HOUSTON NEPHROLOGY GROUP

Independent nephrology, greater Houston — four offices, four decades

Nephrology Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (RPM + PCM + TCM) as the operating spine — the interstitial care layer between quarterly nephrology visits

Purpose of this report

This report maps Houston Nephrology Group's public footprint and market position to a single 2026 initiative: a managed Remote Care Service Line that monitors and manages the practice's chronic kidney disease and hypertension panel between visits — generating recurring professional-fee revenue the practice owns, while building the clinical infrastructure every future payment arrangement will require. All modeled figures are illustrative, modeled — verify against practice data.

Prepared July 2026
Remote care infrastructure and analysis powered by CoachCare

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Executive Summary

Houston Nephrology Group, P.A. is one of greater Houston's most durable independent nephrology franchises: a physician-owned professional association that has served the metro for more than four decades, with six nephrologists and advanced-practice support across four offices — Memorial City, Katy, the Cypress/290 corridor, and Willowbrook. The group's clinical breadth spans the full arc of kidney care: chronic kidney disease (CKD) management, hypertension, dialysis management, vascular access, kidney biopsy, critical care nephrology, and transplant care, anchored by a named affiliation with Memorial Hermann Memorial City Medical Center. (Practice website and NPPES, accessed July 2026.)

The group's starting position is defined by a striking asymmetry. Clinically, it manages exactly the panel — hypertension, diabetes, progressive CKD — where continuous management between visits changes outcomes most. Operationally, its public footprint shows **no remote patient monitoring, no chronic care management program, no home-dialysis marketing, and no promoted patient-facing digital tools beyond an eClinicalWorks portal and online bill pay** (practice website reviewed July 27, 2026). Between quarterly visits, the practice is largely blind to the blood-pressure and volume trends that drive progression, hospitalization, and unplanned dialysis starts. That gap is the whole opportunity: in a Houston market where Medicare Advantage now covers roughly 55% of Medicare beneficiaries nationally (KFF, 2026) and Harris County seniors choose among 64–69 MA plans, payers increasingly reward exactly the continuous, documented management the practice does not yet capture — or bill for.

> **The central argument**
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> A managed Remote Care Service Line — BP/weight remote physiologic monitoring (RPM), Principal Care Management (PCM), and Transitional Care Management (TCM) at discharge — becomes **the interstitial care layer between quarterly nephrology visits, where progression actually happens.** It delivers value two ways at once:
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> **1. Standalone value.** Recurring, subscription-like professional-fee revenue on the panel the practice already manages: a modeled $873,184 in practice net reimbursement over 24 months, $375,206 of practice margin (43.0% of net reimbursement), reaching a ~$46,533/month steady state by month 15 — margin turning positive in month two with no negative-margin quarter, and cumulative breakeven in month three. CoachCare funds the on-site enrollment staffing; the practice adds no headcount.
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> **2. Clinical and strategic infrastructure.** The same enrollment, device, triage, and billing engine powers every nephrology value lever: earlier detection of progression, resistant-hypertension comanagement, planned dialysis starts instead of crash starts, transplant-list stability, referral durability with primary care — and readiness for value-based kidney care arrangements, built on fee-for-service economics the practice owns today. All figures illustrative, modeled — verify against practice data.

The 2026 payment environment strengthens the case. The CY2026 Medicare Physician Fee Schedule added short-window RPM codes — **99445** (device supply, 2–15 days of data) and **99470** (first 10 minutes of management) — so post-discharge and titration windows that were previously unbillable now generate revenue. Nephrology's RPM and PCM economics run on codes the practice

bills under its own NPIs, at Novitas Texas locality 18 (Houston) rates, with no new payer contract required.

2026–2027 Priority Recommendations

1. **Validate the panel and re-run the model.** This report models a 950-patient Medicare panel (estimated range 800–975, derived from claims data and physician-count benchmarks — not a chart count). A chart-count validation across the four offices is the first discovery step; the forecast is panel-limited, so the number moves with the panel.
2. **Stand up BP/weight RPM for the CKD 3b–5 and resistant-hypertension cohort.** The modeled RPM census reaches its ceiling of 250 active enrollments by month 8 — the fastest-ramping, highest-yield program in the stack.
3. **Layer PCM for the kidney-dominant subset.** Principal Care Management captures monthly management of the single dominant condition (CKD) for patients whose longitudinal primary care remains elsewhere — in a nephrology panel chronic kidney disease genuinely is the single dominant condition Principal Care Management was written for, which is why its eligible share (85%) is the highest in the stack; modeled ceiling 242 active enrollments by month 15.
4. **Wire the service line into eClinicalWorks.** The practice's EMR is confirmed from its own patient portal and staff login (July 2026). CoachCare's existing eClinicalWorks integration carries enrollment, documentation, and claims-ready billing files; exact product and version are confirmed in contracting.
5. **Formalize the primary-care attribution policy.** Chronic Care Management (CCM) for shared patients stays with the referring PCP; nephrology owns RPM + PCM for kidney-dominant patients, with co-management reporting flowing back. This is deliberately referral-safe — the model assumes zero CCM revenue to the practice.
6. **Treat the program's data as a strategic asset.** A consented, monitored panel with documented monthly management is the entry requirement for every value-based kidney care arrangement. Build it now under fee-for-service economics; no participation in any payment model is asserted or required anywhere in this report.

