

Long Island Kidney Associates, P.C.

Nephrology Service Line Performance & Optimization 2026 Strategy Report

A Remote Care Service Line — RPM (blood pressure + weight), Principal Care Management, and Transitional Care Management — as the interstitial-care layer between nephrology visits, where CKD progression actually happens.

Purpose of this document

Prepared July 2026 to support Long Island Kidney Associates' 2026 planning discussions. It combines the practice's public footprint (site content reviewed July 2026), the CY2026 Medicare payment environment, and a modeled 24-month economic analysis of a CoachCare-operated Remote Care Service Line. All modeled figures are **illustrative, modeled — verify against practice data**. Panel size, EMR vendor, and staffing inputs are estimates flagged for validation in a first discovery working session.

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Executive Summary

Long Island Kidney Associates, P.C. is an independent, physician-owned, single-specialty nephrology group: five nephrologists practicing from offices in Bethpage (Nassau County) and Babylon (Suffolk County), with hospital privileges spanning four hospitals — Good Samaritan University Hospital (West Islip), South Shore University Hospital (Bay Shore), Plainview Hospital, and St. Joseph Hospital (Bethpage) — affiliations at seven skilled nursing facilities, and rounding relationships at eight in-center dialysis units across the two counties (practice site content reviewed July 2026). The group manages the full chronic kidney disease spectrum: CKD and diabetic nephropathy, hypertension, glomerular disease, anemia of CKD, polycystic kidney disease, and dialysis care.

The starting position is a dense chronic-care panel — an estimated **≈1,350 Medicare patients** (estimated range 1,100–1,420; see Section 6.1) — managed through an episodic model: office visits plus hospital, SNF, and dialysis-unit rounding. Between those touchpoints, the physiology that determines CKD trajectories — blood pressure, fluid status, medication response — goes unobserved. The practice's public materials (reviewed July 2026) describe no remote patient monitoring, chronic-care-management, or kidney-care-management program, which means the opportunity is a clean first build: new infrastructure and new recurring revenue, with nothing to displace and no incumbent program to unwind.

The central argument

A CoachCare-operated **Remote Care Service Line** — blood-pressure and weight RPM, Principal Care Management (PCM) for CKD, and Transitional Care Management (TCM) attached to the group's existing hospital and SNF rounding — delivers value through two channels at once:

1. Standalone economics. **\$1,209,683 in net reimbursement and \$515,495 in practice profit over 24 months — a 24-month practice margin of 42.6% of net reimbursement — with margin turning positive in month two, no negative-margin quarter, and steady state of ≈\$76,000/month in net reimbursement from month 23. CoachCare funds and staffs the enrollment and monitoring engine; the enrollment specialist is CoachCare's expense, not the practice's.**

2. The interstitial-care layer. The same infrastructure works the levers that define nephrology outcomes: slowing CKD progression, controlling resistant hypertension, avoiding unplanned “crash” dialysis starts in favor of planned, access-ready starts, keeping transplant candidates stable and listed, and tightening transitions across four hospitals and seven SNFs the group already rounds in.

Illustrative, modeled — verify against practice data.

Three features of this account sharpen the case. **First**, the wedge: nephrology care is quarterly, but CKD progression is continuous — the interstitial-care layer between visits is where deterioration happens, and it is currently unmanaged. **Second**, the group's operating model is already distributed — physicians travel to four hospitals, seven SNFs, and eight dialysis units. TCM and post-discharge RPM attach directly to those existing rounding workflows rather than requiring new ones. **Third**, timing: CY2026 Medicare rules added short-window RPM codes (99445, 99470) that make post-discharge monitoring billable in the first two weeks — precisely the window the group's SNF and

hospital footprint feeds — and roughly 53% of New York Medicare beneficiaries are now in Medicare Advantage (January 2026), a market that increasingly rewards documented, continuous chronic-disease management.

2026–2027 Priority Recommendations

1. **Stand up blood-pressure + weight RPM** for the CKD 3b–5 and resistant-hypertension cohort. Modeled ramp reaches its 355-enrollment ceiling in month 11.
2. **Layer PCM** for patients whose dominant condition is CKD; modeled ramp reaches 344 active enrollments in month 23. RPM and PCM bill concurrently for the same patient with discrete time and documentation.
3. **Attach TCM to existing rounding workflows** — capture 99495/99496 at hospital and SNF discharges the group already touches, feeding each discharge into a short-window RPM period (99445). TCM is not included in the modeled forecast; it is incremental upside.
4. **Build the optimal-starts pathway on RPM data** — use trend deterioration to trigger timely modality education, access planning, and home-dialysis preparation, converting unplanned starts into planned ones.
5. **Run a discovery working session** to validate the three flagged inputs: Medicare panel count (est. 1,350; range 1,100–1,420), current EMR vendor and version (public signals conflict), and the advanced-practice-provider roster (none publicly listed; each additional billing provider is upside to the model).
6. **Govern it as a service line** — one scorecard (Section 5), monthly review of enrollment, capture rate, revenue per patient per month, and the clinical panel: BP control, planned-start share, home-modality share.

