COACHCARE · REMOTE CARE STRATEGY

Ocala Kidney Group, Inc.

Nephrology Service Line
Performance & Optimization — 2026 Strategy Report

A Remote Care Service Line (RPM + PCM) as the operating spine — and the **performance engine behind the practice's CKCC / KCE shared-savings contract.**

> **Purpose of this report**
> This document reads Ocala Kidney Group's own public operating position — an independent, value-based-care-forward nephrology group carrying downside risk inside a DaVita-managed Kidney Contracting Entity — and lays out how a physician-led, in-clinic Remote Care Service Line becomes both a new professional-fee revenue line **and** the interstitial-care infrastructure that drives the group's total-cost-of-care performance. All financial figures are illustrative and modeled; they are meant to frame a conversation, not to quote a contract, and should be verified against the practice's own data.

Prepared for: Rafael L. Mulet, Chief Administrative Officer · Dr. Rebecca Ong, KCE Governing Body Designee
Prepared by: CoachCare — Remote Patient Monitoring & Chronic Care Management
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Executive Summary

Ocala Kidney Group is an independent, physician-owned nephrology practice that has served Marion County and the surrounding retiree-dense corridor since 1984. It operates three offices — two in Ocala plus a Leesburg clinic that anchors the Lake County / Villages corridor — with roughly ten to eleven board-certified nephrologists, two of them fellowship-trained interventionalists, and about eight advanced-practice providers. The group runs its own dialysis vascular access center and holds dialysis-unit medical directorships across a DaVita-dense market. **This is not a practice that needs convincing about value-based care: it already carries it.**[1]

Starting position. Ocala Kidney Group is a confirmed participant in the CMS Kidney Care Choices (KCC) model through the Comprehensive Kidney Care Contracting (CKCC) option — specifically the DaVita-managed Kidney Contracting Entity **Integrated Kidney Care of Florida, LLC**, with Dr. Rebecca Ong seated on the KCE governing body.[2] That means the group already shares accountability for the total cost of care of its aligned fee-for-service Medicare CKD and ESRD patients. It has made the bet. What it does not yet have is the day-to-day, between-visit clinical infrastructure — connected monitoring, structured titration, transition-of-care follow-up — that actually moves total cost of care. That gap is the opportunity.

The 2026 payment backdrop reinforces the timing. CMS extended the CKCC options (Graduated, Professional, and Global) through December 31, 2027, keeping the shared-savings machinery running for at least two more performance years, while the 2026 Physician Fee Schedule continues to pay for remote physiologic monitoring and principal care management — including new short-window monitoring codes. In other words, the same clinical work is reimbursed twice: once as professional fees, and again as improved performance against the KCE benchmark.[3]

> **The central argument — value two ways at once**
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> 1. **Standalone value.** A managed Remote Care Service Line — RPM and PCM at top-of-license staffing, with TCM at every hospital discharge — is a recurring, subscription-like professional-fee line that is margin-positive before a single value-based dollar is counted. Over 24 months the model projects about **$2,976,447 in net Medicare reimbursement** and roughly **$1,260,083 in practice profit after CoachCare's fees, about a 42% margin.**
> 2. **Connective tissue.** That same infrastructure — enrollment, connected BP and weight devices, 24/7 alert-and-triage, nurse navigation, titration support, billing capture, analytics — is exactly what drives CKCC / KCE performance: fewer hospitalizations, crash-start avoidance, readmission reduction. Build the engine once; it pays as fee-for-service revenue and as shared-savings performance simultaneously.

The clinical wedge. Nephrology is a quarterly-visit specialty caring for a disease that progresses continuously. Between those visits — as blood pressure drifts, weight climbs, and CKD advances toward stage 5 — is where crash-starts, avoidable admissions, and unplanned dialysis initiations are decided. A Remote Care Service Line is the interstitial-care layer for that gap: the connective tissue between quarterly visits, where progression actually happens.

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[1] Ocala Kidney Group — practice website (About Us, Meet the Team, Locations), ocalakidneygroup.com, accessed July 2026. Provider count and locations verified; ~$4.39M Medicare-allowed figure treated as an unverified input to confirm in discovery.

[2] DaVita CKCC portal — "KCE Leadership, Participants, and Providers | IKC of Florida, LLC," ckcc.davita.com/ikc-florida/kce-leadership-participants-providers-fla/. IKC of Florida is a Cohort 1 CKCC entity participating under the Professional option per the CMS KCC participant list (cms.gov/files/document/kcc-model-participants-cy2025.pdf). Confirm the entity's current-year risk arrangement in contracting.

[3] CMS, Kidney Care Choices (KCC) Model and "Kidney Care Choices Model Performance Year 2026 Model Update," cms.gov, 2025; the KCF option closes at the end of 2025 while the CKCC (Graduated/Professional/Global) options are extended through Dec 31, 2027.