1. Footprint & Operating Model

Houston Nephrology Group operates as a classic independent specialty group: physician-owned (professional association), hospital-affiliated but not hospital-employed, spanning the western and northwestern arcs of the Houston metro. Office locations (practice website, July 2026):

Office	Address	Corridor
Memorial City — Medical Plaza III (HQ)	915 Gessner Rd, Suite 360, Houston, TX 77024	I-10 West / Memorial
Memorial Hermann Katy — Medical Plaza I	23920 Katy Fwy, Suite 555, Katy, TX 77494	Katy / West
Doctors Pavilion	10425 Huffmeister Rd, Suite 420, Houston, TX 77065	Cypress / US-290

Office	Address	Corridor
Willowbrook	13219 Dotson Rd, Suite 200, Houston, TX 77070	Willowbrook / SH-249

The clinical roster comprises six physicians — Drs. Vijay Sreenarasimhaiah, Colville T. Williams, Ariel M. Velasco, Redentor R. Roy, Adil R. Ali, and Masood Mahmood, all boarded in nephrology and internal medicine — supported by nurse practitioners (third-party directory data lists two named NPs; working count ~8–9 clinicians, to be confirmed in discovery). Services span dialysis management, vascular access creation and maintenance, hypertension, kidney biopsy, critical care nephrology, CKD, transplant care, and diabetic kidney disease. The practice names Memorial Hermann Memorial City Medical Center as its hospital affiliation; directory sources report privileges at additional Houston-area hospitals (unverified).

Four offices, one specialty, one EMR: the practice already runs a hub-and-spoke ambulatory model. A remote care service line extends that model to the 90 days between visits — without adding clinic slots, staff, or square footage. The operating principles this report applies:

Design principle	What it means for Houston Nephrology Group
Longitudinal by default	Every CKD 3b–5 and resistant-HTN patient is monitored between visits, not only seen at them
One front door	A single enrollment pathway across all four offices; the patient experience is identical at every site
Hub-and-spoke monitoring	One monitoring and triage hub covers all four offices; alerts route to the treating nephrologist
Single scorecard	One monthly dashboard: enrolled census, adherence, BP control, alerts, revenue capture
Digital as care, not IT	Devices and the patient app are clinical instruments generating billable, chartable data — not a portal add-on

2. The Remote Care Service Line — The Spine

2.1 What It Is: The Nephrology Remote Care Stack

The service line is three coordinated Medicare programs billed by the practice under its own provider numbers, run on CoachCare's managed infrastructure — enrollment, cellular-connected devices, 24/7 alert and triage coverage, nurse navigation, titration support, billing capture, and analytics.

Program	CPT codes	What it does	Cadence
RPM — Remote Physiologic Monitoring	99453, 99454 / 99445, 99457 / 99470, 99458	Cellular BP cuff and scale at home; daily readings; alert-driven triage and treatment-to-target titration support	Recurring monthly

Program	CPT codes	What it does	Cadence
PCM — Principal Care Management	99426, 99427 (clinical staff); 99424, 99425 (physician)	Monthly management of the single dominant condition (CKD) for patients whose primary care remains elsewhere	Recurring monthly
TCM — Transitional Care Management	99495, 99496	Structured 30-day post-discharge management: contact within 2 business days, medication reconciliation, timely follow-up	Per discharge — upside; not in forecast

The coordination rules (and why this design is referral-safe)

RPM and PCM stack. Both may be billed for the same patient in the same month, with discrete documented time; CoachCare's billing engine enforces the concurrency and time-segregation rules automatically.

CCM stays with primary care. Chronic Care Management for shared patients belongs to the referring PCP's longitudinal relationship. This model deliberately assumes zero CCM revenue to the nephrology practice — nephrology owns RPM + PCM for kidney-dominant patients, the PCP keeps the longitudinal wrapper, and one shared care plan lives in the EMR. Referring physicians see a partner, not a competitor.

