

GEORGIA NEPHROLOGY

Largest independent nephrology practice in Georgia · Est. 1976 · 50th anniversary, 2026

Nephrology Service Line Performance & Optimization

2026 STRATEGY REPORT

A remote-care service line (RPM + PCM) as the operating spine for the interstitial care between quarterly nephrology visits — where CKD progression actually happens.

Purpose of this report

This report reads Georgia Nephrology's public position, then models a nephrology **remote-care service line** — remote patient monitoring (RPM) and principal care management (PCM) — as a standalone, margin-positive addition to the practice, and as the operational foundation any future kidney value model will require. Every present-day fact is sourced and date-stamped; every financial figure is illustrative and modeled at 2026 Georgia Medicare locality rates, to be validated against the practice's own data before contracting.

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Confidential — prepared for Georgia Nephrology. Figures are illustrative, discovery-stage estimates; verify against practice data.

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Executive Summary

Georgia Nephrology is the largest independent nephrology practice in Georgia — 20 nephrologists and 11 advanced-practice providers across nine metro-Atlanta offices, founded in 1976 and marking its 50th anniversary in 2026.¹ The group serves a dense chronic-kidney-disease and dialysis-adjacent panel across Gwinnett, DeKalb, Rockdale, Fulton, Hall, and Walton counties; provides medical direction at more than thirty dialysis centers operated by the national dialysis organizations it medical-directs; runs a substantial clinical-research arm; and is a member of a leading Atlanta clinically integrated network (a care-coordination affiliation, not ownership). It runs a modern, nephrology-specific Epic electronic health record.

The opening is whitespace. There is no public evidence of a remote-patient-monitoring, chronic-care-management, or connected-device program — the group offers telephone/video visits and a patient portal, and nothing further.² There is also no confirmed value-based upside capture: the practice makes a generic, unnamed “value-based care” claim, but every gated model — kidney total-cost models, Shared Savings / REACH accountable-care participation, and Medicare Advantage risk — is **not confirmed** on the public record, and the available evidence points against current participation while several in-market peers are already inside value-based structures.³

The central argument

A managed nephrology remote-care service line — **RPM for blood pressure and weight, PCM for the single dominant high-risk condition** — delivers value two ways at once, and every section of this report reinforces both:

- 1. Standalone value.** Recurring, subscription-like professional-fee revenue at top-of-license staffing that is margin-positive on fee-for-service alone, before any value-based dollar. The 24-month model shows a **42.2% blended practice margin** and **\$1.03M in practice net** on a 4,000-patient Medicare panel.
- 2. Connective tissue.** One shared infrastructure — enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, titration support, billing capture, analytics — that simultaneously slows CKD progression in the space between quarterly visits, supports crash-start avoidance and planned optimal starts, strengthens the primary-care referral loop, and becomes the operating substrate any future kidney value model (the kidney total-cost models and their successors) will require. Build once, reuse everywhere.

The wedge is the interstitial-care layer. Nephrology sees its patients quarterly, but CKD progresses daily. Blood pressure, weight, and volume drift between visits; a missed trajectory is how a patient arrives in the emergency department and starts dialysis in crisis instead of

¹Practice size, provider counts, office footprint, and founding date: ganephrology.com — About the Practice, Providers, and Locations pages, retrieved September 2026.

²Remote-care whitespace verified by direct review of the Services and About pages plus targeted search; only telehealth and a patient portal are present. ganephrology.com, retrieved September 2026.

³Value-based posture: the site names no specific program. The practice is absent from the one Georgia kidney value-entity roster (which names other Georgia groups); the regional network's Shared Savings ACO states it did not participate in the Shared Savings Program in PY2025 and does not name the practice; no Medicare Advantage risk contract found. CMS Kidney Care Choices participant files could not be opened and are flagged for a direct pull. Sources 2023–2026.

through a planned, lower-cost optimal start. Remote monitoring is how the group holds the line in that window — clinically and economically.

The billing environment is a tailwind. The care-management code families (RPM 99453/99454/99457/99458, the new short-window codes 99445/99470, and PCM 99424–99427) are established, recurring, and were expanded for 2026. Georgia's Medicare Advantage penetration is high — roughly 56.3% of the state's Medicare beneficiaries as of August 2026 — and fee-for-service parity is the floor for these care-management code families; individual MA contracts set their own terms, and this model is built on fee-for-service rates.⁴

Independence is the strategic frame. A margin-positive service line diversifies revenue and strengthens the group's central role in each patient's kidney journey — an alternative to selling into a system or platform to capture value-based upside.

Priority Recommendations for 2026–2027

1. **Stand up a nephrology remote-care service line on the existing Epic stack**, leading with RPM (blood-pressure and weight monitoring) for the CKD stage 3b–5 and resistant-hypertension cohorts.
2. **Layer PCM** for patients with a single dominant high-risk condition, running RPM and PCM concurrently where time and documentation are discrete.
3. **Use CoachCare's funded on-site enrollment specialist** to reach scale without adding practice headcount — the enrollment labor is CoachCare's expense, not the practice's.
4. **Target the optimal-starts and crash-start-avoidance population first** for the highest combined clinical and economic return per enrolled patient.
5. **Validate the modeled economics against the practice's own Medicare chart counts and MAC-locality rates** before contracting, and confirm the Epic integration path and fees.
6. **Build the shared infrastructure now as the foundation for any future kidney value model** — without claiming, or depending on, current value-based participation.