An honest read on the panel. This corridor is one of the most Medicare-Advantage-saturated in the country. CKCC aligns only traditional fee-for-service Medicare, and RPM/PCM reimbursement on Medicare Advantage patients is plan-dependent — so the value model must be segmented, not applied uniformly across the panel. Panel and enrollment figures in this report are illustrative estimates and should be confirmed against the practice's actual data before contracting. Section 5 states these assumptions plainly.

2026–2027 Priority Recommendations

1. **Stand up a physician-led Remote Care Service Line (RPM + PCM).** Launch BP/weight RPM and CKD-focused PCM as one managed service line across all three offices, staffed at top-of-license with CoachCare-funded enrollment and monitoring labor.
2. **Wire the service line directly to the CKCC / KCE scorecard.** Instrument the program around the metrics that move total cost of care — admissions, crash-starts, 30-day readmissions — so every enrolled patient is simultaneously a billable encounter and a shared-savings data point.
3. **Make crash-start avoidance the flagship use case.** Target CKD stage 4–5 patients approaching transition; use monitoring and titration to convert unplanned, catheter-based "crash" starts into planned, access-ready, home-modality-eligible starts — the single largest cost lever in the KCE.
4. **Segment the panel by payer before sizing.** Confirm the fee-for-service vs. Medicare Advantage split and the CKD-stage distribution to size the addressable population honestly and set realistic enrollment targets.
5. **Deploy on the native Greenway integration.** Enroll, document, and bill inside the existing Greenway environment via CoachCare's native integration — confirm the exact product and version (Intergy vs. Prime Suite) in technical discovery.
6. **Coordinate with DaVita IKC rather than duplicate it.** Position CoachCare as the in-clinic, physician-led, billing-generating layer that feeds KCE performance — complementary to any population-health support the KCE already provides.

1. Footprint & Operating Model

Ocala Kidney Group is the established independent nephrology practice in Marion County. It is physician-owned, with no private-equity or platform backing — its value-based exposure comes through a **contract** with DaVita's Kidney Contracting Entity, not through ownership. The practice has grown its clinical and administrative bench steadily, including recent finance/HR and advanced-practice hires, a signal of a back office maturing toward larger operational commitments.

Footprint

Dimension	What we see
Offices	Three: main Ocala (SE 3rd Ct.), West Ocala / admin HQ (Route 200 corridor), and Leesburg (Lake County). The Villages tie is via dialysis-unit medical directorships and hospital privileges, not a clinic.
Clinicians	~10–11 board-certified nephrologists (two fellowship-trained interventionalists, FASDIN) + ~8 advanced-practice providers — roughly 18 clinical providers.
Procedural capability	Owns a Dialysis Vascular Access Center staffed by interventional nephrologists — unusual clinical sophistication and a native fit for access-ready, planned-start workflows.
Hospital affiliations	AdventHealth Ocala (fka Munroe Regional), Ocala Regional Medical Center,

Dimension	What we see
	West Marion Community Hospital.
EMR	Greenway (confirmed via the myhealthrecord.com patient portal). Product line — Intergy vs. Prime Suite — to be confirmed in contracting (lean Intergy).
Value-based posture	Confirmed CKCC participant inside DaVita's Integrated Kidney Care of Florida, LLC; Dr. Rebecca Ong on the KCE governing body.

The buying center

This is a value-based-care conversation, not a CPT-capture pitch, and the decision map reflects that. **Rafael L. Mulet** (VP Strategic Execution & Chief Administrative Officer) is the top operational decision-maker — the owner of the practice's economics and infrastructure. **Dr. Rebecca Ong**, as the KCE governing-body designee, is the value-based-care champion who connects clinical strategy to the shared-savings contract. Finance/HR (Debbie Schlosser), operations (Zina Padgett), and billing (Annette Gutekunst) round out the implementation stakeholders.

Design principles for a remote-care operating model

Principle	What it means at Ocala Kidney Group
Longitudinal by default	CKD is continuous; care between quarterly visits becomes the default, not the exception.
One scorecard	Fee-for-service capture and CKCC total-cost-of-care performance are read on a single dashboard, not in separate silos.
Hub-and-spoke	One central monitoring and triage engine serves all three offices and every dialysis-directorship relationship.
Top-of-license staffing	Nurses and care managers run enrollment, monitoring, and titration support; physicians practice at the top of their license.
Digital as care	Connected devices and 24/7 alerting are treated as clinical care delivery, not IT — and are documented and billed as such.