One attribution policy for shared patients, set at kickoff and documented in the care plan, prevents duplicate-billing denials and referral friction before either can occur.

2.2 Standalone Value: Four Value Layers

1. **Direct professional-fee revenue.** Recurring monthly billing on the existing panel — modeled at $873,184 practice net reimbursement over 24 months, $46,533/month at steady state, independent of any payer negotiation or value-model participation (Section 5).
2. **Avoided cost.** The model projects ~34 avoided hospitalizations over 24 months from early intervention on BP and volume alerts — roughly $509,000 of avoided admission cost at an illustrative $15,000 per admission — plus the far larger, unmodeled economics of converting unplanned dialysis starts into planned ones (Section 4).
3. **Referral durability with primary care.** Monthly co-management reporting to referring PCPs — with CCM deliberately left in their hands — makes Houston Nephrology Group the easiest nephrology referral in the market to make, and to keep making.
4. **Strategic readiness.** A consented, device-connected panel with documented monthly management and a working readmission-prevention loop is the qualifying infrastructure for value-based kidney care arrangements — built here on fee-for-service economics the practice owns today. No participation in any payment model is asserted, and none is required for any dollar in this report.

The CY2026 billing stack, at the rates that apply to this practice (Novitas, Texas locality 18 — Houston) where locality rates were resolved, and illustrative national magnitudes elsewhere:

Service / code	Type	~CY2026 amount	Notes
RPM 99453 — setup & patient education	One-time	~$20*	Requires ≥2 days of data
RPM 99454 — device supply, 16–30 days	Monthly	$51.87	Locality rate (Novitas TX-18)
RPM 99445 — device supply, 2–15 days	Monthly	~$52*	New for 2026: short windows now billable
RPM 99457 — management, first 20 min	Monthly	$52.23	Locality rate (Novitas TX-18)
RPM 99470 — management, first 10 min	Monthly	~$26*	New for 2026
RPM 99458 — each additional 20 min	Monthly	~$41*	
PCM 99426 — clinical staff, first 30 min	Monthly	$68.73	Locality rate (Novitas TX-18)
PCM 99427 — each additional 30 min	Monthly	$54.73	Locality rate (Novitas TX-18)
TCM 99495 / 99496 — moderate / high complexity	Per discharge	~$200 / ~$280*	Not in the forecast — incremental upside

** Illustrative national non-facility magnitudes; actual payment is locality-adjusted and set by the regional MAC. All rates: verify against the current CY2026 PFS and Novitas locality files before financial planning.*

Recurring-revenue mechanics

At the modeled steady state — 250 active RPM enrollments and 242 on PCM — the service line produces $46,533 of practice net reimbursement and $20,623 of practice margin per month, month after month, on the panel the practice already manages. It behaves like subscription revenue: the census, not visit volume, drives the P&L. Illustrative, modeled — verify against practice data.

2.3 The Interstitial Care Layer: One Infrastructure, Every Lever

CKD progression is not an event that happens in the exam room; it happens in the 90 days between exam rooms — in unmedicated weekends of 160/100 blood pressures, in three kilograms of silent fluid gain, in the missed diuretic refill. The same shared infrastructure that captures those signals powers every value lever the practice cares about:

