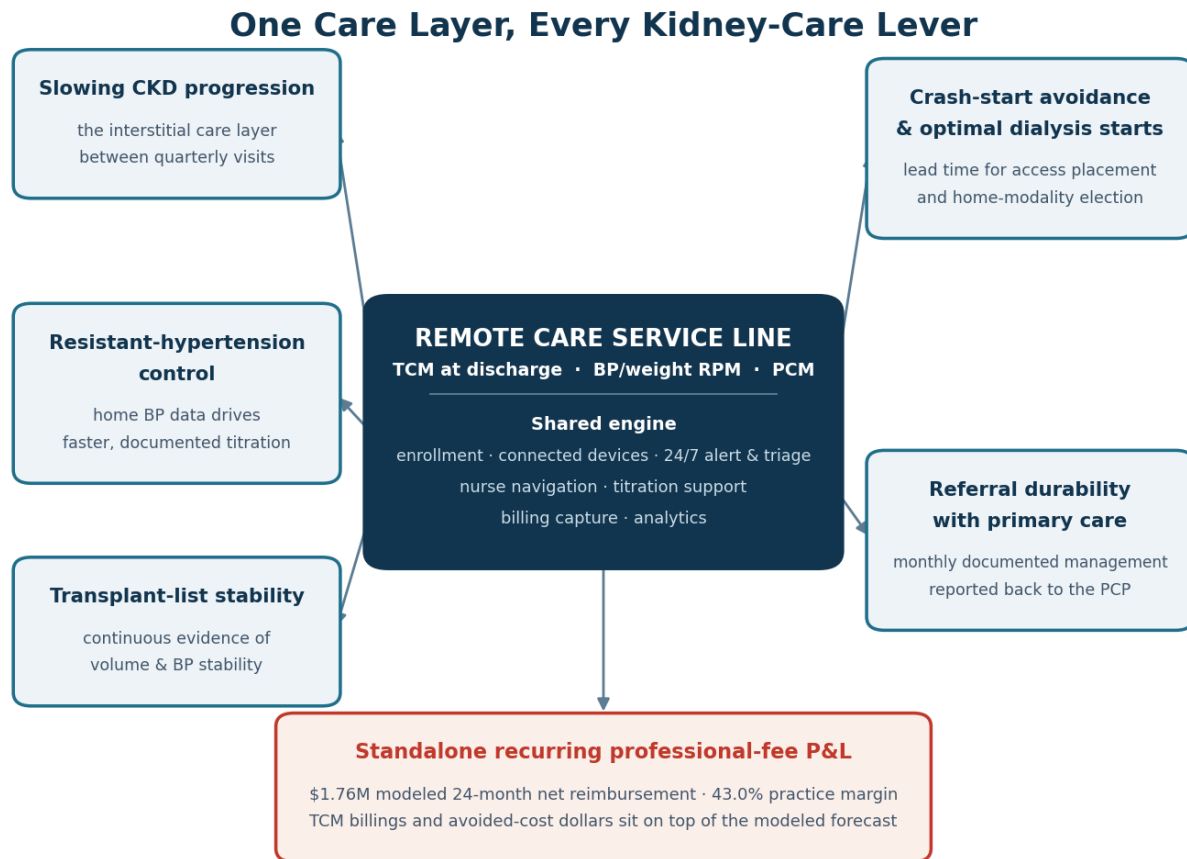


Figure 1. One shared engine behind six kidney-care levers. Clinical levers (blue) are covered in Section 3; the standalone P&L (red outline) in Section 4.

Lever	What the shared infrastructure contributes	Where
Slowing CKD progression	Daily BP/weight signal plus titration support across the weeks between visits — the interstitial care layer itself	§3.1
Resistant-hypertension control	Home BP monitoring with medication-titration support and escalation to an office visit when patterns demand it	§3.2
Crash-start avoidance & optimal starts	Lead time: deterioration visible weeks early triggers modality education, access placement, and planned starts	§3.3
Transplant-list stability	Volume, BP, and adherence stability — documented continuously — protects listing candidacy	§3.4
Referral durability with primary care	Monthly documented management with a reporting loop to referring PCPs	§2.2, §6
Standalone recurring P&L	Billing capture across RPM + PCM (TCM and CCM additive)	§4

3. The Clinical Case: Where CKD Progression Actually Happens

3.1 The Interstitial Period

A CKD stage 3b–5 patient on quarterly follow-up spends roughly one hour per year in direct contact with nephrology. The drivers of progression — uncontrolled blood pressure, volume shifts, AKI episodes layered on chronic disease, nephrotoxic exposures, missed diuretic and antihypertensive titrations — operate in the other 8,759 hours. Today those hours are invisible to the practice; whatever happens in them arrives at the next visit as a fait accompli, or at the emergency department sooner.