1. Practice Footprint & Operating Model

1.1 Footprint, scale, and independence

Georgia Nephrology, LLC is physician-owned and independent, with no private-equity backing or national-platform ownership found on the public record.⁵ Founded in 1976, it has grown to **20 nephrologists and 11 advanced-practice providers** across **nine metro-Atlanta offices** — Lawrenceville (headquarters), Buford, Conyers, Decatur, Gainesville, Johns Creek, Lithonia, Monroe, and Snellville — several with on-site laboratories. It is the largest of the independent

⁴Georgia Medicare Advantage penetration ~56.3% of Medicare beneficiaries, August 2026 (CMS-sourced via healthinsurance.org and statranker). County-level figures for the served counties were not individually verified.

⁵Ownership/structure: physician-owned independent practice; no PE or national nephrology-platform ownership found. ganephrology.com and corroborating business records, 2026.

nephrology groups in its market; ten of its physicians were named to a leading regional “Top Doctors” list for 2026, more than any other Atlanta nephrology group.⁶

The clinical footprint is broad and CKD-dense: general nephrology and CKD management, dialysis medical direction, home-dialysis education and training, kidney-transplant referral and evaluation support, glomerular (glomerulonephritis) disease, vascular-access management, hypertension, anemia of CKD, electrolyte management, on-site labs, telehealth, and clinical research through the group's research institute. The group provides **medical direction only** — day-to-day physician care, not ownership or a joint venture — at more than thirty dialysis centers operated by the national dialysis organizations it medical-directs.⁷

Read for the service line

The group already sits at the center of a large CKD and dialysis-adjacent population but touches most of those patients only quarterly in clinic. That gap between visits — across a research-forward, independent group with a modern Epic stack and no remote-care program — is exactly the space a remote-care service line fills.

1.2 Operating model and design principles

A remote-care service line works best when it is run as a service line — with a single scorecard, a clear front door, and top-of-license staffing — rather than as a scattering of enrollments. The design principles below carry through the rest of this report.

Design principle	What it means for Georgia Nephrology
Longitudinal by default	Every eligible CKD and hypertension patient has a monitored plan between visits, not only after an acute event.
One scorecard	Clinical, operational, and financial metrics for the service line live on a single dashboard the group reviews monthly.
Hub-and-spoke	Central care-management and triage staff support all nine offices; enrollment happens where the patient already is.
One front door	A single enrollment and device-provisioning path, ordered inside the existing Epic workflow.
Top-of-license	Physicians set the plan; CoachCare-funded staff and connected devices do the daily monitoring, outreach, and documentation.

2. The Remote Care Service Line — The Spine

This is a **single-arm specialty service line**. Nephrology is a specialist practice, not a longitudinal primary-care panel, so the model is deliberately focused: **RPM and PCM are the billed, modeled programs**. Chronic care management (CCM) and transitional care management (TCM) appear here as part of the clinical picture — they describe real work the

⁶Recognition: ten Georgia Nephrology physicians named to Atlanta Magazine “Top Doctors” 2026 — the most of any Atlanta nephrology group. atlantamagazine.com, 2026.

⁷Dialysis footprint: medical direction only at 30+ centers operated by national dialysis organizations; no ownership or joint-venture equity claimed or found (unverified as to any stake). ganephrology.com — Dialysis Centers, 2026.

group does around hospitalizations and multi-condition patients — but they are **not modeled as revenue** in this business case, and advanced primary care management (APCM) is excluded entirely: it is billed by the primary-care practice that owns a patient's longitudinal panel, which a specialty nephrology group does not.

2.1 What it is: the RPM + PCM stack

RPM — remote patient monitoring. Cellular-connected blood-pressure cuffs and weight scales stream discrete readings from the patient's home. A care team reviews the data, intervenes on drift, and documents the monthly management time. For a CKD and hypertension panel this is the highest-yield monitoring modality: blood pressure and volume are the levers that most directly govern progression.

PCM — principal care management. For a patient whose care is dominated by a single high-risk condition expected to last at least three months, PCM funds a structured monthly management program around that one condition. In nephrology it fits the advanced-CKD patient who does not need a full multi-condition wrapper but does need disciplined, documented monthly management.

The one coordination rule. RPM and PCM may be billed together for the same patient when the time and documentation are discrete — RPM captures device-based physiologic monitoring, PCM captures condition-management time. The billing engine enforces the separation so the same minute is never counted twice.

Clinical context, not modeled revenue: CCM (for patients with two or more chronic conditions, nearly universal in CKD stage 3b–5) and TCM (in the 30 days after a hospitalization) describe care the group already delivers and could bill. They are held out of the financial model here so that every dollar in this business case comes from RPM and PCM alone. If the group later chooses to bill them, they are upside to these figures, not part of them.