1. Practice Footprint & Operating Model

1.1 The practice at a glance

Attribute	Detail (source vintage: July 2026 unless noted)
Legal identity	Long Island Kidney Associates, P.C. — independent, physician-owned professional corporation; single-specialty nephrology group (NPPEs organizational NPI 1295036531)
Offices	Bethpage, NY (4250 Hempstead Turnpike, Suite 17 — Nassau County) and Babylon, NY (373 W. Main Street, Suite B — Suffolk County)
Physicians	Five nephrologists: Sushil Sagar, MD (President/Owner); Tazleem Khan, MD (Vice President & Partner; Clinical Assistant Professor, NYIT); Victor Chang, MD; Niranjana Gunasekaran, DO; Navneet Kaur, MD
Advanced practice providers	None publicly listed (roster unverified — validate in discovery; each additional billing provider is model upside)
Clinical scope	CKD, diabetic nephropathy, hypertension, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, lupus nephritis, anemia of CKD, renal artery stenosis, electrolyte disorders, nephrolithiasis, renal osteodystrophy
Dialysis care	In-center hemodialysis management via rounding at eight affiliated units; home dialysis acknowledged as a patient option, with no structured practice-run home program described publicly
Office hours	Monday–Friday (9am–6/7pm); closed weekends — underscoring the value of 24/7 monitoring coverage between visits

1.2 The care network: hospitals, SNFs, dialysis units

The group's clinical reach extends well beyond its two offices. This network is the raw material for a transitional-care and remote-monitoring program: every node below generates discharges, medication changes, and fluid-status risk that currently land in the unmonitored gap between visits.

Network layer	Facilities
Hospitals (4)	Good Samaritan University Hospital (West Islip); South Shore University Hospital (Bay Shore); Plainview Hospital (Plainview); St. Joseph Hospital (Bethpage)
Skilled nursing facilities (7)	Gurwin Jewish Nursing & Rehabilitation Center; Berkshire Nursing & Rehabilitation; Apex Rehabilitation and Healthcare; Woodbury Heights Nursing and Rehabilitation; East Neck Nursing & Rehabilitation; Massapequa Center Rehabilitation & Nursing; Our Lady of Consolation Nursing & Rehabilitative Care Center
Affiliated in-center dialysis units (8)	Rounding affiliations at units in East Islip, Amityville, Hicksville (2), Massapequa, Bellmore, Lindenhurst, and Bay Shore, plus dialysis rounding at East Neck Nursing & Rehabilitation (West Babylon)

1.3 Operating-model read: a distributed rounding practice

Two observations shape the strategy. **The practice already operates a distributed care model** — five physicians covering two offices, four hospitals, seven SNFs, and eight dialysis units. The organizational muscle for caring for patients where they are, rather than only in clinic, already exists. A Remote Care Service Line extends that same logic into the home: the patient's blood pressure cuff and scale become one more “rounding site,” visited daily by the monitoring engine and escalated to the nephrologist only when clinically warranted.

Second, the panel is concentrated where remote care pays best. CKD patients are hypertensive, fluid-sensitive, poly-medicated, and hospitalization-prone — the exact profile where daily physiologic data changes decisions and where Medicare's care-management codes (RPM, PCM, TCM) were designed to pay for the work. The practice's public materials describe no existing remote-care program (reviewed July 2026), so the modeled economics in Section 6 represent net-new revenue on work the group's clinical model already implies.

1.4 Design principles for the 2026 service line

Principle	What it means here
Longitudinal by default	Every CKD 3b–5 and resistant-HTN patient is evaluated for RPM/PCM enrollment at the point of visit — continuous management between quarterly visits becomes the default, not the exception
One front door	A single enrollment workflow (CoachCare-staffed) across both offices, all hospital/SNF discharges, and dialysis-adjacent CKD patients
Attach to existing workflows	TCM and post-discharge RPM ride the rounding the physicians already do at 4 hospitals and 7 SNFs — no new sites of service
Digital as care, not admin	Device data feeds clinical decisions (titration, diuretic adjustment, modality timing); billing capture is a by-product, not the point
Single scorecard	Clinical, operational, and financial KPIs reviewed monthly by the partners (Section 5)
Top-of-license staffing	CoachCare's enrollment, device logistics, and monitoring staff do the acquisition and surveillance work; nephrologists supply oversight and clinical judgment only

2. The Remote Care Service Line — The Spine

2.1 What it is: the nephrology billing stack

The service line is a managed clinical program built on three Medicare code families, sequenced around the nephrology encounter pattern: TCM at the discharge, RPM as the continuous physiologic layer, and PCM as the monthly clinical-management wrapper for CKD. CoachCare operates enrollment, connected devices (cellular blood-pressure cuff and scale), 24/7 alert-and-triage, nurse monitoring, documentation, and billing-report generation; the practice's physicians provide clinical oversight.