Connected BP-cuff and scale monitoring converts that interval into monitored clinical time. Readings flow daily against patient-specific thresholds; a 24/7 monitoring layer triages what crosses them; the practice's clinicians see the patients the data flags — not the data itself. The visit cadence does not change. What changes is that the period between visits stops being unmanaged.

3.2 Resistant Hypertension

Blood-pressure control is the most modifiable determinant of CKD progression, and hypertension management is already a named service of this practice. Home BP data changes the clinical quality of that service: it distinguishes true resistant hypertension from white-coat and masked patterns, gives titration decisions a dataset instead of a single office reading, and shortens the loop between a medication change and the evidence of its effect. For the subset of genuinely resistant patients, the monitoring layer is the co-management substrate the practice's nephrologists already know how to use — better data, faster titration, documented response.

3.3 Crash-Start Avoidance & Optimal Dialysis Starts

The single most expensive and most harmful event in the kidney-care journey is the unplanned dialysis start: the patient who arrives in the hospital in uremic crisis and begins renal replacement therapy on a central venous catheter — with the infection risk, the hospitalization, and the downstream cost that entails. A planned start — with a matured access or an elected home modality, prepared by structured education — is better on every axis: clinically, financially, and in the patient's experience of the transition.

The difference between the two is almost entirely **lead time**, and lead time is what continuous monitoring buys. A declining trajectory visible weeks-to-months early triggers, in order: structured modality education; timely access placement (a procedure line this practice already runs); home-dialysis election where appropriate — supporting the peritoneal and home hemodialysis services the practice already offers; and transplant referral while the patient is still a strong candidate. The Value Analysis models ~78 avoided hospitalizations over 24 months (~\$1.17M at \$15,000 per admission) from monitoring-driven early intervention — an illustrative, modeled figure, and one that does not attempt to price the crash starts avoided on top of it.

3.4 Transplant-List Stability

For patients in transplant evaluation or on a waiting list, candidacy is protected by exactly the things the monitoring layer manages: blood-pressure control, volume stability, medication adherence, and the absence of decompensation events. Continuous physiologic data gives the practice — and the transplant centers it refers to — longitudinal evidence of stability rather than snapshots, and the alert layer catches the deterioration that would otherwise cost a patient their window.

4. Value Analysis: The Modeled 24-Month Forecast

The forecast below was produced with CoachCare's Value Analysis workbook using Medicare fee-for-service reimbursement at the practice's New York locality rates and a deliberately conservative program scope: RPM and PCM only. *All modeled figures are illustrative, modeled — verify against practice data.*

4.1 Panel Estimate & Model Assumptions

The panel is an estimate — validate it first

The model assumes a **Medicare panel of 2,900 patients (range 2,500–3,100)**. Method: a commercial dataset reports ~\$4.06M in Medicare allowed charges for the group; dividing by ~\$1,300 per beneficiary-year gives an upper bound of ~3,100, and ~360 Medicare patients per nephrologist across eight physicians supports ~2,900. Every figure in this section scales with the panel — confirming it against chart counts is the first discovery-call agenda item, after which the Value Analysis is re-run on actuals.

