COACHCARE | SERVICE LINE STRATEGY

Northeast Ohio Nephrology Associates, Inc.

411 E. Market Street, Akron, Ohio · Summit County — an independent, physician-owned nephrology practice

Nephrology Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (RPM + PCM) as the operating spine for CKD population management, CKCC Global-risk performance, and a margin-positive standalone P&L billed under the practice's own TIN

Purpose of this document

Prepared by CoachCare, July 2026, as a discussion document for the physician leadership of Northeast Ohio Nephrology Associates. It assembles the practice's public footprint, its CY2024 Medicare service record, its verified position inside a Global-risk Kidney Contracting Entity, the 2026–2027 Medicare policy environment, and a modeled financial forecast into a single argument: the practice already carries full downside risk on total cost of care for its aligned kidney patients, and the layer of care that determines that cost — the months between quarterly nephrology visits — is currently neither staffed nor billed.

All facts are drawn from public sources current to July 2026 and cited in the References section. All financial projections are illustrative and modeled in CoachCare Value Analysis (MAC-locality rates auto-resolved for ZIP 44304 — CGS Jurisdiction 15, Ohio statewide locality) — verify against practice data before budgeting.

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Executive Summary

Northeast Ohio Nephrology Associates, Inc. (“NEONA”) is an independent, physician-owned single-specialty nephrology corporation, founded in 1987 and operating from one office at 411 E. Market Street in Akron, Ohio. Six nephrologists — Darryl P. Anderson, MD; Andrew Chiao, DO; Charina P. Gayomali, MD; Michael W. George, MD; Valerie Jorge Cabrera, MD; and Thomas Kayani, MD — carry the entire clinical load: office CKD and hypertension care, inpatient consultation and rounding across at least six affiliated facilities including Cleveland Clinic Akron General, Summa Akron City, Summa Barberton, Western Reserve Hospital and Select Specialty Hospital, and end-stage renal disease management including four DaVita medical directorships — three held by Dr. Kayani and one by Dr. Anderson.[1] Dr. Gayomali is Division Chief of the Section of Nephrology at Summa Health System. The practice runs on eClinicalWorks. It employs no advanced practice providers of its own, and its published non-clinical staff is two people — a practice manager and an administrative assistant.

NEONA is also a **verified aligning provider in Integrated Kidney Care of Ohio, LLC** — a DaVita-affiliated Kidney Contracting Entity participating in the CMS Kidney Care Choices model on the **CKCC Global option: 100% risk on total cost of care** for aligned beneficiaries. All six physicians appear on the KCE's public roster by name, and Dr. Anderson is one of its Governing Body Designees (Cohort 2, performance from January 1, 2023; active in PY2026).[2] DaVita is the practice's value-based-care contracting partner through that entity; NEONA retains its own TIN, NPI and legal identity. Two facts define this report. In CY2024 the group billed **no remote-monitoring, care-management or transitional-care codes of any kind** — its entire Medicare service mix is **twelve distinct HCPCS codes**. And the KCE's Total Quality Score **fell from 87.5% in PY2023 to 80.0% in PY2024**.[3] Under a Global arrangement the quality score is not a report card; it gates the rate at which savings are shared.

The central argument

1. **Standalone value.** RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based upside — modeled at **$1,317,155** of net reimbursement and **$561,568** net to the practice over 24 months, a **42.63% practice margin** (net to the practice ÷ net reimbursement).
2. **Connective tissue.** One shared engine — enrollment, connected devices, 24/7 alerting and triage, nurse navigation, billing capture and analytics — simultaneously serves CKCC Global performance, CKD progression and crash-start avoidance, transitional care after discharge (identified, not modeled), referral durability with primary care, and the standalone P&L. Build once, use everywhere.