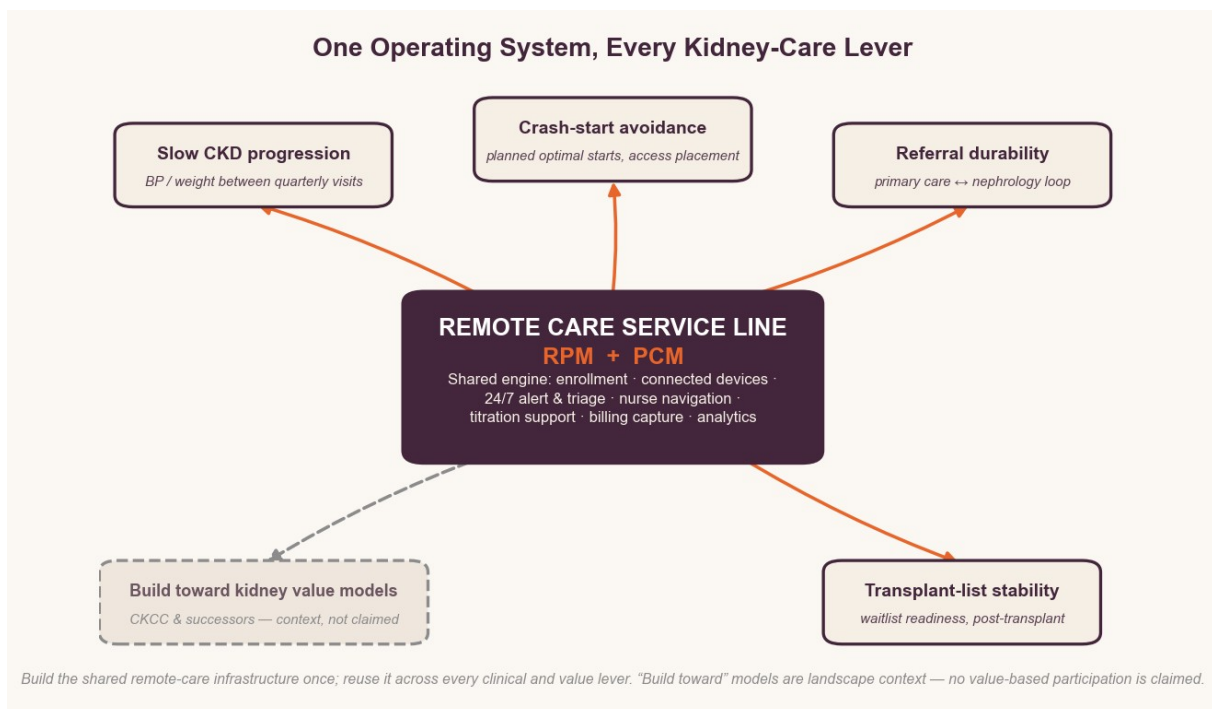


Figure 1. One shared remote-care infrastructure powers every clinical and value lever in the nephrology service line. “Build toward” kidney value models is landscape context only — no value-based participation is claimed for Georgia Nephrology.

2.2 Standalone value: the value layers in play

The service line is margin-positive on professional fees alone. Three value layers carry this business case; a fourth — kidney value-model performance — is deliberately excluded because no value-based participation is confirmed, and is treated only as build-toward context in Section 5.

Value Layer 1 — Standalone professional-fee revenue (RPM + PCM)

Recurring monthly professional-fee revenue from RPM and PCM, at top-of-license staffing. On the modeled 4,000-patient Medicare panel this reaches **\$2.45M in net reimbursement over 24 months**, of which **\$1.03M is practice net** after CoachCare's fees — a **42.2% blended margin**, positive from the second month of operation. Section 3 details the full model. *Illustrative, modeled — verify against practice data.*

Value Layer 2 — Delayed dialysis initiation, crash-start avoidance, and avoided acute-care cost

Continuous blood-pressure, weight, and volume monitoring in the interstitial window is how progression is caught early enough to change the trajectory — slowing decline, and converting unplanned “crash” dialysis starts into planned optimal starts. The 24-month model attributes roughly **116 avoided hospitalizations** to the program, on the order of **\$1.74M in avoided acute-care cost** at an illustrative \$15,000 per event. Crash-start avoidance is a further, larger economic prize that discovery should size against the group's own data. Section 4 develops this layer. *Illustrative, modeled — verify against practice data.*

Value Layer 3 — Referral durability and independence preservation

A monitored patient stays visible to, and engaged with, the nephrology group between visits — strengthening the primary-care referral loop through a shared care plan and data exchange, and keeping the group central to each patient's kidney journey and the optimal-starts pipeline it medical-directs. As a new, margin-positive line, it diversifies revenue and supports the group's independence rather than pushing it toward a sale.

Excluded from this business case (by design)

Kidney value-model (total-cost) performance. The nephrology bundle can, in principle, add a fourth layer: shared-savings-style performance inside a kidney total-cost model. It is excluded here because **no value-based participation is confirmed for Georgia Nephrology**. It appears in this report only as build-toward context (Section 5.3), and no participation, attribution, or upside is claimed.

How the recurring revenue works. RPM and PCM are billed monthly per enrolled, actively managed patient. Revenue is a function of enrolled census × the per-patient-month professional fee, so it compounds as enrollment ramps and then holds as a recurring base — the “subscription-like” quality that makes a service line, rather than a one-time project, out of remote care.

2.3 Connective tissue: one engine, every lever

The same enrollment, device, triage, navigation, titration, billing, and analytics engine that produces the standalone P&L is also what every clinical and value lever runs on. The group builds it once and reuses it across progression control, crash-start avoidance, referral durability, transplant-list readiness, and — if and when the group ever elects to enter one — a kidney value model. The matrix below maps the shared infrastructure to each lever.

Lever	How the same infrastructure powers it
Slow CKD progression	Home BP/weight RPM plus pharmacist-supported titration holds blood pressure and volume to target between quarterly visits.
Crash-start avoidance & optimal starts	Early detection of drift enables planned modality decisions, timely access placement, and home-dialysis readiness instead of an ED-driven crash start.
Referral durability	A shared care plan and data exchange keep the primary-care ↔ nephrology loop tight and the group central to the patient's kidney care.
Transplant-list stability	Monitored blood pressure and adherence support waitlist readiness and post-transplant management.
Build toward kidney value models (context)	The enrollment / device / triage / billing / analytics engine is the operational substrate any future kidney total-cost model requires — no participation is claimed.
Standalone P&L	The very same engine produces the recurring RPM + PCM professional-fee revenue in Sections 2.2 and 3.