Component	Codes	Cadence	Role in the nephrology stack
Transitional Care Management	99495 / 99496	Per discharge	At hospital and SNF discharge — contact within 2 business days, visit within 14/7 days; attaches to existing rounding across 4 hospitals + 7 SNFs. Not included in the modeled forecast — incremental upside.
Remote Physiologic Monitoring	99453, 99454, 99445 (new 2026), 99457, 99470 (new 2026), 99458	Monthly	BP + weight monitoring for CKD 3b–5 and resistant HTN; 99445 makes 2–15-day post-discharge windows billable; the core physiologic data layer
Principal Care Management	99424–99427	Monthly	CKD as the single dominant condition managed by the specialist — care-plan maintenance, medication management, coordination; bills concurrently with RPM (discrete time and documentation)

The coordination rule (one policy, set once)

PCM, CCM, and TCM are never billed for the same patient in the same month by the same practice; **RPM stacks with any of them**. For patients co-managed with referring primary-care physicians, set an attribution policy up front: the nephrology group owns CKD-specific PCM + RPM and TCM at its own discharges; the PCP keeps their general care-management billing; both work from shared data. This is the mechanism behind the referral-durability value layer in 2.2 — the program strengthens PCP relationships instead of competing with them.

2.2 Standalone value: four value layers

- 1. Standalone recurring P&L. Modeled for this practice: \$1,209,683 net reimbursement and \$515,495 practice profit over 24 months — a 24-month practice margin of 42.6% of net reimbursement — with margin turning positive in month two and no negative-margin quarter (Section 6). Revenue is recurring and subscription-like: ≈\$76,000/month in net reimbursement once both censuses sit at ceiling.**
- 2. Delayed dialysis initiation and crash-start avoidance.** Published estimates commonly place unplanned (“crash”) starts at roughly a third or more of U.S. incident dialysis starts; they are

associated with catheter-based initiation, longer hospitalizations, and higher first-year costs and mortality risk. Continuous BP/weight surveillance plus monthly PCM contact gives the group earlier warning of decline — time to slow progression where possible and to plan the start (modality education, access placement) where it is not.

3. **Referral durability with primary care.** A nephrology group that returns structured data to referring PCPs — BP trends, weights, medication changes, care-plan updates — becomes the easiest CKD referral in the market. The attribution policy in 2.1 makes the relationship additive rather than competitive.
4. **First-mover program whitespace.** No remote-care program appears in the practice's public materials (reviewed July 2026), and this is a clean greenfield build. In a market where roughly 53% of New York Medicare beneficiaries are in Medicare Advantage (January 2026) and plans increasingly favor practices that can document continuous management, being the nephrology group with the monitoring infrastructure is a durable strategic position.

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 within 14 / 7 days
RPM 99453	One-time setup	~\$20	Device setup and patient education
RPM 99454 / 99445	Monthly	~\$52–62	Device supply, 16–30 days of data (99454; NY-downstate sample \$62.18); 99445 = new 2026 code for 2–15-day windows
RPM 99457 / 99470	Monthly	~\$52–60 / ~\$26	First 20 treatment-management minutes (99457; NY-downstate sample \$59.90); 99470 = new 2026 first-10-minute code
RPM 99458	Monthly	~\$41	Each additional 20 minutes
PCM 99424–99427	Monthly	~\$60–78	Single high-risk condition (CKD) ≥3 months; staff-time code 99426 NY-downstate sample \$78.01

Rates shown are illustrative national non-facility magnitudes with NY-downstate locality samples where noted (NGS, carrier 13202, locality 02 — the Bethpage ZIP 11714 locality used in the Section 6 model). Actual payment is set by the CY2026 Physician Fee Schedule and the regional MAC; verify current locality rates before financial planning.