Where the P&L sits is the second argument. The KCE's own public disclosure for PY2024 reports shared savings of **$1,491,352**, of which **89.2% was allocated to “Investments (including Infrastructure & Care Resources)”** and **10.8%** was distributed to KCE participants and preferred providers; PY2023 distributions were **$0**. DaVita's VillageHealth DM LLC is the KCE's named Preferred Provider Group for care management.[4] None of that is a judgment about the care delivered. It is an observation about where the P&L sits. A remote care service line billed under NEONA's own TIN differs in three specific ways: the professional fee is the practice's revenue and does not depend on a shared-savings determination; the intervention is device-based physiologic monitoring rather than telephonic

[1] Practice website: physicians page, individual biographies, and Our Affiliations (neonephrology.com), retrieved July 29, 2026; dialysis facility identifiers cross-checked against the CMS Medicare Dialysis Facility listing, updated June 16, 2026.

[2] Integrated Kidney Care of Ohio, LLC — KCE Leadership, Participants and Providers (the CMS-required public transparency roster), retrieved July 29, 2026; corroborated by the CMS Kidney Care Choices PY2026 participants and PY2026 participants + affiliations notices, both dated February 4, 2026.

[3] CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024 (dataset modified May 21, 2026), screened against the full remote-monitoring and care-management code set; and the KCE's public disclosure of PY2023 and PY2024 Total Quality Scores.

[4] Integrated Kidney Care of Ohio, LLC — public disclosure of PY2024 shared savings and their allocation, and of PY2023 results; page datestamps April 2 and July 2, 2026; retrieved July 29, 2026.

navigation; and the population is the practice's **entire panel** — Medicare Advantage, commercial, Medicaid, and every CKD patient not attributed to the KCE — rather than the aligned sub-panel alone.

The third fact is capacity. Average HCC risk across the six physicians' CY2024 Medicare panels runs **3.27 to 3.94** against a national average of 1.00. CKD and hypertension prevalence both sit at 75% — the value CMS publishes as its cap — with diabetes at 49–62% and heart failure at 37–48%.[5] The same six physicians delivered **954 subsequent-hospital-care services and 227 hospital admissions** in CY2024 across at least six affiliated inpatient facilities. Every one of those admissions also opened a transitional-care window (99495/99496) that went unbilled — an identified second opportunity that is deliberately **not included in the financial model in this report**. With no advanced practice providers and a two-person administrative team, the constraint on managing this panel between visits is neither conviction nor software. It is people. That is exactly what a full-service model supplies.

The timing is specific. CMS has extended the CKCC options of the Kidney Care Choices model through the end of PY2027, so the 24-month window modeled here sits inside the model's final and most consequential performance years.[6] Separately, the CY2026 Physician Fee Schedule expanded remote monitoring in ways that suit nephrology: 99445 pays the monthly device-supply amount for 2–15 days of data, which makes short post-discharge and dialysis-transition windows billable, and 99470 pays for the first 10 minutes of monthly management time.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **~2,050 Medicare patients across six nephrologists** — a discovery-stage estimate to validate against chart counts — all of them in scope in Year 1, with RPM and PCM only. It projects net reimbursement of **$387,939** in Year 1 and **$929,216** in Year 2 (**$1,317,155** over 24 months — RPM $864,847, PCM $452,308); **$561,568** net to the practice after CoachCare fees; 99,044 physiologic readings; approximately **63 avoided hospitalizations** (≈$945,000 at $15,000 per admission — value that also flows into the KCE's total-cost-of-care result); and 12,173 care-team hours delivered, about 5.9 full-time equivalents of clinical labor the practice does not have to hire. *All figures are illustrative, modeled — verify against practice data.*