3. The Value Analysis: Modeled Economics

How to read these numbers

Every figure in this section is a **discovery-stage estimate**, modeled in CoachCare's Value Analysis workbook at 2026 Georgia Medicare locality rates (carrier 10212, locality 01 — Atlanta). They are illustrative, not a quote or a guarantee of payment, and should be re-run against Georgia Nephrology's own Medicare chart counts and contracted rates before any commitment.⁸

3.1 Modeling assumptions

The panel is modeled at **4,000 total Medicare patients** — an estimate built from roughly 200 active office Medicare patients per nephrologist across 20 physicians, with a plausible range of 3,200–4,800. This is the single most important number to confirm; the whole model scales with it, and it should be re-run once chart counts are in hand.⁹

⁸Economics modeled in CoachCare's Value Analysis workbook (Georgia_Nephrology_CoachCare_Value_Analysis_2026.xlsx), 30 September 2026, at CY2026 Physician Fee Schedule rates for MAC locality 10212-01. Rates are locality-adjusted; figures are illustrative and require validation against practice data.

⁹Panel of 4,000 Medicare patients is an estimate (20 nephrologists × ~200 active office Medicare patients; range 3,200–4,800). Re-run the model after obtaining actual Medicare chart counts.

Assumption	Modeled value
Total Medicare panel (estimate)	4,000 patients (range 3,200–4,800)
In scope, Year 1	Full panel (4,000)
MAC / locality	Georgia · carrier 10212, locality 01 (Atlanta)
EMR / integration	Epic (nephrology-specific build); \$4,000 setup, \$150/mo, \$1.50/patient — confirm in contracting
RPM eligibility × acceptance → ceiling	75% × 35% → 1,050 patients
PCM eligibility × acceptance → ceiling	85% × 30% → 1,020 patients
Enrollment staffing	≥1 CoachCare-funded on-site enrollment specialist @ 80 enrollments/mo (CoachCare's expense)
Bulk discount applied	15%
Programs modeled	RPM + PCM only (CCM, TCM, APCM not modeled)

3.2 The 24-month picture

Over 24 months the service line generates **\$2,445,405 in net reimbursement**. After CoachCare's fees of \$1,414,488, the practice keeps **\$1,030,917 in net** — a **42.2% blended margin**. The ramp matters as much as the total: month 1 is slightly negative at **–\$4,964**, because one-time implementation and Epic integration setup land that month, and the service line is **margin-positive from month two** onward.

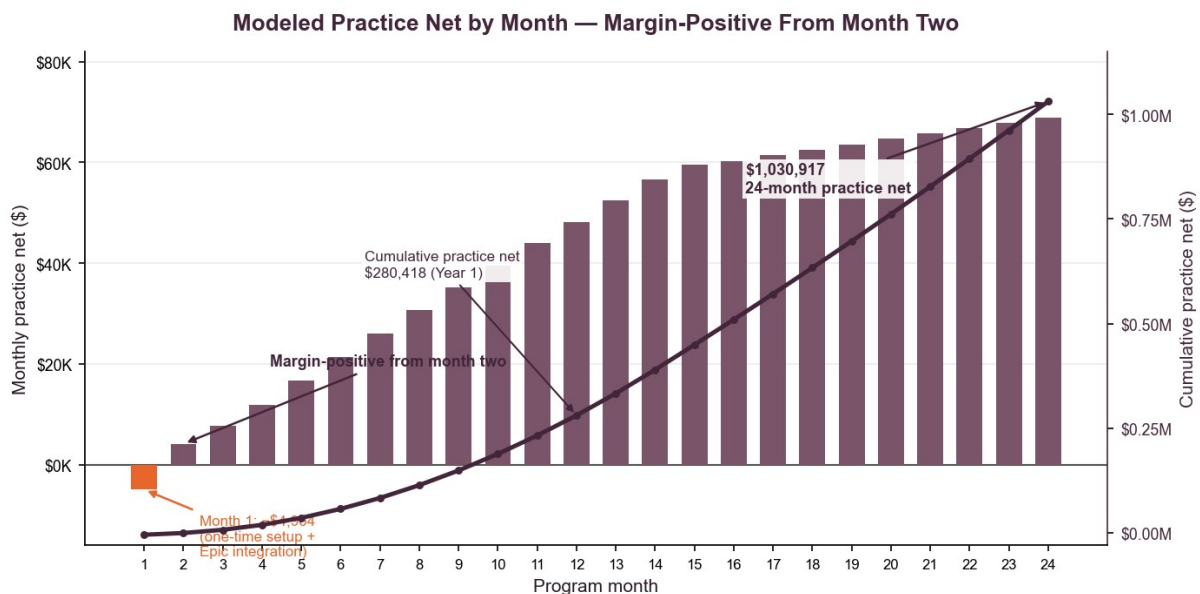


Figure 2. Modeled monthly practice net (bars) and cumulative practice net (line). Month 1 is negative on one-time setup and Epic integration; the line turns positive in month 2 and reaches \$1,030,917 by month 24.

Period	Net reimbursement	CoachCare fees	Practice net	Margin
Year 1	\$682,154	\$401,736	\$280,418	41.1%
Year 2	\$1,763,250	\$1,012,752	\$750,498	42.6%
24-month total	\$2,445,405	\$1,414,488	\$1,030,917	42.2%

Margin widens from Year 1 to Year 2 (41.1% → 42.6%) as the enrolled base matures and one-time costs fall away. The enrollment specialist's cost is carried by CoachCare throughout; it is embedded value to the practice and is never subtracted from the practice margin shown here.