2. The Remote Care Service Line — The Spine

Everything in this report rests on one idea: a **single managed service line** that Ocala Kidney Group runs as its own — not a vendor bolt-on — delivering value two ways at once. Because this is an independent nephrology group and not a primary-care panel owner, the architecture is a single **specialty arm**: remote physiologic monitoring (RPM) and principal care management (PCM), with transitional care management (TCM) at every hospital discharge. There is no separate primary-care billing arm in this model.

2.1 What it is — the specialty-arm stack

Layer	Codes	What it does clinically
TCM — transition at discharge	99495 / 99496	Structured 30-day post-hospitalization transition; 2-business-day contact plus a follow-up visit. Directly attacks the 30-day readmissions that hit the KCE benchmark.
RPM — the monitoring engine	99453 · 99454 / 99445 · 99457 / 99470 · 99458	Connected BP and weight monitoring for CKD and resistant hypertension. Setup, device/data,

Layer	Codes	What it does clinically
		and treatment-management time — including new short-window monitoring codes for transitional periods.
PCM — the CKD wrapper	99426 / 99427	Principal care management for the single dominant high-risk condition (advanced CKD): monthly care-plan management, titration, coordination — the interstitial layer between quarterly visits.

The one coordination rule to set up front

RPM and PCM may be billed together for the same patient in the same month, provided the time and documentation are discrete — this is what makes the combined per-patient economics work. The rule to govern is **attribution for shared patients**: principal care management (PCM) and a primary physician's chronic care management (CCM) cannot both be billed for the same patient in the same month. Set a simple policy — nephrology owns the PCM wrapper for the dominant CKD condition plus RPM and TCM-at-discharge; the primary-care physician owns any longitudinal CCM — governed by one shared care plan in Greenway.

2.2 Standalone value — four value layers & the billing stack

Before any shared-savings upside, the service line stands on its own across four value layers:

1. **Direct professional-fee revenue.** Recurring, subscription-like RPM and PCM fees at top-of-license staffing — the layer modeled in dollars below.
2. **Avoided cost.** Fewer hospitalizations and readmissions across the panel — roughly 154 admissions avoided over 24 months in the model, worth on the order of $2.31 million at $15,000 per admission.
3. **Value-model performance.** The same clinical activity that generates fees also improves the practice's CKCC / KCE total-cost-of-care position (Section 6).
4. **Referral durability & strategic defense.** A daily-touch program deepens the group's relationships with referring primary care and health-system partners and hardens its position as the independent nephrology group of record in the corridor.

The CY2026 billing stack (Florida locality)

Rates below are Florida-locality 2026 magnitudes resolved for the practice's ZIP (carrier/locality 09102-99, First Coast Service Options). They are **illustrative — verify the current-year Physician Fee Schedule and local MAC pricing in contracting**; they are shown to size the opportunity, never as a quote.

Service / code	Type	FL 2026 magnitude	Notes
TCM 99495 / 99496	Per discharge	~$200 / ~$280	Moderate / high complexity; 2-business-day contact + visit
RPM 99453	One-time setup	~$21	Requires ≥2 days of data
RPM 99454 / 99445	Monthly (device/data)	~$50	99454 = 16–30 days; 99445 = new 2–15-day short-window code (2026)

Service / code	Type	FL 2026 magnitude	Notes
RPM 99457 / 99470	Monthly (management)	~$51 / ~$26	First 20 min / new first-10-min code (2026)
RPM 99458	Monthly (add'l)	~$41	Each additional 20 min
PCM 99426 / 99427	Monthly (specialty)	~$68 / ~$54	Principal care management for the dominant CKD condition

Recurring-revenue mechanics

A CKD patient enrolled in both RPM and PCM generates roughly **$150–$170 per patient per month** in professional fees (device/data + monitoring time + the PCM wrapper), billed every month the patient stays engaged. Multiply modest steady-state enrollment across a multi-thousand-patient panel and the line compounds — which is exactly what the 24-month build in the next figure shows: a Year-1 ramp that roughly triples into Year 2 as census matures.