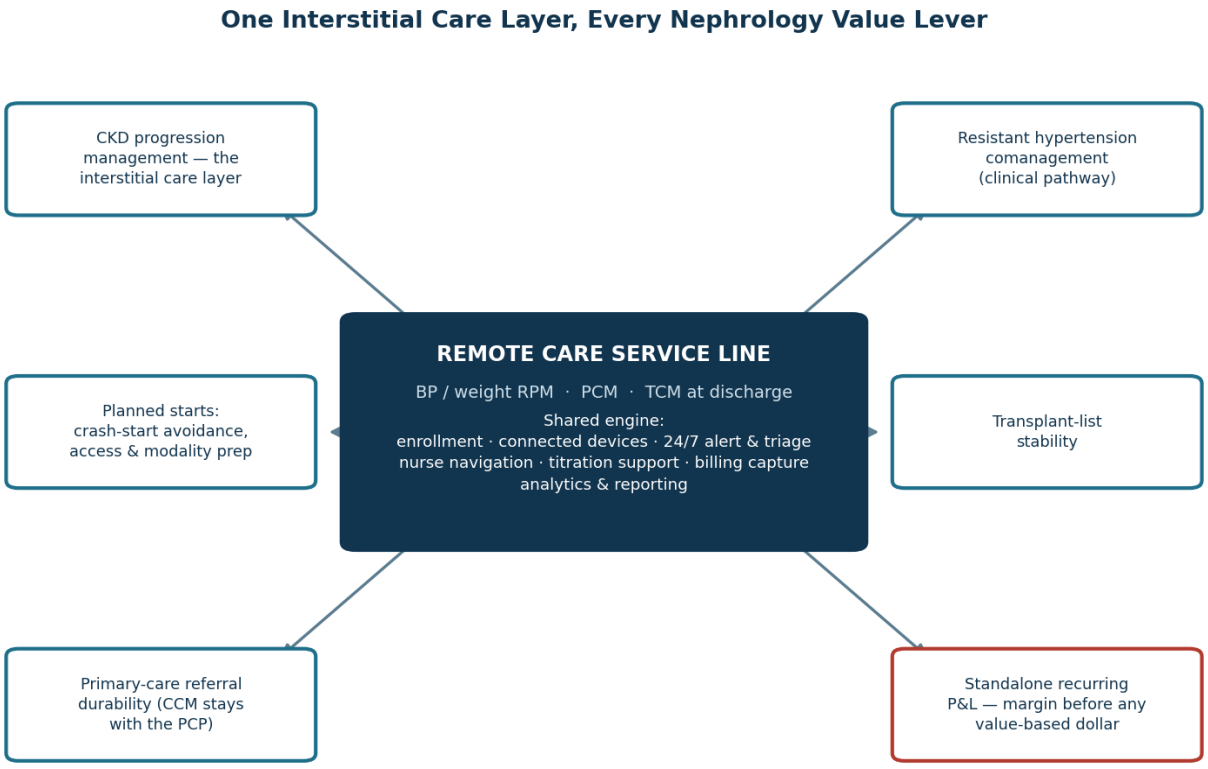

Figure 1. One shared remote-care engine powers every nephrology value lever. CCM remains with the referring PCP by design.

Value lever	What the shared engine contributes	Where the value lands
CKD progression management	Daily BP/weight surveillance; treatment-to-target titration support between visits	Slower progression; RPM/PCM revenue; stronger visit-interval control
Resistant hypertension comanagement	Home BP series that distinguish true resistance from nonadherence or white-coat effect; structured med-titration loop (clinical pathway)	Better control; documentation that supports comanagement with referring PCPs
Planned starts, not crash starts	Early detection of decompensation buys time for access placement, modality education, home-dialysis preparation	Fewer emergent inpatient starts; better patient outcomes; avoided admissions
Transplant-list stability	BP/volume stability and continuous documentation help keep listed patients active and evaluation-ready	Protects the transplant pipeline and the referral relationships behind it
Primary-care referral durability	Monthly co-management reports; CCM deliberately left with the PCP	The referral network compounds instead of eroding
Standalone recurring P&L	Billing capture across RPM + PCM; CoachCare-funded enrollment staffing	$375,206 modeled 24-month practice margin (Section 5)

3. Market Position & Digital Whitespace

3.1 A Four-Decade Franchise in a Consolidating Market

Independent nephrology is consolidating nationally: dialysis organizations, payer-aligned management companies, and health systems are assembling kidney-care networks in every large metro, and Houston is among the most actively contested. In that environment, a four-decade independent group's durable assets are its referral relationships, its hospital affiliation, and its panel. Each of those assets is defended — or eroded — by the same thing: whether the practice can demonstrate, with data, that its patients are better managed between visits than anyone else's.

The payer mix sharpens the point. Nationally, about 55% of eligible Medicare beneficiaries are enrolled in Medicare Advantage in 2026 (KFF), and Harris County beneficiaries choose among 64–69 MA plans; Texas metros generally run at or above the national share. MA plans measure admissions, readmissions, and chronic-disease control at the provider level — and steer volume accordingly. A monitored panel with documented monthly management is how an independent specialty group stays on the right side of that arithmetic, while the underlying RPM/PCM revenue itself is billed under fee-for-service rules the practice controls.

3.2 The Digital Whitespace Diagnosis

A review of the practice's public digital footprint (website and linked services, July 27, 2026) finds a near-total absence of remote care and care-management programming:

Capability	Observed status (July 2026)
Remote patient monitoring (RPM)	Not advertised anywhere on the practice site
Chronic / principal care management billing programs	Not advertised
Home-dialysis program marketing	None; dialysis content is generic
Kidney-disease patient education offering	Not advertised
Patient portal	Present — eClinicalWorks portal linked from the home page
Online bill pay	Present
Telehealth visits	Offered by at least three physicians (third-party directory data)

> **What the whitespace means**
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> There is no incumbent program to displace, no sunk vendor investment to defend, and no internal build competing for capital. Every dollar of the modeled forecast is net-new revenue on services the practice is not currently delivering or billing. The practice's one existing digital asset — an active eClinicalWorks portal — is precisely the integration point the service line plugs into (Section 6).