3.3 Enrollment, patients, and the per-program split

The two programs ramp differently, and the report treats them separately rather than as one blended curve. **RPM fills first and saturates**: it reaches its ceiling of 1,050 enrolled patients at about month 15 and holds. **PCM keeps climbing**: at month 24 it stands at roughly 626 patients, still well below its 1,020 ceiling and still ramping. Netting out patients enrolled in both programs, the service line reaches roughly **944 unique patients by month 12** and **1,238 by month 24**, carrying **1,676 active program enrollments** at month 24 — services, not patients.

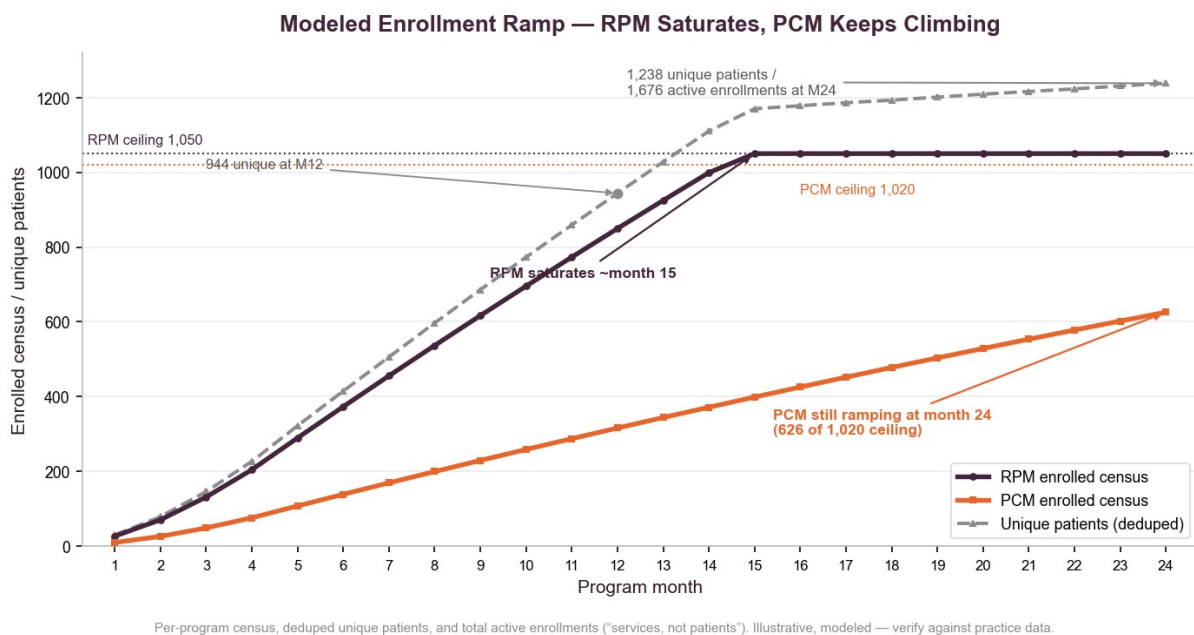


Figure 3. RPM saturates at its 1,050 ceiling near month 15; PCM is still ramping at month 24 (626 of a 1,020 ceiling). Deduped unique patients reach 1,238 at month 24, across 1,676 active enrollments.

The dollar split follows the enrollment shape. Over 24 months, RPM is the larger arm at **\$1,730,735 in net reimbursement (\$753,784 practice net)**; PCM contributes **\$714,670 (\$337,166 practice net)** and — because it is still ramping — carries the most remaining upside past the 24-month window.

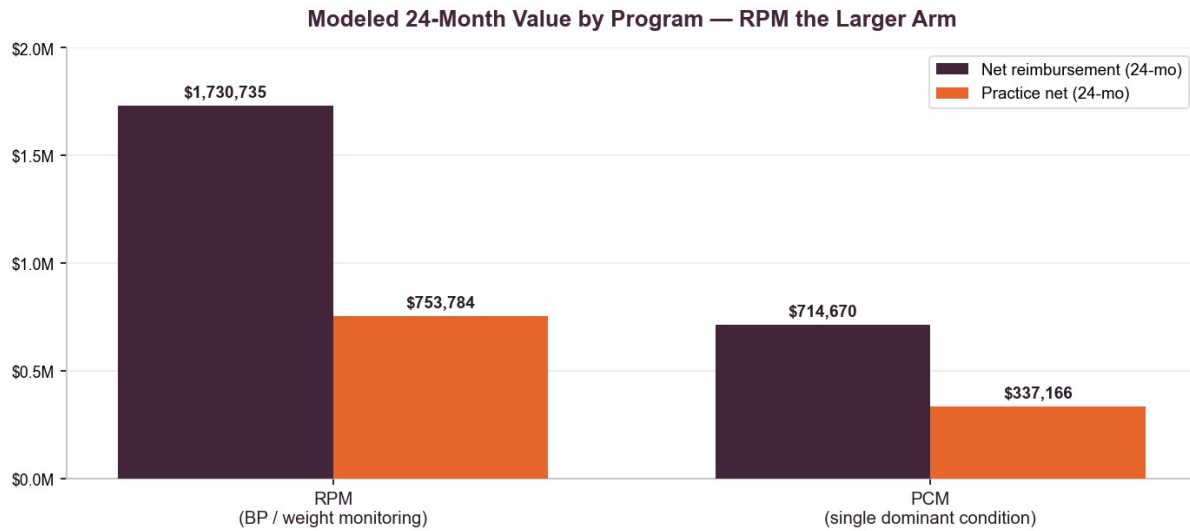


Figure 4. Modeled 24-month value by program. RPM is the larger, ceiling-limited arm; PCM is smaller at 24 months but still climbing toward its ceiling, with upside beyond the modeled window.