Recurring-revenue mechanics

Unlike visit revenue, service-line revenue compounds with census, not schedule density: each enrolled patient generates a predictable monthly billing pattern (RPM device supply + management time, plus PCM), independent of whether that patient has an office visit that month. The modeled census ceilings — 355 RPM and 344 PCM active enrollments — produce ≈\$76,000/month in net reimbursement at steady state without adding physician hours:

CoachCare's monitoring staff performs the surveillance work, and physician involvement is oversight and exception management. *Illustrative, modeled — verify against practice data.*

2.3 The interstitial-care layer: one infrastructure, every lever

Nephrology's defining operational problem is that disease progression is continuous but care is episodic. A CKD 4 patient is typically seen quarterly; progression to a crash start, a missed transplant window, or an uncontrolled-hypertension admission happens between those visits. The Remote Care Service Line is the **interstitial-care layer** — the infrastructure that occupies the space between visits. Built once, it powers every value lever at the same time:

One Infrastructure, Every Nephrology Value Lever

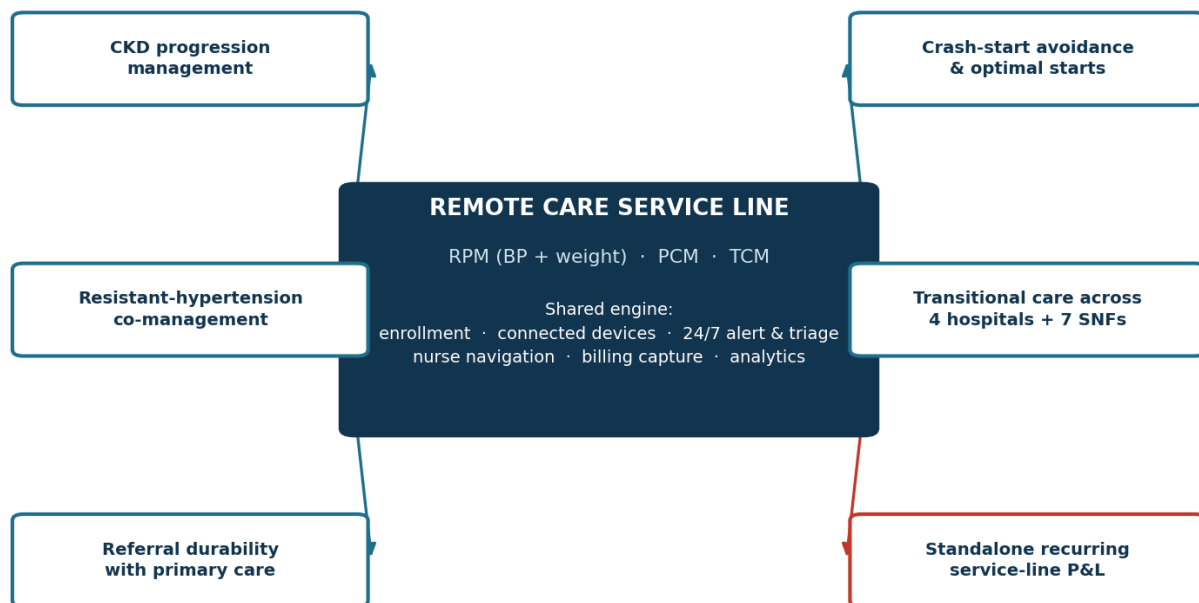


Figure 1. One shared enrollment/device/monitoring/billing engine powers all six nephrology value levers simultaneously.

Value lever	What the shared infrastructure does	Payment vehicle
CKD progression management	Daily BP/weight surveillance; medication-adherence contact; early detection of trajectory change between quarterly visits	RPM + PCM
Resistant hypertension co-management	Home BP trend data replaces single office readings; supports titration decisions and adherence work (clinical co-management with referring PCPs)	RPM + PCM
Crash-start avoidance & optimal starts	Deterioration trends trigger modality education, access planning, home-dialysis preparation while there is still runway	RPM + PCM (program value: avoided admissions)

Value lever	What the shared infrastructure does	Payment vehicle
Transitional care (4 hospitals + 7 SNFs)	Discharge capture on existing rounding; 2-day contact; short-window monitoring through the highest-risk 30 days	TCM + 99445 short-window RPM (upside; not modeled)
Transplant-list stability	BP/weight stability and documented adherence help keep candidates active and evaluation-ready	RPM + PCM
Referral durability	Structured data back to referring PCPs; shared care plan; clean attribution policy	Indirect (referral volume protection)
Standalone P&L	Billing capture, documentation, and claims-report generation on all of the above	\$1.21M net / \$515K profit modeled over 24 months

3. The 2026 Payment Environment for Remote Care

Three features of the CY2026 environment make this the right build year for this group.

Short-window RPM is now billable (new codes 99445 and 99470)

Through CY2025, RPM's device-supply code (99454) required 16 days of readings in a 30-day period — which made short, high-risk monitoring windows effectively unbillable. CY2026 added **99445** (device supply, 2–15 days of data) and **99470** (first 10 minutes of treatment management), making the first two post-discharge weeks a billable monitoring window. For a group whose patients flow through four hospitals and seven SNFs, this converts the TCM period itself into monitored, revenue-bearing time — the exact window when readmission risk and medication churn peak.

A mature, concurrent code stack

RPM and PCM bill concurrently for the same patient in the same month with discrete time and documentation — Medicare's explicit design for specialty chronic-disease management. The modeled economics in Section 6 assume roughly 70% of PCM patients are dual-enrolled in RPM, which is the operating pattern the codes were built for: the device layer generates the data; the PCM layer does the monthly clinical management on top of it.