3.3 The 2026 Payment Environment

Two CY2026 Physician Fee Schedule changes materially improve nephrology remote-care economics. First, **99445** pays for RPM device supply with as few as 2–15 days of transmitted data, where 16 days were previously required — so short post-discharge windows, titration bursts, and late-month enrollments now bill. Second, **99470** pays for the first 10 minutes of monthly RPM management, capturing lighter-touch months that previously fell below the 20-minute 99457 threshold. Both slot directly into the CKD workflow: the fragile weeks after a hospitalization and the dose-adjustment windows between visits are exactly where kidney patients generate the most clinically important data.

The direction of travel is equally important: CMS keeps expanding paid, auditable codes for continuous chronic-disease management delivered outside the visit. Practices that build the capture infrastructure early compound the benefit with each fee-schedule cycle.

4. The Clinical Case: Managing CKD Between Visits

4.1 The 90-Day Gap

A typical CKD 3b–5 patient sees their nephrologist every 8–13 weeks. Between those visits, the two most consequential variables in kidney care — blood pressure and volume status — go unobserved. Uncontrolled hypertension is the most modifiable driver of CKD progression; fluid accumulation is the most common preventable path to admission. A cellular BP cuff and scale close that observation gap with daily data, and the service line's triage layer converts the data into action: alert thresholds set by the treating nephrologist, escalation to the practice only when clinically warranted, and documented treatment-to-target adjustment between visits.

4.2 Resistant Hypertension: A Comanagement Pathway

The practice already treats resistant and secondary hypertension as a named service. Home BP series transform that work: two weeks of daily readings distinguish true treatment resistance from nonadherence and white-coat effect before therapy escalates; monthly RPM management codes pay for the titration follow-through; and the resulting documentation makes the practice the natural comanagement destination for every referring PCP's hardest hypertension patients. This is a clinical pathway and a referral magnet — the revenue is the monitoring and management itself.

4.3 Planned Starts, Not Crash Starts

The most expensive event in kidney care is the unplanned dialysis start: the patient who presents decompensated, starts dialysis in the hospital on a central venous catheter, and never had the runway for access placement, modality education, or home-dialysis preparation. Every element of a better start — a maturing fistula, a modality decision, a transplant evaluation — needs months of lead time. Continuous monitoring is how a practice buys that lead time at panel scale: the drifting weights and climbing pressures that precede decompensation become schedulable clinic events instead of emergency-department arrivals. The modeled forecast counts only the avoided hospitalizations (~34 over 24 months); the planned-start economics on top of that accrue to whoever bears total-cost risk — and to the practice's standing with every payer and hospital partner watching those starts.

4.4 Transplant-List Stability

For the practice's transplant-track patients, list eligibility is an ongoing maintenance problem: blood-pressure control, volume stability, and documented follow-through all bear on staying active and evaluation-ready. A monitored panel gives the practice early warning when a listed patient drifts — and a continuous record that supports the transplant center relationship. The same infrastructure, another lever.

5. The Value Analysis: Modeled Economics

5.1 Panel & Assumptions

The forecast below is a CoachCare Value Analysis built on the practice's geography, specialty, and estimated Medicare panel, at CY2026 Novitas Texas locality 18 (Houston) rates. Key inputs:

Input	Value	Basis
Medicare panel (estimate)	950 patients	Estimated range 800–975 — see method callout below; validate in discovery
Programs modeled	RPM + PCM	Nephrology stack; CCM structurally assigned to primary care (modeled at zero); TCM excluded (upside)
Program eligibility	RPM 75% · PCM 85%	Nephrology panel profile: 713 RPM-eligible and 808 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 acceptance	RPM 35% · PCM 30%	Modeled enrollment acceptance across the eligible population
Enrollment staffing	1 on-site enrollment specialist, 80 enrollments/mo	Funded by CoachCare — embedded value, not a practice expense
Rates	CY2026 PFS, Novitas TX locality 18	e.g., 99457 $52.23 · 99454 $51.87 · 99426 $68.73 · 99427 $54.73
EMR integration	eClinicalWorks	Confirmed from practice portal evidence; fees included in modeled totals

How the panel was estimated (and why it must be validated)

950 is an **estimate, not a chart count.** Method: practice Medicare allowed charges of $1,266,847 (commercial claims dataset) ÷ ~$1,300 allowed per specialty Medicare beneficiary-year → 975 upper bound (the divisor is calibrated on specialty-practice benchmarks); cross-checked against ~160 Medicare patients per nephrologist × 6 physicians. Working range **800–975; 950 modeled.** First discovery step: pull actual Medicare chart counts across the four offices and re-run the analysis — the forecast is panel-limited, so it scales with this number.