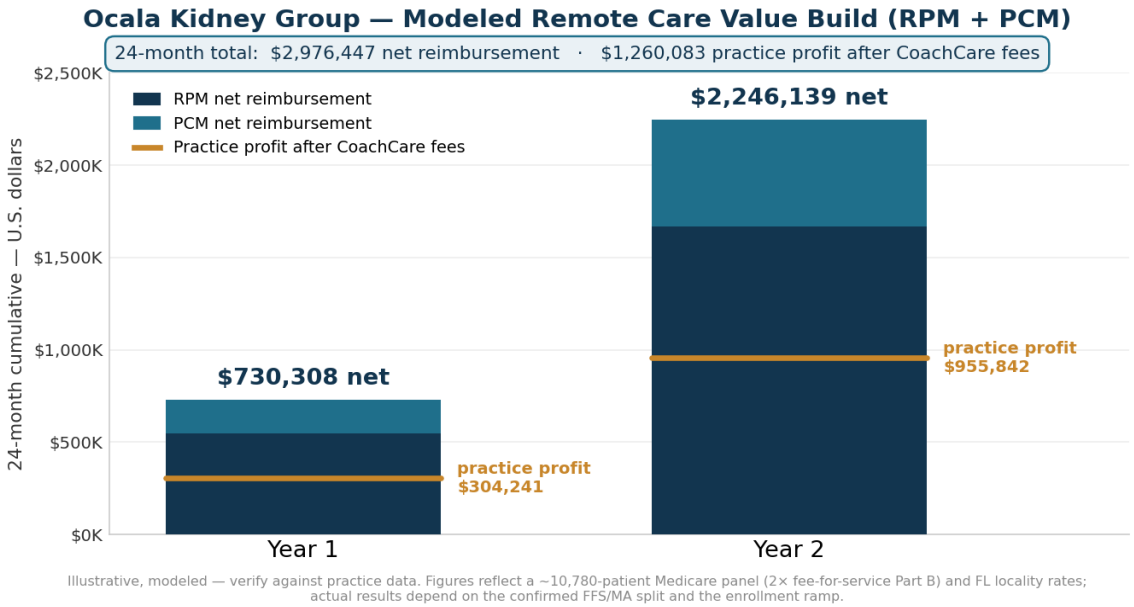

Figure 1. Modeled 24-month value build — RPM + PCM net reimbursement by year, with practice profit after CoachCare fees. Illustrative, modeled — verify against practice data.

2.3 Connective tissue — one engine, every lever

The reason to build this once is that the same operating system serves every lever the practice cares about. Enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, titration support, billing capture, and analytics are a single shared engine. Point it at a billable encounter and it produces professional-fee revenue; point it at the KCE benchmark and it produces shared-savings performance. **It is the same engine.**

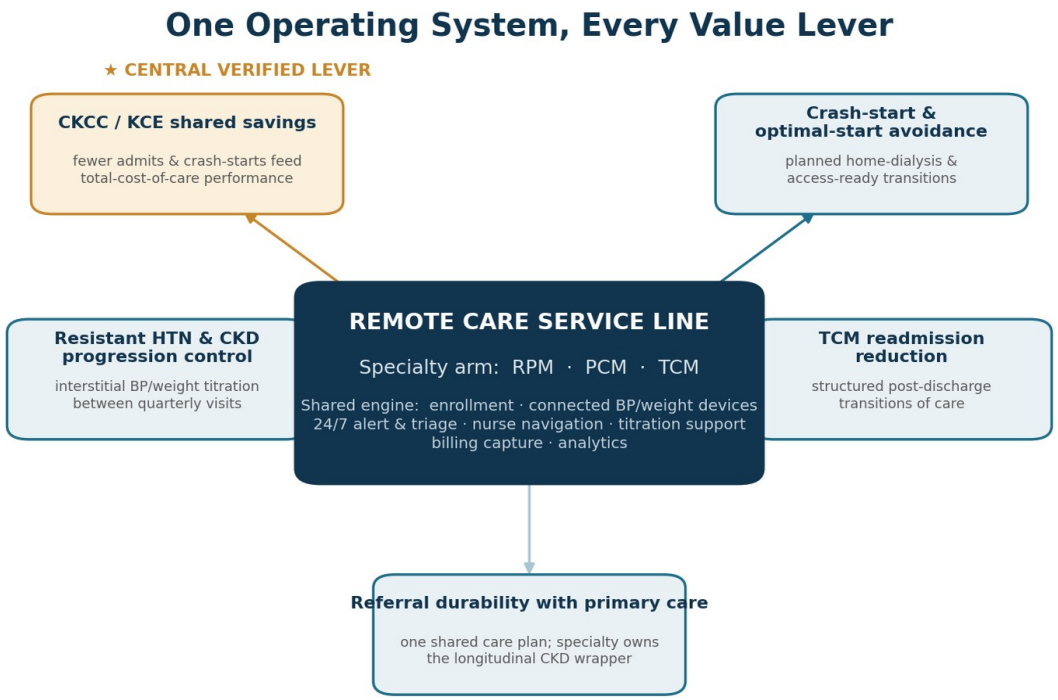

Figure 2. One operating system, every value lever. The CKCC / KCE lever (gold) is the verified, central performance driver for Ocala Kidney Group.