A majority-Medicare Advantage market

As of January 2026, roughly 53% of New York Medicare beneficiaries — about 2.1 million people — are enrolled in Medicare Advantage (statewide figure; Nassau/Suffolk county-level rates not separately verified). Two implications: first, MA plans generally mirror Part B coverage of RPM/PCM/TCM, so the revenue model extends across most of the panel; second, MA plans concentrate network and referral advantages on practices that can demonstrate continuous management and lower admission rates. The documented monitoring record this service line produces is exactly that demonstration.

Rate discipline

All rates cited in this report are illustrative CY2026 magnitudes; the Section 6 model prices claims at the NY-downstate locality (NGS carrier 13202, locality 02). Verify against the current-year fee schedule and payer mix before budgeting. *Illustrative, modeled — verify against practice data.*

4. Clinical Value Pathways

4.1 CKD progression management between visits

Blood pressure is the most modifiable driver of CKD progression, and office readings taken four times a year are a poor proxy for it. Home BP and weight streams give the nephrologist a continuous view: sustained pressure elevation prompts titration between visits; weight inflection flags fluid retention before it becomes an admission; missed-reading patterns expose adherence problems early. The monitoring engine handles surveillance and first-line outreach; the nephrologist sees exceptions, not noise. Over a panel, this converts quarterly snapshots into managed trajectories — the clinical core of the interstitial-care layer.

4.2 Resistant hypertension co-management

The practice already treats hypertension as a named service. For resistant-hypertension patients, home BP trend data is the difference between guessing and managing: it distinguishes true resistance from white-coat effect and non-adherence, and it gives titration decisions a feedback loop measured in days instead of quarters. Framed to referring PCPs, this is a co-management offer — send the difficult hypertensive, get back a monitored, titrated patient with a data record — which reinforces the referral-durability layer in Section 2.2.

4.3 Optimal starts and crash-start avoidance

An unplanned dialysis start — initiated in hospital, typically via catheter — is the most expensive and most dangerous way to begin renal replacement therapy; published estimates commonly place unplanned starts at roughly a third or more of U.S. incident starts. The countermeasure is time: enough warning to educate on modality (including home dialysis), place access, and schedule the start. Continuous RPM data plus monthly PCM contact is precisely the early-warning system — deterioration trends become triggers for the optimal-starts conversation while there is still runway. The practice's public materials acknowledge home dialysis as a patient option without describing a structured preparation program; this pathway supplies the infrastructure such a program runs on. The model values each avoided hospitalization at \$15,000 (planning assumption); Section 6.4 quantifies the modeled avoidance volume.

4.4 Transplant-list stability

Transplant candidacy is won and lost between evaluations: uncontrolled blood pressure, fluid overload events, and documentation gaps stall or deactivate listings. For the group's transplant-track patients, the same RPM/PCM layer maintains the stability record — controlled pressures, stable weights, documented adherence — that keeps candidates active, evaluation-ready, and attractive to transplant centers.

4.5 Transitional care on existing rounding workflows

The group's physicians already round at four hospitals and seven SNFs — they are frequently the first to know a patient is being discharged. TCM converts that position into a billable, protocolized pathway: contact within two business days, medication reconciliation, a face-to-face within 7/14 days, and — new in CY2026 — a billable short-window RPM period (99445) through the highest-risk

weeks. For SNF-heavy panels, this is the difference between learning about the readmission and preventing it. TCM volume is deliberately **not included** in the Section 6 forecast: with seven SNF affiliations feeding discharges, it is material upside to the modeled figures.

5. Operating System for Service Line Performance

A service line earns the name when it is governed like one. One scorecard, reviewed monthly by the partners, spanning three domains:

Domain	KPI	Target / notes
Clinical	BP control rate among enrolled (<140/90 sustained)	Trend up quarter over quarter; the headline clinical metric
Clinical	Planned-start share of incident dialysis starts	Track planned vs. unplanned; the crash-start countermeasure metric
Clinical	Home-modality share of new starts	Follows the optimal-starts pathway (4.3)
Clinical	Enrolled-patient admissions per 100 per year	Model plans on ≈44 avoided hospitalizations over 24 months (6.4)
Operational	Enrolled census — RPM / PCM	Ramp to ceilings: RPM 355 by month 11; PCM 344 by month 23
Operational	Time-to-first-billable-enrollment	Days from program launch to first claim; the launch-quality metric
Operational	Data-days compliance (16+ days/month)	Drives 99454 capture; monitoring-engine outreach keeps it high
Financial	Capture rate (billable events billed)	The discipline metric — CoachCare billing reports make it auditable
Financial	Net revenue per enrolled patient per month	Steady-state model: ≈\$76,000/mo across 458 unique patients (699 program enrollments)
Financial	Actual vs. modeled net reimbursement	Monthly variance review against the Section 6 curve

The scorecard is deliberately small. Ten numbers, one page, monthly cadence — enough to steer enrollment pace, catch capture leakage early, and give the partners a factual basis for the month-12 decision about expanding scope (TCM formalization, panel expansion, APP-driven growth).