5.2 Headline Results

	Year 1	Year 2	24-Month Total
Practice net reimbursement	$317,518	$555,666	$873,184
CoachCare program fees (all-in)	$188,080	$309,898	$497,978
Practice margin	**$129,437**	**$245,769**	**$375,206**

24-month practice margin: 43.0% of net reimbursement (Year 1 40.8%, Year 2 44.2%). By program: RPM contributes $498,402 of 24-month net reimbursement ($220,116 margin) and PCM $374,782 ($180,874 margin); program-level margins are stated before ancillary and one-time fees, which are not allocated by program. 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. CoachCare's fees include the platform, cellular devices, 24/7 monitoring and triage staffing, the on-site enrollment specialist, eClinicalWorks integration, and billing support — the on-site enrollment specialist is CoachCare's expense, embedded value never subtracted from the practice margin above, and the practice's only operating contribution is clinical oversight it already provides. All figures illustrative, modeled — verify against practice data.

5.3 The Ramp, the Ceilings, and Month One

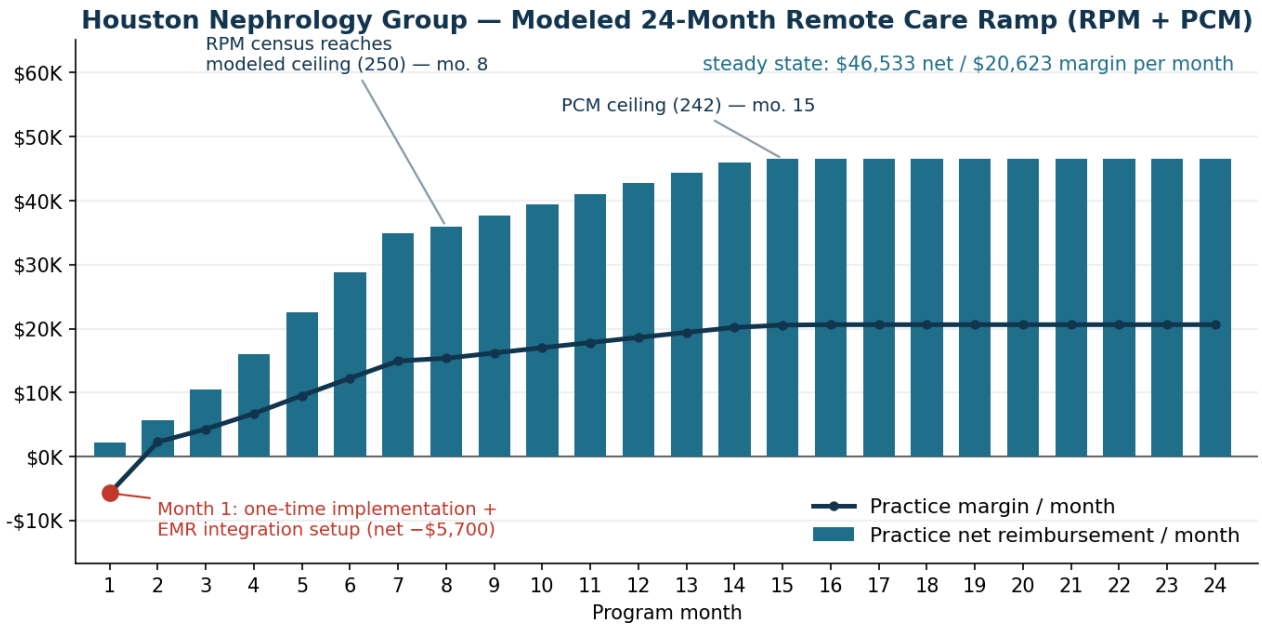

Figure 2. Modeled monthly practice net reimbursement (bars) and margin (line), months 1–24. Month 1 absorbs one-time implementation and EMR integration setup; the censuses reach their modeled ceilings in months 8 (RPM) and 15 (PCM).