2026–2027 Priority Recommendations

1. **Charter the Remote Care Service Line as a named program with its own P&L.** RPM + PCM across CKD stages 3b–5, uncontrolled and resistant hypertension, and patients approaching or recently starting dialysis. Name a physician lead — Dr. Anderson is the natural choice given the KCE governing-body seat — paired with the practice manager on operations. Target the first billable enrollment within 90 days.
2. **Keep the service line under NEONA's own TIN.** The modeled $561,568 of 24-month net-to-practice is fee-for-service revenue the practice retains regardless of how any performance year reconciles. Whatever the KCE distributes is additive to it. Ownership of the P&L is the point (Sections 2.2 and 5).
3. **Turn on the eClinicalWorks integration on day one.** Enrollment flags and service ordering inside the existing chart, enrollment status visible in real time, patients receiving services in under five days, and automated claim generation through the CoachCare billing engine, which removes the manual per-patient monthly claim step entirely. For a two-person administrative team that is the difference between a program that runs and one that does not (Section 8).
4. **Aim the program at the CKCC measures a monitored census actually moves.** Hospitalizations and total cost of care; optimal (planned) dialysis starts and home modality; blood-pressure control and slowed progression; and audit-ready documentation of the measures being scored. The Total Quality Score fell 7.5 points between PY2023 and PY2024 — under Global, a direct hit to the savings rate (Section 5).

[5] CMS Medicare Physician & Other Practitioners — by Provider, CY2024 (dataset modified May 21, 2026). CMS caps published chronic-condition prevalence values at 75%.

[6] CMS Innovation Center, Kidney Care Choices Model — PY2026 Model Update Quick Reference and model page. The Kidney Care First option ended December 31, 2025; the CKCC options were extended by one year, to the end of PY2027.

5. **Decide the transitional-care question separately, and soon.** 227 admissions in CY2024, none billed for TCM. It is a second revenue line, deliberately excluded from this model so the forecast stays conservative — and it is also the highest-risk clinical window a CKD patient passes through (Section 6.3).
6. **Write the coordination policy with the KCE before the first enrollment.** NEONA owns RPM and PCM on the kidney condition; the referring primary-care physician owns any longitudinal primary-care wrapper; the KCE's care-navigation activity runs on one shared care plan with explicit task ownership. This prevents duplicate-billing denials and partner friction (Sections 2.1 and 9.3).

1. Footprint & Operating Model

1.1 The practice

Founded in 1987 and still physician-owned, NEONA operates from a single clinic at 411 E. Market Street in Akron — Summit County, ZIP 44304 — with no satellite offices. The corporate record is a single-specialty group under its own organizational NPI; no management services organization, private-equity sponsor or platform parent appears in any public source, and the practice describes itself in its own recruiting material as a private practice. Six nephrologists deliver all of the clinical work.

Physician	Nephrology fellowship	Notes relevant to this report
Darryl P. Anderson, MD	Penn State Hershey	Governing Body Designee, Integrated Kidney Care of Ohio, LLC; medical director, DaVita Coventry Dialysis; largest fee-for-service panel in the group
Andrew Chiao, DO	University of Rochester, 2019–21	Assistant Professor of Internal Medicine, NEOMED
Charina P. Gayomali, MD	Hospital of St. Raphael / Yale-New Haven, 2007–09	Division Chief, Section of Nephrology, Summa Health System (2021–present); additionally fellowship-trained in hospice and palliative medicine
Michael W. George, MD	Cleveland Clinic Foundation, 2021–23	Joined the practice August 2023; highest average panel acuity in the group (3.94)
Valerie Jorge Cabrera, MD	Yale School of Medicine / Yale-New Haven, 2014–16	Listed on the Western Reserve Hospital medical staff directory
Thomas Kayani, MD	Vanderbilt, 1999–2001	Medical director at three DaVita units — Akron Renal Center, Summit Renal Center, and Summit Renal Home Therapies; Assistant Professor of Internal Medicine, NEOMED

What the practice does not have is as informative as what it does. Public records show no vascular access center, no ambulatory surgery center, no in-house laboratory, no infusion suite, no transplant program, and no published clinical-research program; a renal-dietitian NPI record exists at the address but was last updated in 2007 and the individual does not appear on the current staff page, so it should not be counted as current infrastructure.[7] This is a structural observation, not a criticism, and it cuts in the practice's favour two ways. There is no competing capital project absorbing management attention or capital. And a remote care service line would be the practice's **first ancillary P&L** — designed from scratch on the practice's own terms rather than retrofitted around existing ancillary economics.