6. Modeled Economics: The Value Analysis

This section summarizes a CoachCare Value Analysis built for Long Island Kidney Associates in July 2026, priced at the practice's own Medicare locality (NGS, carrier 13202, locality 02 — Bethpage ZIP 11714). Illustrative, modeled — verify against practice data.

6.1 Panel estimate and modeling assumptions

Panel size is an estimate — validate first

The model uses **1,350 Medicare patients**, the midpoint-leaning value of an estimated range of **1,100–1,420**. Method: the practice's public Medicare allowed-charge magnitude divided by a per-beneficiary-year revenue norm yields a $\approx 1,420$ upper bound (the divisor is calibrated on cardiology practices, so it is treated as an upper bound for nephrology), corroborated by ≈ 270 Medicare patients per physician across five nephrologists. The first discovery step is replacing this estimate with actual chart counts — every modeled figure scales with it.

Input	Value used	Note
Medicare panel (in scope, year 1)	1,350 (estimate)	Range 1,100–1,420; validate against practice data
Billing providers	5 physicians	No APPs publicly listed; any confirmed APPs raise capacity — upside
Programs modeled	RPM + PCM	CCM held at \$0 (structural in the model, not a demand forecast); TCM excluded — upside
Eligibility and acceptance	75% eligible (RPM) / 85% (PCM); 35% (RPM) / 30% (PCM) accept	1,013 RPM-eligible and 1,148 PCM-eligible. In a nephrology panel, chronic kidney disease genuinely is the single dominant condition Principal Care Management was written for — which is why PCM's eligible share is the highest in the stack
Enrollment staffing	1 dedicated on-site enrollment specialist	CoachCare-funded — CoachCare's expense, not deducted from practice figures
Rates	CY2026 PFS, NY-downstate locality	NGS carrier 13202, locality 02

6.2 Headline results

Modeled result	Year 1	Year 2	24-month
Net reimbursement to practice	\$380,183	\$829,500	\$1,209,683
— RPM	\$267,929	\$478,761	\$746,691
— PCM	\$112,253	\$350,739	\$462,992

Modeled result	Year 1	Year 2	24-month
CoachCare fees (all-in)	\$223,422	\$470,766	\$694,188
Practice profit	\$156,761	\$358,734	\$515,495

24-month practice margin: 42.6% of net reimbursement (Year 1 41.2%, Year 2 43.2%). Values are rounded to the nearest dollar and Year 2 is stated as the 24-month total less Year 1, so individual rows may differ by \$1. Implementation and EMR-integration setup costs land in month one, producing a modeled month-one result of -\$4,066; margin turns positive in month two (+\$2,333) and every month thereafter — there is no negative-margin quarter — with cumulative breakeven in month three. The on-site enrollment specialist is CoachCare's expense: embedded value that is never subtracted from the practice margin above.