Program	Net reimbursement (24-mo)	Practice net (24-mo)	Ceiling	Status at M24
RPM	\$1,730,735	\$753,784	1,050	Saturated ~M15
PCM	\$714,670	\$337,166	1,020	Still ramping (626)
Combined	\$2,445,405	\$1,030,917	—	—

3.4 Clinical and operational value

Beyond the professional-fee P&L, the model quantifies the clinical and operational output of the service line over 24 months. These figures are modeled on the same assumptions and carry the same verify caveat.

Modeled output (24 months)	Value
Billable claims / units generated	~44,441
Physiologic readings captured	~183,199
Hospitalizations avoided	~116 (~\$1.74M avoided acute-care cost @ \$15K each)
Care-team hours saved	~20,548 (≈ 9.9 FTE-years)
Unique patients reached / active enrollments at M24	~1,238 unique / 1,676 enrollments

The avoided-cost and hours-saved figures are modeled on CoachCare defaults; the hospitalization-avoidance estimate in particular should be validated against the group's own acute-care and dialysis-start data, where the crash-start economics are likely to be larger than the generic per-event figure used here. *Illustrative, modeled — verify against practice data.*

4. Clinical Value Layers: Where CKD Progression Happens

The economics in Section 3 rest on a clinical premise: the most consequential kidney care happens between the quarterly visits, not during them. This section develops the three clinical value layers the service line delivers.

4.1 Slowing progression in the interstitial window

Chronic kidney disease progresses through blood pressure and volume. A patient seen once a quarter can drift for weeks before anyone sees it; by the next visit, the damage is done and the conversation is about catching up. Home RPM closes that window: daily blood-pressure and weight readings stream to the care team, drift triggers an alert, and titration happens in days instead of months. For Georgia Nephrology's CKD stage 3b–5 and resistant-hypertension cohorts — where blood pressure is both the problem and the lever — this is the single highest-yield use of remote monitoring.

The kidney-disease burden behind this is large and under-managed. In Georgia, an estimated 1.2 million adults have CKD and only about 147,000 are aware of it; roughly 3.8% of adults self-report kidney disease, and Southeast end-stage-renal-disease incidence runs above the national average.¹⁰

4.2 Crash-start avoidance and optimal starts

The most expensive moment in kidney care is an unplanned “crash” start — a patient who arrives at the hospital in decompensation and begins dialysis emergently, through a catheter, without a planned modality or access. The alternative is an **optimal start**: progression is tracked, the modality decision (including home dialysis) is made ahead of time, permanent access is placed on schedule, and the transition is planned. Georgia Nephrology already offers home-dialysis education and training and medical-directs a dense dialysis footprint — the clinical pieces are in place; what is missing is the monitoring layer that flags the trajectory early enough to act.

This is where the service line's clinical and financial value converge. The 24-month model attributes about 116 avoided hospitalizations and roughly \$1.74M in avoided acute-care cost to the program; crash-start avoidance sits inside and beyond that figure, because a converted crash start avoids not only an admission but a far more costly and worse-outcome dialysis initiation. Discovery should size this against the group's own crash-start rate — it is likely the largest single economic prize in the business case, and it is deliberately modeled conservatively here. *Illustrative, modeled — verify against practice data.*

A note on resistant hypertension

Resistant hypertension is a natural clinical fit for BP-focused RPM and for co-management with the group's hypertension service. It is referenced here as a clinical cohort and monitoring target only — not as a procedural or device-sales revenue lever.

¹⁰CKD burden: ~3.8% adult self-reported kidney disease in Georgia (2023 BRFSS, America's Health Rankings); National Kidney Foundation estimate of ~1.2M Georgia adults with CKD, ~147K aware; Southeast ESRD incidence above national average (CDC CKD context). 2023–2025.

4.3 Referral durability and independence

A remote-care service line is also a retention and referral engine. A monitored patient has a monthly, documented touch with the nephrology group between visits, which keeps the group visible to referring primary-care physicians through a shared care plan and data exchange, and keeps patients from drifting to another group or an employed program. For an independent practice, that durability matters twice over: it protects the referral base that feeds the practice, and it builds a new, recurring, margin-positive revenue line that strengthens the case for staying independent rather than selling into a system or platform to capture value that a service line can capture directly.

5. The 2026–2027 Policy & Payment Environment

5.1 The care-management billing tailwind

The codes this service line bills are established, recurring, and were expanded for 2026. RPM pays a one-time setup (99453), a recurring device-supply fee (99454), and monthly management time (99457 for the first 20 minutes, 99458 for each additional 20). For 2026, CMS added **short-window codes — 99445 and 99470** — that open billable monitoring in the 2–15-day and first-10-minute windows, which fit post-hospitalization and post-procedure transitions. PCM (99424–99427) funds structured monthly management of a single dominant high-risk condition. None of this depends on a new CMS model; it is standard Physician Fee Schedule billing, and the model uses illustrative national-to-locality magnitudes that must be confirmed against the Georgia MAC.