1.2 The operating model

The clinical week is split across four settings and at least ten physical sites: the office at 411 E. Market Street; inpatient rounds at Cleveland Clinic Akron General, Summa Akron City, Summa Barberton, Summa Rehab, Western Reserve Hospital and Select Specialty Hospital; dialysis rounds; and four DaVita medical directorships. Summit County alone has 16 Medicare-certified dialysis facilities for a population of 538,370, of whom 20.2% are 65 or older — a heavy end-stage renal disease footprint in a small geography.[8]

Two structural features matter for what follows. First, **the practice holds decision rights on risk.** Dr. Anderson's seat on the KCE governing body means the economic conversation about total cost of care does not have to be escalated anywhere — it happens inside this building. Second, **the practice holds**

[7] CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024: no vascular access, ambulatory-surgery, laboratory or infusion codes appear in the group's published service mix. The renal-dietitian NPI record at the practice address was last updated in 2007 and does not appear on the current staff page.

[8] CMS Medicare Dialysis Facility listing, updated June 16, 2026; U.S. Census Bureau American Community Survey 2024 one-year estimates, table B01001.

an unusual system relationship. Dr. Gayomali has run the Section of Nephrology at Summa Health System since 2021, and Summa is the practice's densest hospital tie, with three Summa facilities among its affiliations. Summa's own accountable care organization has 13 participants, all primary care and none in nephrology — so the referral relationship between Summa's primary-care base and this practice runs directly rather than through a shared risk vehicle.

The administrative layer is the constraint. The practice's published non-clinical staff is two people: Aren Marencik, Practice Manager, and Amy Yankovich, Administrative Assistant. The all-staff page lists no registered nurses, no care coordinators, no population-health staff, no billing department and no IT function; the only current job posting is for a medical assistant.[9] Combined with no advanced practice providers of the practice's own, that is a structural statement about capacity rather than intent: there is nobody in the building who could be redeployed to staff a chronic-care program, and a group at this size and acuity should not have to build one from scratch to participate in the economics it already carries risk for.

1.3 Design principles for the 2026 service line

Principle	What it means at NEONA
Longitudinal by default	Every CKD 3b–5, uncontrolled-hypertension and pre-dialysis patient leaves an encounter enrolled in monitoring or monthly management — not merely scheduled for a return visit a quarter later
One front door	A single enrollment, consent and device-logistics workflow; referral to the service line is one order inside eClinicalWorks, with enrollment status visible in the chart in real time
The partner carries the load	Six physicians, no advanced practice providers of their own, and two administrative staff means the practice supplies clinical direction and supervision while the partner supplies enrollment, devices, monitoring, documentation and claims
One cross-setting view	Office, dialysis and hospital care are documented in systems the practice does not control. The monitoring layer becomes the one record that follows the patient across all of them (Section 8.1)
Whole panel, not just the aligned panel	CKCC attribution reaches traditional-Medicare beneficiaries only. The service line bills across fee-for-service and Medicare Advantage alike — in a county where 63.14% of Medicare eligibles are enrolled in MA
Single scorecard	Clinical, operational and financial KPIs for the service line reviewed monthly by the physician lead and the practice manager, and fed into the KCE governance cycle (Sections 5 and 9.5)

[9] neonephrology.com all-staff and careers pages, retrieved July 29, 2026, corroborated by the practice's Indeed employer page. Third-party firmographic estimates of headcount conflict with each other and with the practice's own published roster; the roster is used here.

2. The Remote Care Service Line — The Operating Spine

This section defines the service line precisely, prices its standalone economics against NEONA's own Medicare base, and shows how one infrastructure serves every value lever the practice faces in 2026–2027.