Assumption	Value	Basis
Medicare panel (in scope, year 1)	2,900 (estimate)	Range 2,500–3,100; method above
Programs modeled	RPM + PCM	TCM and CCM excluded — additive upside
Program eligibility	RPM 75% · PCM 85%	Nephrology program-eligibility profile — in a CKD panel chronic kidney disease is the single dominant condition, which is exactly what Principal Care Management was written for, so PCM carries the higher rate
Acceptance among eligible patients	RPM 35% · PCM 30%	CoachCare program experience
Enrollment engine	1 on-site enrollment specialist	CoachCare's expense; ~80 enrollments/month capacity, plus 12 referring providers at 5 referrals each per month and 70% acceptance
Reimbursement	Medicare FFS, NY locality (Poughkeepsie area)	CY2026 Physician Fee Schedule

4.2 Enrollment Ramp & Program Ceilings

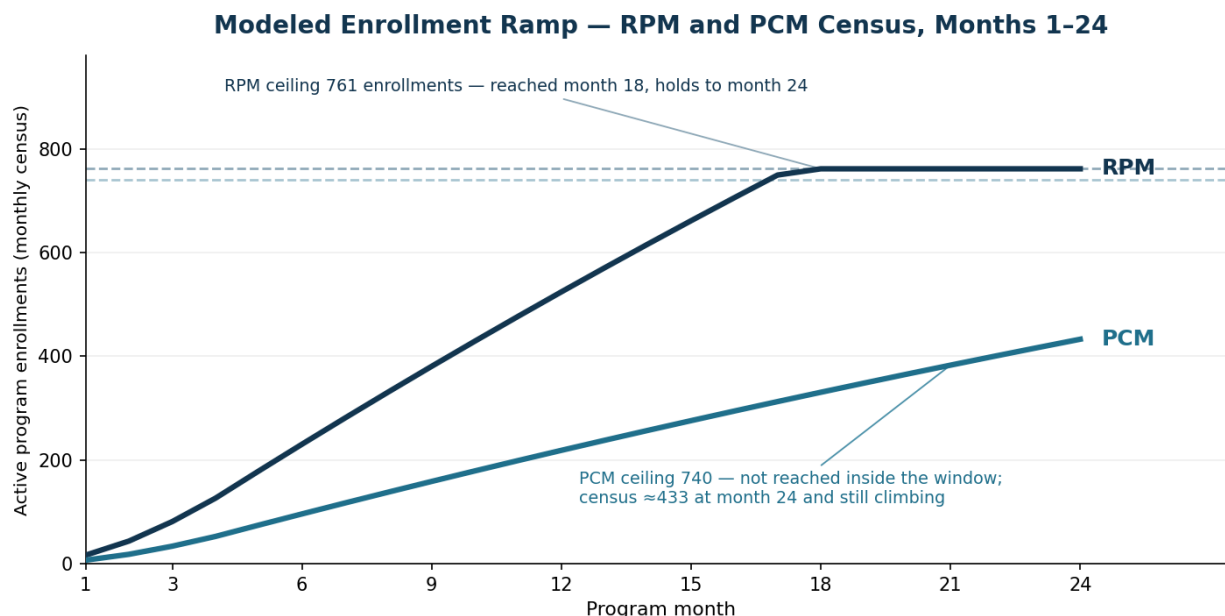


Figure 2. Modeled monthly enrolled census. Ceilings are panel × eligibility × acceptance: RPM 761, PCM 740.
Illustrative, modeled — verify against practice data.

The RPM census reaches its 761-enrollment ceiling in month 18 and holds through month 24. PCM does not saturate inside the window: its census is ≈433 against a 740 ceiling at month 24, and still climbing. So only one of the two programs plateaus, and only over the final six months. Two consequences follow. For RPM, the binding constraint after month 18 is the eligibility-and-acceptance arithmetic rather than outreach capacity, and it is a validated, larger panel that raises that ceiling — every 100 patients of panel moves the RPM ceiling by ~26 and the PCM ceiling by ~26. For PCM the constraint is still enrollment pace, so that program keeps building past month 24. Because the RPM ceiling binds for part of the window, the 24-month result remains sensitive to the panel estimate — which is why Section 4.1 leads with validating it.