5.2 Medicare Advantage and the fee-for-service floor

Georgia's Medicare Advantage penetration is high — roughly **56.3% of the state's Medicare beneficiaries as of August 2026**. For a care-management service line this is a manageable, not a limiting, fact. Fee-for-service parity is the **floor** for these care-management code families, and individual MA contracts set their own terms on top of that floor. This Value Analysis is built entirely on fee-for-service rates; MA-contracted terms are a contracting-stage conversation, and where they differ they tend to do so from the FFS floor upward. County-level MA figures for the served counties were not individually verified and should be pulled in discovery.

5.3 The kidney value-model landscape (build-toward context)

No value-based participation is claimed

This subsection is **landscape context only**. Georgia Nephrology's participation in every kidney or accountable-care value model is **not confirmed** on the public record, and the available evidence points against current participation. Nothing in this report models, claims, or depends on value-based upside for the group.

For context, the federal kidney total-cost models (the Kidney Care Choices options) were reworked in 2024: the comprehensive options were **extended through December 31, 2027**, while the Kidney Care First option **ended December 31, 2025**. No named successor kidney

model for 2028 and beyond has been announced as of this writing.¹¹ The strategic point for Georgia Nephrology is narrow and honest: whatever kidney value model exists after 2027, it will require exactly the operational substrate this service line builds — enrollment, connected devices, triage, monitoring, and billing capture across the CKD panel. Standing the service line up now is margin-positive on its own terms and leaves the group **model-ready** if and when it ever chooses to enter one. That is the only sense in which value models appear in this business case.

Unverified flags carried from research

- **Value-based participation (CKCC/KCE, Shared Savings / REACH, MA risk):** not confirmed — evidence points against current participation; CMS kidney-model participant files remain to be pulled directly.
- **EMR:** Epic (nephrology-specific build) confirmed at the patient-portal level; the underlying EHR contract is not independently confirmed beyond the portal.
- **Dialysis relationship:** medical direction only; no ownership or joint-venture stake verified.
- **Panel size, home-dialysis depth, county-level MA mix:** estimates / discovery items — confirm before contracting.

6. EMR Integration: The Epic-Connected Service Line

Georgia Nephrology runs a nephrology-specific Epic electronic health record.¹² That is an advantage, not an obstacle: CoachCare's program is built to live inside the Epic environment, so the group's staff enroll and monitor patients without learning a separate system, and the remote-care data lands in the chart where clinicians already work.

6.1 The five integration pillars

1. **Integrated enrollment.** Enrollment flags and trigger ordering live inside the existing clinical workflow; CoachCare's team enrolls qualified Medicare patients on the group's behalf, and enrollment status is visible in Epic in real time.
2. **Bi-directional exchange of health history.** Patient health history is exchanged both ways at intake, so the monitoring program starts with the record the clinic already has.
3. **Discrete device vitals in the chart.** Connected-device readings land as discrete, structured vitals in the record — not as scanned PDFs — so they are trendable and clinically usable.
4. **Audit-ready compliance documentation.** The care summary and time documentation needed to support each claim are generated and stored in the record.

¹¹Kidney Care Choices status: comprehensive (CKCC) options extended through 31 December 2027; Kidney Care First ended 31 December 2025; no named successor for 2028+ announced as of September 2026. CMS Kidney Care Choices model pages and FierceHealthcare, 2024–2026.

¹²EMR: nephrology-specific Epic build, confirmed at the patient-portal level (portal served on the vendor's dedicated MyChart domain). The underlying EHR contract is not independently confirmed beyond the portal; confirm the exact integration path in contracting. 2026.

- 5. Automated claim generation.** Claims are produced by CoachCare's billing engine, removing the manual per-patient, per-month claim step.

Proof points. Patients begin receiving RPM and care-management services in **under five days** from the moment they are flagged, and CoachCare is the **only care-management application integrated with Epic that provides automated claims creation** — which shortens the path from enrollment to reimbursement.

“Key to achieving a program that is efficient, effective and sustainable is creating a seamless, intuitive user experience for the patient and provider, and that's what our integration with Epic accomplishes.”

— CoachCare

6.2 Integration economics and path

The Epic integration is modeled at **\$4,000 for setup, \$150 per month, and \$1.50 per patient**. These are the figures carried in the Value Analysis and already reflected in the practice-net numbers in Section 3 (the month-1 setup is part of why month 1 is slightly negative). The exact integration path and fees should be confirmed in contracting — the group's specific Epic instance and its interoperability posture will determine the precise route.

7. Implementation Playbook

7.1 Scope, populations, and staffing

Goal. Stand up a nephrology remote-care service line across the group's nine offices, reaching a material share of the Medicare panel within 12 months and a recurring, margin-positive revenue base by month two.

Target populations, in priority order:

- **CKD stage 3b–5 with hypertension** — the core RPM cohort; blood pressure and weight are the levers of progression.
- **Resistant hypertension** — high-yield BP monitoring and co-management.
- **Optimal-starts / crash-start-risk patients** — the highest combined clinical and economic return per enrollee.
- **Single-dominant-condition patients** — the PCM cohort, for structured monthly management.

Staffing. Physicians set the plan; the daily monitoring, outreach, and documentation run on CoachCare-funded staff and connected devices. At least one CoachCare-funded on-site enrollment specialist works at roughly 80 enrollments per month — the enrollment labor is CoachCare's expense and embedded value to the practice, not a line the group staffs or funds.