6.3 Ramp, ceilings, and month-by-month shape

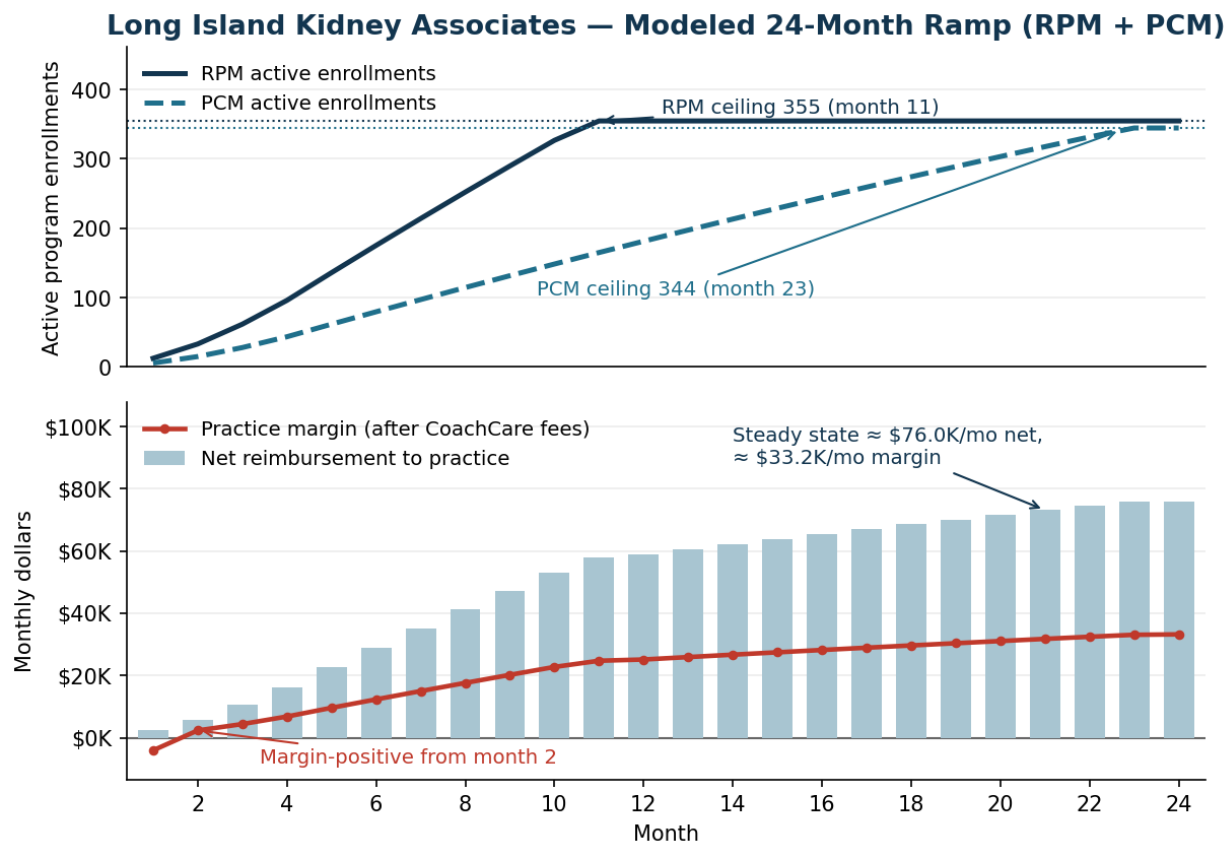


Figure 2. Modeled 24-month enrollment and financial ramp. Illustrative, modeled — verify against practice data.

- **RPM ceiling: 355 active enrollments** ($1,350 \times 75\% \text{ eligible} \times 35\% \text{ acceptance}$), reached in month 11 and held.
- **PCM ceiling: 344 active enrollments** ($1,350 \times 85\% \text{ eligible} \times 30\% \text{ acceptance}$), reached in month 23 and held.
- **Steady state (month 23 onward):** ≈\$76,000/month net reimbursement, ≈\$33,200/month practice profit.

- **Enrolled patients vs. enrolled services: program enrollments total 699 at month 24, but with ≈70% of PCM patients dual-enrolled in RPM those enrollments represent 458 unique patients — about 34% of the estimated panel. The 458 is the patient count; the 699 is the sum of program enrollments.**

6.4 Clinical and operational value

Modeled 24-month clinical/operational output	Value
Claims / billable units generated	≈19,049
Physiologic readings captured	≈68,881
Hospitalizations avoided (modeled)	≈43.7 — ≈\$656,000 at a \$15,000-per-admission planning value
Care-team hours saved (CoachCare performs the monitoring work)	≈9,312 hours ≈ 4.5 FTE-years

The staffing line deserves emphasis: the enrollment specialist and the monitoring/triage workforce are **CoachCare's expense and CoachCare's payroll**. The ≈9,312 hours of surveillance, outreach, and documentation over 24 months is capacity the practice does not have to hire, train, or manage — embedded value on top of the modeled profit, not a cost against it.

Reading these numbers

All figures in this section are outputs of a parameterized model: locality-priced CY2026 rates, estimated panel size, and the program's nephrology eligibility and acceptance assumptions. They are planning magnitudes, not commitments. **Illustrative, modeled — verify against practice data.**

7. Implementation Playbook

7.1 First-call discovery agenda

1. **EMR confirmation.** Public signals about the practice's EMR conflict — a commercial healthcare dataset of older vintage lists one ambulatory vendor, while a physician-directory listing points to a different platform. Neither is confirmed. Confirming the current vendor and version is the first agenda item; it determines the integration path and finalizes a small EMR-dependent fee component in the model.
2. **Panel validation.** Replace the 1,350 estimate (range 1,100–1,420) with actual Medicare chart counts by CKD stage — every modeled figure scales with this input.
3. **Provider roster.** Confirm whether the group employs NPs/PAs (none are publicly listed). Each additional billing provider raises enrollment capacity and the model's ceilings.
4. **Discharge volumes.** Size the TCM opportunity: monthly discharges the group touches across the four hospitals and seven SNFs. TCM is excluded from the current forecast, so this is pure upside sizing.