4.3 Financial Results

	Year 1	Year 2	24-Month Total
Net reimbursement (practice)	\$461,454	\$1,302,976	\$1,764,430
CoachCare fees (incl. one-time)	\$269,288	\$736,213	\$1,005,500
Practice profit	\$192,167	\$566,763	\$758,930

Program (24-month)	Net reimbursement	Practice profit
RPM	\$1,241,532	\$553,769
PCM	\$522,898	\$249,584

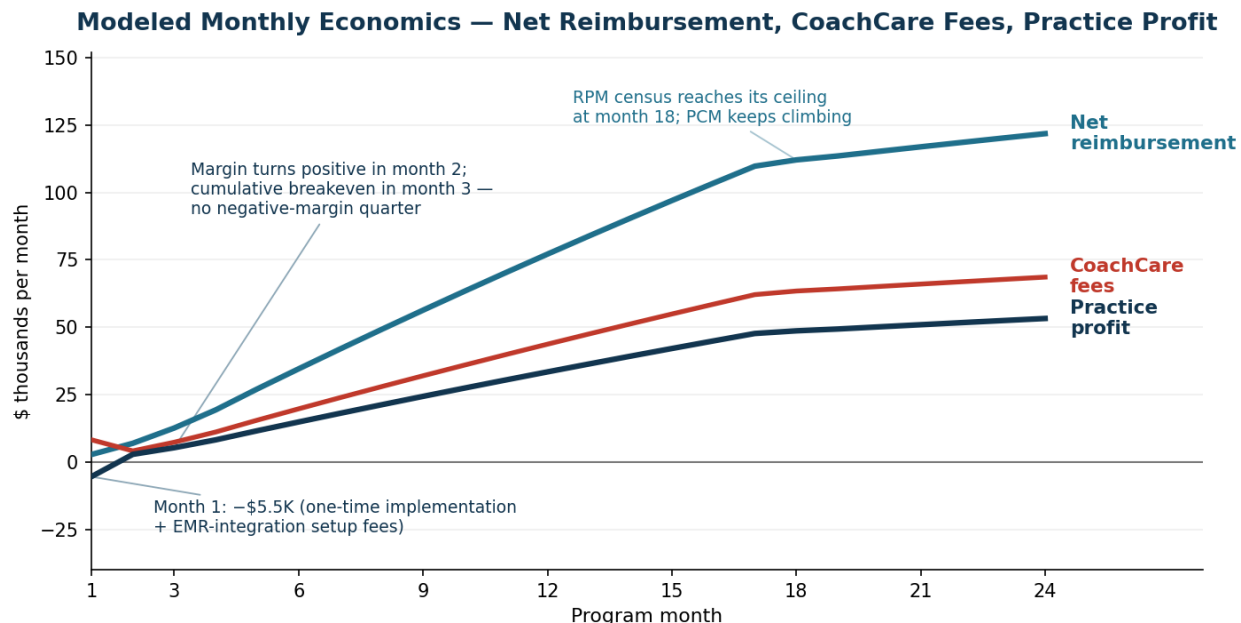


Figure 3. Modeled monthly economics, NY locality rates. Illustrative, modeled — verify against practice data.

Month-one economics, stated plainly

Month 1 is modeled at $-\$5,474$: one-time program implementation and EMR-integration setup fees land before the first full billing cycles. The program is margin-positive from month two ($\$2,827$ in month 2) and reaches cumulative breakeven in month three — there is no negative-margin quarter. Steady-state monthly profit is $\approx\$33.4K$ by month 12, rising to $\approx\$53.2K$ by month 24.

24-month practice margin: 43.0% of net reimbursement (Year 1 41.6%, Year 2 43.5%). Month 1 is modeled at $-\$5,474$ because one-time implementation and EMR-integration setup fees land there; margin turns positive in month two and there is no negative-margin quarter. Month-24 census is 1,194 active program enrollments (RPM 761 + PCM 433) — 891 unique patients after de-duplicating those enrolled in both programs (590 by month 12). The on-site enrollment specialist is CoachCare's expense — embedded value, never subtracted from practice margin. All figures illustrative, modeled — verify against practice data.

4.4 Clinical-Operations Impact

Modeled measure	24-Month (modeled)
Claims processed	30,167
Vitals readings captured	123,173
Hospitalizations avoided (modeled)	~78
Care-hours saved for the practice	13,971 (≈ 6.7 clinical FTE-years)

The care-hours line deserves emphasis in a workforce-constrained market: the enrollment, monitoring, triage, and documentation labor behind those hours is **CoachCare staffing, carried as CoachCare's expense inside the program fee** — embedded value to the practice, never a deduction from the practice margin shown above. The practice's twelve providers spend their time on the patients the data flags.