2.1 What it is: the nephrology clinical & billing stack

The Remote Care Service Line is not a device program and not an app. It is a managed clinical service built on Medicare remote-monitoring and care-management benefits, configured for a nephrology group:

Program	Core codes	What it does	Where it lands at NEONA
RPM — Remote Physiologic Monitoring	99453; 99454 / 99445; 99457 / 99470; 99458	Cellular blood-pressure cuffs and weight scales; daily physiologic data; 24/7 review and alert triage; monthly clinical management time	The between-visit layer for CKD 3b–5 and for a panel whose hypertension prevalence sits at the CMS published cap; weight and fluid tracking around dialysis transitions; short post-discharge windows via the new 99445
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Chronic kidney disease as the qualifying condition. In a nephrology panel the single dominant condition genuinely is the kidney disease — the clinical situation PCM was written for
TCM — Transitional Care Management ***(identified, not modeled)***	99495 / 99496	30-day post-discharge transition: contact within two business days; face-to-face visit within 14 or 7 days	227 admissions in CY2024, none billed for TCM. A genuine second revenue line and the highest-risk clinical window in CKD — and explicitly excluded from every financial figure in this report

Chronic Care Management is not in the modeled stack, and this is deliberate rather than an oversight. It is the multi-condition instrument of primary care, and NEONA has no primary-care panel to bill it against; the model therefore carries it at zero eligibility. The specialty stack modeled in this report is RPM plus PCM, and nothing else.

The one coordination rule

RPM and PCM stack. They may be billed for the same patient in the same month with discrete time and documentation — that pairing is the core of this program. What does not stack: only one practitioner may bill RPM for a given patient in any 30-day period.

The practical rule for NEONA: the practice owns RPM + PCM on the kidney condition; the referring primary-care physician owns any longitudinal primary-care management wrapper; the KCE's care-navigation activity is aligned through **one shared care plan** rather than duplicated billing. Write the attribution policy before the first enrollment — it prevents denials and partner friction inside the KCE.

2.2 Standalone value: a margin-positive service line

Before any value-based upside, the service line stands on four layers of value:

1. **Direct professional-fee revenue.** Recurring monthly billing on a population the practice already manages clinically, delivered at top-of-license staffing under general-supervision rules. Modeled at $1,317,155 of net reimbursement over 24 months.
2. **Total-cost performance inside the KCE.** Fewer crash starts, fewer fluid-overload admissions and fewer emergency-department touches are the currency of a CKCC Global reconciliation. Modeled

at approximately 63 avoided hospitalizations over 24 months — about $945,000 at $15,000 per admission — value that lands in the KCE result on top of the fee-for-service revenue.

3. **Clinical capacity the practice does not have to hire.** 12,173 care-team hours over 24 months, roughly 5.9 full-time equivalents, delivered by the partner under the practice's protocols and supervision. For a group with six physicians, no advanced practice providers of its own and two administrative staff, this is the layer that makes the program possible at all.
4. **Strategic position.** The practice keeps its own TIN, its own data and its own patient relationships while adding an infrastructure layer it would otherwise have to build, buy, or rely on a partner whose economics sit upstream to supply.

The CY2026 billing stack

Service / code	Type	~CY2026 magnitude	Notes
RPM — 99453	One-time setup	~$20	Device setup and patient education; requires qualifying data days
RPM — 99454 / 99445	Monthly	~$52	99454 = 16–30 days of data; 99445 = new 2026 short-window code (2–15 days) at the same magnitude — post-discharge and dialysis-transition windows now billable
RPM — 99457 / 99470	Monthly	~$52 / ~$26	First 20 minutes of management time / new 2026 first-10-minute code
RPM — 99458	Monthly	~$41	Each additional 20 minutes
PCM — 99424 / 99425	Monthly	~$79 / ~$57	Physician or qualified health professional: first 30 minutes / each additional 30
PCM — 99426 / 99427	Monthly	~$60 + ~$50 addl	Clinical staff under supervision: first 30 minutes / each additional 30 — the workhorse codes for a full-service care team
TCM — 99495 / 99496 ***(not modeled)***	Per discharge	~$200 / ~$280	Contact within two business days; face-to-face within 14 or 7 days — upside beyond every figure in this report

Rates are illustrative

The figures above are illustrative national non-facility magnitudes for CY2026. Actual payment is locality-adjusted and set by the regional Medicare Administrative Contractor — CGS Administrators, Jurisdiction 15, for Ohio. The financial model in this report uses MAC-locality rates auto-resolved for ZIP 44304 in CoachCare Value Analysis (Ohio statewide locality); verify against the current CY2026 Physician Fee Schedule and the applicable locality files before budgeting. Note also the dual-eligible share of the panel — 182 dual-eligible beneficiaries across the six physicians in CY2024 — for whom Medicare cost-sharing is generally covered, which reduces patient-collection friction at enrollment.