How the same infrastructure powers each lever

Lever	How the one engine powers it
CKCC / KCE shared savings (verified)	Admissions avoided, crash-starts prevented, and readmissions reduced flow straight into the KCE total-cost-of-care math — the practice's live shared-savings contract.
Crash-start & optimal-start avoidance	Monitoring + titration convert unplanned catheter starts into planned, access-ready, home-modality-eligible starts — the largest single cost driver in the KCE.
Resistant HTN & CKD progression control	Interstitial BP/weight titration between quarterly visits slows progression and controls resistant hypertension (a clinical lever, not a procedural one).
TCM readmission reduction	Structured post-discharge transitions cut the 30-day readmissions that hit both fee-for-service and the KCE benchmark.
Referral durability with primary care	One shared care plan; nephrology owns the longitudinal CKD wrapper, deepening PCP relationships rather than competing with them.
Standalone P&L	Every enrolled patient is a recurring professional-fee encounter — margin-positive before any value-based dollar.

3. 2026 Policy & Payment Environment: CKCC / KCE

For most specialty groups the 2026 policy question is whether any CMS model applies at all. Ocala Kidney Group is past that question: it is already inside one. That is what makes this account different — the value-based lever is not a maybe, it is a signed contract.

The model, briefly

The CMS Kidney Care Choices (KCC) model, run through CMMI, lets nephrology entities take accountability for the total cost of care of aligned **fee-for-service** Medicare beneficiaries with late-stage CKD (stage 4–5) and ESRD. Under the Comprehensive Kidney Care Contracting (CKCC) option, a Kidney Contracting Entity (KCE) is measured against a cost benchmark and shares in savings — or losses — depending on its risk track. CMS has extended the CKCC options (Graduated, Professional, and Global) through December 31, 2027.

CKCC risk track	Mechanics
Graduated	One-sided entry phasing incrementally into two-sided risk — lower reward, lower exposure.
Professional	50% shared savings / 50% shared losses on the total cost of Part A and Part B services for aligned beneficiaries.
Global	100% risk for the total cost of all Part A and Part B services for aligned beneficiaries — maximum reward and exposure.

Integrated Kidney Care of Florida, LLC — the KCE Ocala Kidney Group participates in — is a Cohort 1 CKCC entity participating under the **Professional** option per the CMS participant list, which implies a roughly 50/50 share of savings and losses on aligned patients' total cost of care. **Confirm the entity's current-year risk arrangement in contracting**, because it sets the exact dollar value of every avoided admission and every prevented crash-start.

The Medicare Advantage caveat — segment, do not over-index

Honest sizing: two populations, not one

This corridor is Medicare-Advantage-heavy — MA penetration in the Villages market runs around 60%, well above the national average. Two consequences the model must respect:

- **CKCC aligns fee-for-service Medicare only.** The shared-savings math applies to the FFS segment of the panel, not the MA segment.
- **MA is modeled at fee-for-service rates.** MA plans are federally required to reimburse at least 100% of Medicare's allowables, so fee-for-service magnitudes are a defensible planning proxy across the panel — confirm each plan's actual terms in contracting.

The practical move is to segment: the FFS cohort delivers professional fees **and** CKCC performance; the MA cohort delivers professional fees at plan terms and better clinical outcomes. Confirm the actual FFS/MA split in discovery before finalizing enrollment targets.

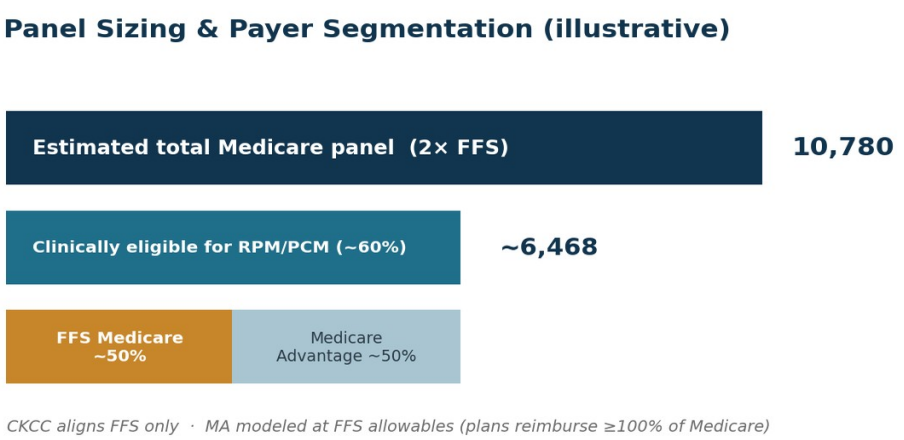

Figure 3. Panel sizing and payer segmentation (illustrative). Panel = 2× fee-for-service Part B (≈5,390 FFS + ≈5,390 MA); MA modeled at FFS allowables, CKCC attributes FFS only — confirm the FFS/MA mix against practice data.

Why this is one transformation, not two projects

The RPM/PCM service line and the CKCC contract are not separate initiatives competing for the same nurses. They are the same initiative viewed from two angles. Every enrolled patient produces a professional-fee encounter and a total-cost-of-care data point; every prevented admission books as avoided cost and as KCE savings. Run one program, measured on one scorecard, and both the fee-for-service line and the shared-savings line improve together.