4.5 What the Model Does — and Does Not — Include

- **Not included (upside):** TCM billings at the five covered hospitals; commercial and Medicare Advantage panel revenue; the avoided-cost dollars of Section 3.3. The forecast is Medicare fee-for-service, RPM + PCM only.
- **Included conservatisms:** RPM and PCM only, with TCM excluded; a single enrollment specialist; and program ceilings set by panel × eligibility × acceptance.
- **Key sensitivity:** the panel estimate. At the 2,500–3,100 range bounds, ceilings — and therefore steady-state economics — move roughly proportionally (±7–14% around the 2,900 base).
- **Vendor-contingent line:** the month-1 EMR-integration setup fee assumes an integration-catalog platform (Section 5.2); the actual fee depends on the confirmed vendor.

5. Digital Foundation: Whitespace, Integration, and Ownership

5.1 Current State: Total Digital Whitespace

What public research verifies, as of July 2026:

- No patient portal is linked anywhere on the practice website.
- No remote patient monitoring, chronic care management, or care-management program branding appears on the website or in third-party profiles.
- Telehealth availability is noted on one third-party directory profile (vintage undated).
- The practice website is informational — locations, providers, services, payers — with no patient-facing digital workflow.

For a program launch, this is the strongest possible starting position: **there is nothing to displace**. No incumbent vendor contract to unwind, no legacy portal migration, no patient re-training away from a competing app, and no internal program whose sunk cost argues for inertia. The first remote-care program this practice launches will define its patients' digital experience of the practice — under the practice's own brand, from the first enrollment.

5.2 EMR & Integration

What is verified: no public evidence identifies the practice's EMR platform — no portal links, no vendor case studies, no job postings referencing a system (searched July 2026). One commercial healthcare dataset of stale vintage lists eClinicalWorks for the group; that listing is **unconfirmed** and should be treated as a hypothesis, not a fact.

CoachCare maintains bidirectional integrations across the major ambulatory EMR platforms, so the integration path is a configuration question rather than a feasibility question. **Confirming the vendor and integration path is a first-call discovery item.** The Section 4 forecast conservatively carries a one-time EMR-integration setup fee in month 1; the actual amount depends on the confirmed platform, and the forecast is re-run when the vendor is known.

5.3 Owned Infrastructure & the Readiness Path

Remote monitoring programs in kidney care are increasingly run *around* nephrology practices — by hospital systems, payers, and value-based enablement companies — with the panel data, the patient relationship, and the recurring revenue accruing to the program owner. The alternative this report proposes is structural: the practice owns the service line. The devices carry the practice's brand; the monthly touch is the practice's touch; the revenue is practice revenue; and the longitudinal dataset on 2,900 Medicare patients belongs to the group that has managed them all along.

That ownership is also the practice's readiness path. Any value-based kidney-care arrangement — with a payer, a health system partner, or a federal program — demands the same substrate: a consented panel, continuous physiologic data, documented monthly management, and a working admission-prevention loop. The service line builds all four under fee-for-service economics that are themselves margin-positive from month two. No participation in any federal model or payer program is asserted in this report, and none is required for the Section 4 economics — which is precisely the

point: the practice gets paid to become ready, and arrives at any future negotiation holding its own data.

About CoachCare

Over 400 managed conditions for 500,000+ patients · 10,000+ providers committed to remote care excellence · 1,000+ successful implementations · care-plan coding and billing generating over 5 million claims · 100 million+ vitals recorded and 4 million+ care actions enabled.

6. Implementation Playbook

6.1 Scope & Target Populations

Cohort	Program stack	Priority
CKD stage 3b–5 (the core panel)	BP/weight RPM + PCM	Launch cohort — months 1–12
Hospital discharges (5 covered facilities)	TCM cadence + RPM short-window (99445)	Workflow live by month 4–6
Resistant / uncontrolled hypertension	BP RPM with titration support	Enrolled within the core ramp
Transplant evaluation & wait-list	RPM with stability documentation	Months 7–9 pathway
Peritoneal / home-dialysis patients	Weight/BP monitoring support	Months 7–9 pathway

6.2 Staffing Model

- **CoachCare provides:** an on-site enrollment specialist (CoachCare-funded, ~80 enrollments/month — this cost is CoachCare's, embedded in the program fee, never a practice hire); 24/7 monitoring and alert triage; nurse navigation; device logistics; documentation and billing-capture support.
- **The practice provides:** a physician champion; standing orders and escalation thresholds; clinical decisions on flagged patients; the referral of its own panel into the program at the point of care.
- **Top-of-license rule:** nephrologists and NPs see data-flagged patients, not data. The program's labor lives below the license line; the judgment lives above it.