7.2 Scope, staffing, and the CoachCare operating model

Target populations, in enrollment order: (1) CKD stages 3b–5 with hypertension — the RPM/PCM core; (2) resistant-hypertension referrals; (3) transplant-track patients; (4) post-discharge patients from hospital/SNF rounding (TCM pathway, once formalized). Enrollment happens at the point of care — the physician introduces the program; CoachCare's on-site enrollment specialist completes consent, device provisioning, and education the same day.

Function	Who does it	Notes
Program leadership & clinical oversight	Practice (physician champion)	Recommend one named partner as service-line lead
Enrollment & patient onboarding	CoachCare enrollment specialist (on-site)	CoachCare-funded; modeled at 1 FTE
Device logistics (cellular BP cuff, scale)	CoachCare	Pre-provisioned, cellular — no patient Wi-Fi or app dependency
Daily monitoring, 24/7 alert & triage	CoachCare clinical monitoring staff	Escalation protocol set with the practice; physicians see exceptions only
Monthly PCM care management	CoachCare care staff under practice supervision	Documented to code requirements
Billing reports & claims support	CoachCare	Monthly claims-ready reporting into the practice's billing workflow
Claim submission	Practice billing	Practice bills under its own NPIs and retains all reimbursement

7.3 Technology, EMR, and billing architecture

The platform stack is deliberately EMR-independent at its core: cellular devices transmit directly to the CoachCare platform; monitoring, alerting, and documentation live there; and monthly billing packages are delivered claims-ready regardless of the practice-management system in use. On top of that base, CoachCare maintains integrations across the major ambulatory EHR platforms for chart-synchronized documentation where the practice wants it. Because the practice's EMR vendor is unconfirmed (see 7.1), this report deliberately does not assume a specific integration; the model carries an EMR integration allowance, and the integration approach — full integration versus claims-ready reporting — is finalized once the vendor and version are confirmed on the first call. Neither path changes the clinical program or the reimbursement model.

7.4 12-month roadmap

Phase	Months	Milestones
Discover & configure	1	Discovery items in 7.1; BAA and program agreements; escalation protocols; EMR path selected; enrollment specialist onboarded. Implementation costs land here (modeled month-one net of −\$4,066)
Launch RPM	1–2	First cohort enrolled from CKD 3b–5 / resistant-HTN lists; first claims cycle; margin-positive from month two
Layer PCM	2–4	PCM enrollment begins for CKD-dominant patients; dual-enrollment workflow (RPM + PCM) standard
Scale to RPM ceiling	3–11	Steady enrollment cadence to the 355-enrollment RPM ceiling (month 11); monthly scorecard review begins (Section 5)
Formalize TCM	6–9	Discharge-capture workflow live across hospital/SNF rounding; 99445 short-window monitoring post-discharge; incremental to modeled figures
Optimize & decide	9–12	PCM census ≈181 and climbing toward its month-23 ceiling; year-one review vs. model; decision package: TCM formalization, APP capacity, home-dialysis preparation program build-out

7.5 About CoachCare

CoachCare operates remote care programs as a full-service partner — enrollment, devices, monitoring, documentation, and billing support — under the practice's brand and NPIs.

Dimension	Track record
Patient management	400+ managed conditions across 500,000+ patients
Clinician network	10,000+ providers committed to remote care
In-market success	1,000+ successful implementations
Operational scale	5 million+ claims supported; 100 million+ vitals recorded; 4 million+ care actions enabled

References & Data Sources

- Long Island Kidney Associates, P.C. — likadoc.com (home, Our Physicians, Our Services, Hemodialysis, Nursing Facility Affiliations, Contact pages). All site content fetched and reviewed July 2026.
- NPPES NPI Registry, organizational NPI 1295036531 (accessed July 2026). Note: organizational record last updated 2010; officer details subject to change.
- CMS CY2026 Medicare Physician Fee Schedule — RPM (99453/99454/99445/99457/99470/99458), PCM (99424–99427) and TCM (99495/99496) code values; NY-downstate locality pricing via NGS (carrier 13202, locality 02).
- healthinsurance.org, “Medicare in New York” — New York Medicare Advantage enrollment ≈53% of beneficiaries as of January 2026 (statewide; county-level rates not separately verified).
- CoachCare Value Analysis workbook for Long Island Kidney Associates, P.C., built July 2026 (source of all modeled economics in Section 6).
- CoachCare company statistics — coachcare.com (July 2026).

Global caveat

This report was prepared from public sources (vintages noted throughout) and a parameterized economic model. Panel size is an estimate pending chart-count validation; the EMR vendor is unconfirmed pending discovery; advanced-practice staffing is unverified. All reimbursement figures are illustrative CY2026 magnitudes priced at the NY-downstate locality and are subject to fee-schedule and payer-mix variation. All modeled figures are illustrative, modeled — verify against practice data. Questions and follow-up: Connor Knapp, CoachCare — connor.knapp@coachcare.com.