7.2 Technology, workflow, and billing

The technology stack is the shared engine from Section 2.3: cellular connected devices, a 24/7 alert-and-triage layer, nurse navigation, pharmacist-supported titration, and an automated billing engine — all wired into Epic per Section 6. The clinical workflow is: flag eligible patients in Epic

→ CoachCare enrolls and provisions devices → readings stream as discrete vitals → the care team reviews, intervenes, and documents → the billing engine generates the claim. The practice keeps clinical control and top-of-license staffing; the program supplies the labor, devices, and documentation underneath it.

7.3 KPI dashboard and 12-month roadmap

Category	Metric	Target / definition
Clinical	BP at target (monitored cohort)	% of RPM patients at goal BP; trend month over month
Clinical	Avoided hospitalizations / crash starts	Tracked against baseline; validate the modeled ~116 over 24 mo
Operational	Time to first billable enrollment	Days from program start to first billed patient
Operational	Enrolled census (RPM / PCM)	Toward 1,050 (RPM) and 1,020 (PCM) ceilings
Operational	Capture rate	% of eligible, consented patients actively monitored and billed
Financial	Revenue / patient / month	Blended net reimbursement per active enrollment
Financial	Practice net & blended margin	Toward the modeled \$1.03M / 42.2% at 24 months

12-month roadmap.

Phase	Focus	Milestones
Months 1–2	Stand-up	Contract & confirm panel counts; Epic integration live; ES on-site; first cohort enrolled; margin-positive by month 2
Months 3–6	Ramp	Scale RPM across CKD 3b–5 & resistant-HTN cohorts; begin PCM; monthly service-line scorecard live
Months 7–12	Scale & prove	Approach RPM saturation; grow PCM; validate avoided-hospitalization and crash-start data against baseline
Month 12+	Optimize & ready	Hold recurring base; extend PCM toward ceiling; keep the group model-ready for any future kidney value model

About CoachCare

CoachCare runs remote-care programs at scale: **500,000+ patients** managed across 400+ conditions, **10,000+ clinicians** on the platform, **1,000+ programs** stood up in market, more than **5 million claims** generated, and over **100 million vitals** recorded.¹³

Expected impact. A recurring, margin-positive nephrology service line — roughly \$1.03M in practice net over 24 months at a 42.2% blended margin on the modeled panel — that slows CKD progression in the interstitial window, converts crash starts into planned optimal starts, strengthens the referral base, and leaves the group independent and ready for whatever kidney

¹³CoachCare scale figures: coachcare.com (approved company statistics), 2026.

value model comes next. Every figure here is a discovery-stage estimate to be validated against Georgia Nephrology's own data. *Illustrative, modeled — verify against practice data.*

References & Data Sources

Topic	Source & vintage
Practice profile, footprint, services, providers, locations, dialysis medical direction	ganephrology.com (About the Practice, Providers, Locations, Services, Dialysis Centers). Retrieved September 2026.
Physician recognition ("Top Doctors" 2026)	Atlanta Magazine, Top Doctors — Nephrology, 2026.
Remote-care whitespace (no RPM/CCM/device program)	Direct review of practice Services and About pages plus targeted search; telehealth and patient portal only. 2026.
EMR (nephrology-specific Epic; portal-level confirmation)	Practice patient portal served on the EHR vendor's dedicated MyChart domain; vendor product documentation. 2026.
Kidney value-model participation (not confirmed)	Absence from the one Georgia kidney value-entity public roster (which names other Georgia groups); CMS Kidney Care Choices participant/affiliation files (CY2025, CY2026) flagged for direct pull. 2023–2026.
Accountable-care participation (not confirmed)	CMS Shared Savings Program ACO participant-TIN lists (legacy entity present 2012–2013 only); regional clinically integrated network ACO public disclosure stating no Shared Savings participation in PY2025 and naming other nephrology groups. 2013 / 2025–2026.
Kidney Care Choices model status	CMS Kidney Care Choices model pages and PY2026 update; FierceHealthcare (model rework). CKCC extended through 31 Dec 2027; KCF ended 31 Dec 2025. 2024–2026.
Georgia Medicare Advantage penetration (~56.3%, Aug 2026)	CMS-sourced enrollment via healthinsurance.org (Medicare in Georgia) and statranker MA-by-state 2026. County-level figures not individually verified.
CKD / ESRD burden (Georgia)	America's Health Rankings (2023 BRFSS, CKD/GA); National Kidney Foundation Georgia estimates; CDC Chronic Kidney Disease materials. 2023–2025.
CY2026 billing codes (RPM 99453/99454/99457/99458, new 99445/99470; PCM 99424–99427)	CMS Physician Fee Schedule, CY2026; rates modeled at MAC locality 10212-01 and are illustrative, subject to locality adjustment and validation.
EMR integration model (\$4,000 / \$150/mo / \$1.50 per patient) and five Epic pillars	CoachCare Epic Integration overview and talking points. Confirm the exact integration path and fees in contracting.
CoachCare scale statistics	coachcare.com (approved company statistics). 2026.
Value Analysis — all modeled economics	CoachCare Value Analysis workbook, Georgia_Nephrology_CoachCare_Value_Analysis_2026.xlsx, 30 September 2026. Figures are discovery-stage estimates.

Global verification note

This report is an account-based strategy document built on public research and a modeled Value Analysis. Every present-day fact is sourced and date-stamped; items that could not be independently verified are flagged in the text. All financial figures are **illustrative, discovery-stage estimates**, modeled at 2026 Georgia Medicare locality rates and to be validated against Georgia Nephrology's own panel counts, contracted rates, and Epic integration path before any commitment. No value-based participation is claimed for the group.