6.3 Clinical & Billing Workflow

1. **Identify.** EMR registry pull of CKD 3b–5 and uncontrolled-hypertension patients; eligibility screen against Medicare coverage.
2. **Consent & enroll.** The on-site enrollment specialist works the daily schedule — enrollment happens inside the visit flow, not by cold outreach.
3. **Equip.** Connected BP cuff and scale shipped and configured; first readings within days of enrollment (99453 setup).
4. **Monitor.** Daily readings against patient-specific thresholds; 24/7 triage of alerts; escalation to the practice per standing orders.
5. **Manage & document.** Monthly RPM/PCM management minutes delivered and documented; titration recommendations routed to the practice; monthly summary to the referring PCP.
6. **Bill.** Claims assembled and captured monthly across the code stack; capture rate reported on the program scorecard.

6.4 KPI Dashboard

Domain	Metrics
Enrollment	Enrolled census vs. ceiling (RPM 761 / PCM 740); time-to-first-billable-enrollment; enrollments per month vs. ~80 target
Engagement	Share of RPM patients meeting the 16-day reading threshold; device-activation rate
Clinical	BP control rate; alert response time; unplanned vs. planned dialysis-start ratio; hospitalizations per 100 enrolled; home-modality election rate
Financial	Billing capture rate; net reimbursement per enrolled patient per month; monthly net reimbursement vs. model; cumulative profit vs. model

6.5 The First Twelve Months

Phase	Milestones (modeled trajectory)
Months 1–2	Contracting; EMR vendor confirmation and integration; panel validation against chart counts and Value Analysis re-run; thresholds and standing orders set; enrollment specialist on site; first billable enrollments (month 1 modeled at ~\$5,474 on one-time fees; margin-positive from month two, with no negative-margin quarter).
Month 3	First full billing cycles across RPM + PCM; cumulative breakeven (modeled); first program scorecard.
Months 4–6	RPM census ≈230 by month 6; TCM workflow live across the five covered hospitals; monthly PCP reporting loop running.
Months 7–9	Crash-start-avoidance pathway live (education, access planning, home-modality triggers); transplant-stability cohort enrolled.
Months 10–12	RPM census ≈524 and climbing toward its 761-enrollment ceiling (reached month 18); modeled run-rate ≈\$77K/month net reimbursement; year-2 planning: commercial/MA panel extension and a value-based-readiness review on the program's own data.

References & Data Sources

- Advanced Kidney Care of Hudson Valley practice website (advancedkidneycareny.org) — locations, providers, services, payer list. Retrieved July 2026.
- Medicare-derived provider directory (healthcare4ppl.com) — group Medicare enrollment (PAC ID 0143493817), physician roster, hospital-coverage listings. Vintage undated; affiliations unverified.
- County Medicare enrollment and Medicare Advantage penetration — secondary compilation of 2025 CMS enrollment data (understoodcare.com), retrieved July 2026. Verify against current CMS MA penetration files.
- Commercial healthcare dataset (Definitive Healthcare) — Medicare allowed-amount (~\$4.06M) used in the panel estimate; EMR listing (stale vintage, unconfirmed).
- CMS CY2026 Physician Fee Schedule — code values cited as illustrative magnitudes; forecast uses New York locality rates (Poughkeepsie area).
- CoachCare Value Analysis workbook — Advanced_Kidney_Care_CoachCare_Value_Analysis_2026.xlsx, built July 2026: all modeled census, reimbursement, fee, profit, and clinical-operations figures in Section 4.

Global caveat

Facts about the practice and its market are drawn from public sources with as-of dates as noted, and flagged where unverified. **All modeled figures are illustrative, modeled — verify against practice data.** Reimbursement values are locality- and year-dependent — validate against the current Physician Fee Schedule and the practice's actual payer mix. Nothing in this report asserts the practice's participation in any federal model or payer program. The panel size is an estimate to be validated in discovery, after which the Value Analysis should be re-run on actuals.