4. An Operating System for Service-Line Performance

A service line needs an operating system, not just a billing code. The balanced scorecard below reads clinical, operational, financial, and value-model performance on one page — and includes a dedicated remote-care row so the service line is managed like the business it is.

Domain	Representative measures
Remote Care Service Line	Enrolled census; time-to-first-billable-enrollment; billing-capture rate; net revenue per patient per month; device-connectivity / adherence rate.
Clinical (CKD)	Blood-pressure control in resistant HTN; eGFR trajectory / progression rate; % of transitions that are planned (non-crash) starts; home-modality and transplant-referral rates.
Utilization / KCE	Admissions per 1,000 aligned patients; 30-day readmission rate; crash-start rate; ED visits — the levers that move the CKCC benchmark.
Operational	Care-team hours saved and reallocated; alert-to-action time; enrollment throughput per pathway (referral / telephonic).
Financial	Net professional-fee reimbursement; practice profit after fees; projected shared-savings contribution.

CKCC / KCE readiness checklist

- **Attribution & payer segmentation set —** FFS vs. MA identified; aligned CKCC beneficiaries flagged in Greenway so performance is measured on the right denominator.
- **Crash-start registry live —** CKD stage 4–5 patients approaching transition are actively tracked and prioritized for monitoring and access planning.
- **Transition-of-care pathway wired —** Every hospital discharge triggers a TCM workflow and 30-day monitoring window.
- **Shared care plan with primary care —** One care plan in the EMR; attribution policy prevents PCM/CCM double-billing.
- **KCE coordination defined —** Clear division of labor between CoachCare's in-clinic layer and any DaVita IKC population-health support.

5. Performance Snapshot & Economic Model

Because Ocala Kidney Group is a physician group rather than a hospital, its "performance snapshot" is not a CMS readmissions chart — it is the modeled economics of standing up the service line across its panel. The figures below come from the practice's CoachCare Value Analysis, built on Florida locality rates and a nephrology-specific eligibility and enrollment model. **They are illustrative and modeled — every figure should be verified against the practice's own data.**

Financial value — 24-month projection

Metric	Year 1	Year 2	24-month
Net reimbursement — RPM	$546,300	$1,669,910	$2,216,210
Net reimbursement — PCM	$184,008	$576,229	$760,237
Net reimbursement — total	**$730,308**	**$2,246,139**	**$2,976,447**
Less: CoachCare fees (all-in)	($426,067)	($1,290,297)	($1,716,364)
Practice profit after fees	**$304,241**	**$955,842**	**$1,260,083**

As the enrollment ramp matures and billable months accumulate, both revenue and profit roughly triple — a blended margin near 42%. **The practice keeps the profit; CoachCare's fees are already netted out above** — there is no separate invoice to reconcile against these numbers.

Clinical & operational value — 24-month projection

Metric	Year 1	Year 2	24-month
Billed claims / units	14,131	42,219	56,351
Physiologic readings captured	58,667	183,528	242,195
Hospitalizations avoided	~37	~117	**~154**
Avoided-hospitalization value (≈ $15K each)	$558,750	$1,747,950	~$2.31M
Care-team hours saved	6,115	19,136	25,251
Full-time-equivalent hours saved	~2.9 FTE	~9.2 FTE	~12.1 FTE-yrs

Metric	Year 1	Year 2	24-month

Modeling notes & assumptions (read before quoting any figure)

- **Panel is an estimate.** The ~10,780-patient Medicare panel is modeled as 2× fee-for-service Part B (FFS ≈ physicians × 700 × 0.7 ≈ 5,390; total incl. MA ≈ 10,780), not a practice-supplied count. Every downstream figure inherits that uncertainty — verify against actual panel data.
- **Payer mix matters.** The corridor skews ~60% Medicare Advantage; MA is modeled at fee-for-service allowables (plans reimburse ≥100% of Medicare) while CKCC attributes fee-for-service only — segment and confirm the FFS/MA split before setting targets.
- **Rates are locality magnitudes.** Florida 2026 PFS magnitudes (First Coast Service Options) — verify current-year values in contracting.
- **Avoided-admission value is directional.** Modeled at ~$15,000 per admission and a 40% RPM-attributable reduction; a planning estimate, not a guarantee.

6. Powering CKCC / KCE: Total-Cost-of-Care Performance

This is the section that matters most for Ocala Kidney Group, because it is where the service line stops being a revenue line and becomes a **performance engine for a contract the practice has already signed.** Inside the CKCC Professional arrangement, the KCE is measured against a total-cost-of-care benchmark for its aligned FFS patients. The three biggest movers of that benchmark — hospitalizations, unplanned dialysis starts, and 30-day readmissions — are precisely the outcomes a Remote Care Service Line is built to change.