Program	Modeled ceiling	Arithmetic	Ceiling reached
RPM	250 active enrollments	950 × 75% eligible × 35% acceptance	Month 8
PCM	242 active enrollments	950 × 85% eligible × 30% acceptance	Month 15

Both ceilings bind well before month 24 — meaning **the panel estimate, not outreach capacity, is the binding constraint** on the 24-month number. That is the right constraint to have: it makes the forecast conservative, and it means a validated larger panel (or a second enrollment cohort) raises the ceiling directly. Two census figures matter here and they are not interchangeable: at month 24 the model carries 492 active program enrollments (250 RPM + 242 PCM) across 322 unique patients, because many patients are enrolled in both programs. The 322 is the patient count; the 492 is the sum of program enrollments.

Month-one economics — read before quoting the ramp

Month 1 nets **−$5,700**: the one-time implementation fee and eClinicalWorks integration setup land in the first month, ahead of meaningful enrollment revenue. Monthly margin turns positive in month two (+$2,281) and stays positive every month thereafter — there is no negative-margin quarter — and cumulative margin turns positive in month three. From month 15 the program runs at steady state: ~$46,533/month net reimbursement, ~$20,623/month margin.

5.4 Beyond Fee Revenue: Clinical & Operational Value

Measure (modeled, 24 months)	Value	Note
Billable claims generated	~15,761	Captured and scrubbed by CoachCare's billing engine
Physiologic readings captured	~53,442	Daily BP/weight data flowing into clinical review
Hospitalizations avoided	~33.9	≈ $509,000 avoided cost at an illustrative $15,000/admission
Care-team hours saved	~7,896	≈ 3.8 FTE-years of triage, outreach, and documentation absorbed by CoachCare's team

The staffing line deserves emphasis: the on-site enrollment specialist and the 24/7 monitoring team are CoachCare's expense, embedded in the program fee. The practice gains the equivalent of more than three and a half clinical FTE-years of between-visit work over 24 months without hiring, training, or managing anyone — in a market where clinical staffing is the scarcest resource an independent group has.

6. eClinicalWorks Integration

The practice's EMR is **eClinicalWorks** — confirmed directly from the practice's own digital footprint (its patient portal and staff EMR login, both linked from the practice website, reviewed July 2026). This matters for speed: CoachCare maintains an existing eClinicalWorks integration, so the service line connects to the system the practice already uses rather than introducing a parallel record.

- Enrollment candidates identified from the existing EMR problem list and schedule — no manual list-building
- Device readings, alert dispositions, and monthly management documentation written back to the chart
- Claims-ready billing output aligned to the practice's existing revenue-cycle workflow
- The already-live patient portal becomes an on-ramp: patients who use it are pre-qualified digital adopters for home devices

Integration setup and recurring fees are included in the modeled CoachCare fee totals in Section 5. The exact eClinicalWorks product and version — and the practice-management configuration — are confirmed in contracting; no findings in this report depend on that detail.

7. Value-Based Readiness on Fee-for-Service Economics

Kidney care is moving — payer by payer, contract by contract — toward accountability for total cost and outcomes: delayed progression, planned starts, home modality uptake, avoided admissions. This report **asserts no current value-model participation by Houston Nephrology Group, and none is required** for any figure modeled here; every dollar in Section 5 is ordinary fee-for-service billing under the practice's own provider numbers.

That is precisely what makes the service line the right on-ramp. Every value-based kidney care arrangement — whatever its label, sponsor, or year — prices the same underlying capabilities: a consented, monitored panel; continuous physiologic data; documented monthly management; a working admission-prevention loop; and credible planned-start performance. Those capabilities take 12–24 months to build and season. Building them now, on fee-for-service economics the practice owns and controls, means the group arrives at any future negotiation — with a payer, a partner, or a program — holding the data instead of promising it.

> **The optionality position**
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> Whether the practice ultimately pursues a value-based arrangement, deepens its fee-for-service program, or does both, the same infrastructure serves. Nothing in this strategy requires committing to a payment model today — and nothing in it forecloses one tomorrow. The program pays its own way from month two either way (Section 5).

8. Implementation Playbook

8.1 Scope & Target Population

- **Cohort 1 — RPM:** CKD stages 3b–5 with hypertension, resistant/secondary hypertension, and volume-sensitive patients (diuretic-managed, post-AKI); cellular BP cuff ± scale. Modeled ceiling 250 active enrollments.
- **Cohort 2 — PCM:** kidney-dominant patients whose longitudinal primary care remains with a community PCP; monthly disease-specific management. Modeled ceiling 242 active enrollments.
- **Cohort 3 — TCM:** every practice patient discharged from an affiliated hospital; 30-day structured transitions. Unmodeled upside on top of the forecast.

8.2 Staffing: CoachCare's Team, the Practice's Clinical Control

CoachCare supplies and funds the working layer: one on-site enrollment specialist (modeled at 80 enrollments/month) working the schedule across all four offices, the 24/7 monitoring and triage team, nurse navigation, and billing support. The practice supplies what only it can: clinical protocols, alert thresholds, and the treating relationship. Escalations reach the practice only at the clinical decision point — everything upstream of that point is absorbed by the program.

8.3 Clinical Workflow

- Identify: EMR-driven candidate lists by stage, diagnosis, and device-appropriateness, reviewed by the treating nephrologist
- Enroll & equip: on-site consent at the visit; cellular devices shipped and activated — no patient Wi-Fi, apps, or pairing required
- Monitor: daily readings against nephrologist-set thresholds; out-of-range alerts triaged by the monitoring team
- Intervene: protocolized outreach first; clinical escalation to the practice with full context when warranted
- Document & bill: every interaction time-stamped and chart-written; claims assembled, scrubbed, and captured monthly

8.4 The KPI Dashboard

Domain	KPIs	Target discipline
Clinical	BP control rate in monitored cohort; reading-adherence rate; alert-to-contact time	Trend vs. baseline each month; thresholds set by the practice
Operational	Enrolled census vs. ceiling (250 RPM / 242 PCM); time-to-first-billable-enrollment; monthly enrollment velocity vs. 80/mo	Census is the single most important operating number

Domain	KPIs	Target discipline
Financial	Billing capture rate; revenue per enrolled patient per month; monthly net reimbursement vs. the $46,533 steady-state benchmark	Reviewed monthly against the Value Analysis ramp

8.5 The 12-Month Roadmap

Milestone	Timing	What happens
Contract & configure	Month 1	eClinicalWorks integration setup; protocols, thresholds, and the primary-care attribution policy signed off; one-time fees land (month nets −$5,700)
First billable month	Month 2	First enrollment cohort live; monthly margin turns positive (+$2,281)
Cumulative breakeven	Month 3	Program has repaid its startup costs from its own revenue
RPM ceiling	Month 8	250 active RPM enrollments monitored; steady-state RPM revenue
PCM ceiling	Month 15	242 active PCM enrollments; full steady state: ~$46,533/mo net reimbursement, ~$20,623/mo margin
Year-1 review	Month 12	Panel re-validation against chart counts; re-run the Value Analysis; decide cohort-2 expansion and TCM activation

The ask is deliberately small: validate the panel, set the protocols, and let the first cohort enroll. Every subsequent decision — expansion, TCM activation, value-based positioning — is made with live program data rather than projections.

References & Data Sources

- Houston Nephrology Group — practice website: home, about, services, and locations pages (houstonnephrologygroup.com), accessed July 27, 2026. Provider roster, service lines, office locations, hospital affiliation, patient portal and bill-pay links.
- NPPES NPI Registry — Houston Nephrology Group, P.A., organization NPI 1174593032 (record last updated May 21, 2026). Legal structure and authorized official.
- Third-party provider directory (ourhealthnetwork.com), accessed July 27, 2026 — provider counts, NP roster, telehealth availability, directory-reported hospital affiliations (unverified where noted).
- KFF, "Medicare Advantage in 2026: Enrollment Update and Key Trends" — national MA share of eligible Medicare beneficiaries (~55%, 2026).
- MedicareAdvantage.com Harris County, TX plan listings, 2026 — 64–69 MA plans offered.
- CMS CY2026 Medicare Physician Fee Schedule — RPM/PCM/TCM code values, including new codes 99445 and 99470; rates resolved to Novitas Solutions, Texas locality 18 (Houston) where shown.

- Commercial healthcare claims dataset (practice Medicare allowed charges) — input to the panel-size estimate; vintage noted in Section 5.
- CoachCare Value Analysis workbook for Houston Nephrology Group (July 2026) — all modeled enrollment, revenue, fee, margin, and clinical-operations figures in this report.
- CoachCare platform statistics (coachcare.com, July 2026): 400+ managed conditions across 500,000+ patients; 10,000+ providers; 1,000+ implementations; 5,000,000+ claims generated; 100,000,000+ vitals recorded.

Global caveat

This report was prepared from public sources (accessed July 2026, dates as noted) and a modeled financial analysis. All modeled figures are illustrative, modeled — verify against practice data. Reimbursement rates are CY2026 values subject to locality adjustment and fee-schedule updates; confirm against the current PFS and MAC files before financial planning. The Medicare panel figure is an estimate pending chart-count validation. Facts labeled as directory-reported or unverified should be confirmed in discovery. Questions and follow-up: Connor Knapp, CoachCare — connor.knapp@coachcare.com.