The service line is the KCE's interstitial operating model

A KCE can hold risk, but risk is only rewarded if someone changes what happens between visits. That is the whole game in nephrology: the deterioration that drives cost happens in the weeks between quarterly appointments. Connected BP and weight monitoring surface the drift early; nurse-led titration acts on it; TCM catches the post-discharge window. Each intervention is both a billable encounter **and** a reduction in the cost the KCE is accountable for.

How the clinical wedge maps to the shared-savings math

Clinical action	Total-cost-of-care effect
Early detection of BP/weight/volume drift	Fewer emergency presentations and volume-overload admissions — the highest-frequency avoidable cost.
Nurse-led titration between visits	Better-controlled resistant hypertension slows progression toward stage 5 and the costs that come with it.
Planned, access-ready transitions	Crash-starts (catheter-based, inpatient, complication-prone) become planned outpatient starts — a large per-event cost avoided.
Structured TCM at discharge	Lower 30-day readmission rate — a direct KCE and fee-for-service win.

Design decisions to lock in with the KCE

- **Attribution.** Flag CKCC-aligned FFS beneficiaries so performance is measured on the correct denominator.
- **Targeting.** Prioritize CKD stage 4–5 and recently discharged patients — the highest-cost, highest-opportunity cohort.

Clinical action	Total-cost-of-care effect

- **Shared care plan.** One plan in Greenway across nephrology and primary care; clean PCM/CCM attribution.
- **Coordinate with DaVita IKC.** Confirm what population-health and navigation support the KCE already supplies, and slot CoachCare as the physician-led, in-clinic, billing-generating layer that feeds it — not a competing population layer.

7. Crash-Start Avoidance, Optimal Starts & Transplant-List Stability

If Section 6 is the argument, crash-start avoidance is the flagship proof of it. An unplanned "crash" start — a patient arriving in crisis, initiated on dialysis inpatient through a central venous catheter — is among the most expensive and most preventable events in kidney care. It drives an admission, a complication-prone access, a longer length of stay, and a worse long-term trajectory. Converting even a modest share of crash-starts into planned starts is, on its own, a material total-cost-of-care lever.

Why Ocala Kidney Group is unusually well-positioned

Most nephrology groups have to build access-ready workflows from scratch. Ocala Kidney Group already runs its own **Dialysis Vascular Access Center** staffed by two interventional nephrologists. The missing piece is not procedural capability — it is the between-visit signal that tells the team **which** stage 4–5 patient is approaching transition and **when**. That is exactly what BP/weight monitoring and PCM care management provide. Pair the monitoring signal with the access center already in the building, and planned, access-ready starts become the default rather than the exception.

The three clinical outcomes this lever protects

- **Optimal starts (home-modality-eligible).** Patients transitioned in a planned way are far more likely to start on a home modality (PD or home HD) — better for the patient and lower cost inside the KCE.
- **Access-ready starts.** A monitored, forewarned patient reaches transition with a mature fistula or graft rather than a catheter — fewer infections, fewer admissions.
- **Transplant-list stability.** Better interstitial control of blood pressure, volume, and comorbidity keeps transplant-eligible patients stable and list-active rather than cycling through hospitalizations that jeopardize candidacy.

> **The wedge, stated plainly**
>
> Nephrology sees these patients four times a year. The disease progresses 365 days a year. The Remote Care Service Line is the **interstitial-care layer between quarterly visits — where progression, and every crash-start, is actually decided.**

8. Implementation Playbook: Building the Service Line

Goals & scope

Stand up a physician-led Remote Care Service Line — RPM + PCM with TCM at discharge — across all three offices, instrumented from day one against both the fee-for-service P&L and the CKCC / KCE scorecard. CoachCare supplies the enrollment, monitoring, and billing labor and the technology; the practice supplies the clinical direction and the patients.

Target populations (in priority order)

- **CKD stage 4–5 approaching transition —** the crash-start-avoidance cohort; highest cost, highest KCE value.
- **Recently discharged patients —** the TCM / 30-day readmission window.
- **Resistant hypertension in CKD —** the titration-and-monitoring cohort where BP RPM shows fastest control.
- **Aligned FFS Medicare first —** start where CPT capture and CKCC performance both apply, then extend to MA cohorts on a plan-by-plan basis.

Staffing

Top-of-license and CoachCare-funded: one embedded on-site enrollment specialist plus physician referral at appointment — modeled at eight referrals per provider per month at ~80% patient accept, converting ~30% to RPM and ~25% to PCM — with monitoring nurses running day-to-day operations, so the practice adds a revenue line without adding headcount. The model projects roughly 25,251 care-team hours saved over 24 months (~12.1 FTE-years) that the practice reallocates rather than hires against.

Technology, data & billing architecture

> **Native Greenway integration — a day-one advantage**
>
> CoachCare offers a **native Greenway integration** (Greenway Care Coordination Services run on the CoachCare platform), so enrollment, documentation, vitals, and claims live inside the existing Greenway environment rather than in a bolt-on portal. Practices enrolling this way can begin delivering monitored services in **under five days.**
>
> - Bidirectional enrollment by service; automated claim generation; integrated discrete vitals; compliance documentation / integrated care summary; escalation tasks; exchange of health history.
> - **Greenway integration catalog pricing:** ~$2,500 one-time setup, no monthly or per-patient integration fee — **confirm the product line (Intergy vs. Prime Suite) and version in technical discovery**, as the exact integration surface depends on it (lean Intergy).

Clinical workflow

- Enrollment flags in Greenway identify eligible CKD patients at the point of care; enrollment is triggered by service.
- Connected BP and weight devices stream discrete vitals back into the chart; thresholds drive 24/7 alert-and-triage.
- Nurse-led titration and PCM care management act on the signal between quarterly visits; TCM workflows fire at every discharge.
- Billing is generated automatically from documented activity — capture is a system output, not a manual chase.

KPI dashboard

Clinical (BP control, progression rate, planned-start %), operational (enrolled census, time-to-first-billable-enrollment, alert-to-action time), and financial (billing-capture rate, net revenue per patient per month, practice profit after fees, projected shared-savings contribution) — one view, refreshed continuously.

Expected impact & 12-month roadmap

1. **Months 0–2 — Foundation.** Confirm FFS/MA segmentation, panel and CKD-stage counts, and CKCC risk track; stand up the native Greenway integration; define the attribution policy and shared care plan.

2. **Months 2–6 — Ramp.** Enroll the crash-start and post-discharge cohorts first; establish the monitoring, titration, and TCM workflows; begin billing capture; instrument the KCE scorecard.
3. **Months 6–12 — Scale & prove.** Extend enrollment across eligible CKD patients and all three offices; report the first admissions-avoided and crash-start trends against the KCE benchmark; tune targeting toward the highest-cost cohorts.

Expected 24-month outcome (illustrative): ~$2.98M in net professional-fee reimbursement, ~$1.26M in practice profit after fees (about a 42% margin), ~154 hospitalizations avoided (~$2.31M in avoided cost), and a measurable, defensible contribution to the KCE's shared-savings performance — from one service line, built once.

References & Data Sources

1. Ocala Kidney Group, Inc. — practice website: About Us, Meet the Team, Locations, and Greenway (myhealthrecord.com) patient portal. Accessed July 2026.
2. DaVita CKCC portal — "Florida Comprehensive Kidney Care Contracting (CKCC)" and "KCE Leadership, Participants, and Providers | IKC of Florida, LLC." ckcc.davita.com/ikc-florida/.
3. CMS — Kidney Care Choices (KCC) Model overview and fact sheet; "Kidney Care Choices Model Performance Year 2026 Model Update." cms.gov (Center for Medicare & Medicaid Innovation).
4. CMS — KCC model participant list (CY2025) and participant affiliations (CY2024). cms.gov/files/document/kcc-model-participants-cy2025.pdf.
5. CMS — Calendar Year 2026 Medicare Physician Fee Schedule; Florida MAC pricing via First Coast Service Options (carrier/locality 09102-99). Rates shown are illustrative locality magnitudes.
6. Greenway Health / CoachCare — "Greenway Intergy Integration" and Care Coordination Services product materials (Greenway Health, LLC, 2024).
7. U.S. Census Bureau — Marion County, FL population and age-65+ estimates (2024 vintage); Medicare Advantage penetration figures for the Villages market (July 2025).
8. CoachCare Value Analysis — Ocala Kidney Group (2026): nephrology eligibility, enrollment ramp, and 24-month financial/clinical/operational projections used throughout this report.
9. CoachCare — company scale metrics: 500,000+ patients managed, 400+ managed conditions, 10,000+ providers, 1,000+ implementations, 5M+ claims generated, 100M+ vitals recorded.

Global verification note. *Every present-day fact in this report is drawn from the public sources above or from the practice's CoachCare Value Analysis. Financial and clinical figures are illustrative and modeled: the ~10,780-patient panel is a modeled estimate (2× fee-for-service Part B), reimbursement uses Florida locality magnitudes to be reconfirmed against the current-year fee schedule and local MAC, the FFS/MA panel split and CKCC risk track must be verified in discovery, and the EMR product line (Intergy vs. Prime Suite) is to be confirmed in contracting. These numbers are intended to frame a strategic conversation, not to serve as a quotation or a guarantee of results.*