Modeled economics for NEONA

The companion Value Analysis prices an RPM + PCM program on NEONA's Medicare base. The modeled population is an estimated **~2,050 Medicare patients across six nephrologists** — total Medicare, meaning fee-for-service plus Medicare Advantage at the local 63.14% penetration — with all of them in scope in Year 1. *This is a discovery-stage estimate and should be validated against chart counts.* The observed floor is the 1,072 fee-for-service beneficiaries CMS publishes for these six physicians in CY2024; the upper bound is roughly 2,900. Enrollment builds bottom-up from six referring providers at eight referrals per provider per month with 80% patient acceptance, supported by **one on-site enrollment specialist** at approximately 80 enrollments per month — **staffed at CoachCare's expense: embedded value, never deducted from the practice's margin**. Program eligibility is modeled at 75% of the in-scope population for RPM and 85% for PCM, with acceptance of 35% and 30% respectively. PCM

carries the higher eligibility rate deliberately: in a nephrology panel, chronic kidney disease genuinely is the single dominant condition, which is precisely what the code was written for.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$387,939	$929,216	**$1,317,155**
CoachCare fees (incl. setup & integration)	$229,998	$525,590	$755,587
Net to the practice	**$157,941**	**$403,627**	**$561,568**
Practice margin	**40.71%**	**43.44%**	**42.63%**
Net reimbursement by program	—	—	RPM $864,847 · PCM $452,308
Claims / billed units	—	—	25,593
Physiologic readings collected	—	—	99,044
Hospitalizations avoided (modeled)	—	—	~63 (≈$945,000 at $15,000 each)
Care-team hours delivered	—	—	12,173 (≈5.9 FTE)
Active program enrollments at month 24	—	—	959 (RPM 538 · PCM 420)
Unique patients (de-duplicated)	567 at month 12	664 at month 24	—

The margin, and how it is defined

24-month practice margin: 42.63% — net to the practice ÷ net reimbursement. Year 1 is **40.71%** and Year 2 **43.44%**, on $1,317,155 of net reimbursement and $561,568 net to the practice.

Month 1 is modeled at −$5,712 because one-time implementation lands there, and every month from month 2 onward is net-positive. The more useful way to describe the timing is this: the program is **margin-positive from day one** in the sense that matters to a six-physician practice — CoachCare funds the enrollment engine, the devices and the monitoring staff, so no practice capital is at risk while the census builds.

The two arms behave differently, and it matters for planning. RPM reaches its modeled ceiling of 538 patients at month 13. PCM is still climbing at month 24 — 420 enrolled against a ceiling of 523 — because the PCM arm is limited by enrollment pace rather than eligibility. **Year 2 is therefore a growth year, not a steady state**, and the census at month 24 is not the program's terminal size.

Recurring-revenue mechanics — and the double-count that isn't

Each month's enrolled census re-bills, so revenue is a function of census and capture rate rather than visit volume. Year 2 net reimbursement ($929,216) is 2.4× Year 1 ($387,939) on the same referral engine, purely from census accumulation and the continued growth of the PCM arm.

For a CKCC Global participant the two economics compound rather than conflict: RPM and PCM fees are professional-fee revenue to NEONA, while the ~63 modeled avoided hospitalizations (≈$945,000) reduce total cost of care in the KCE's reconciliation. The same intervention is paid once as a service and counted again in the total-cost result — at 100% risk sharing under the Global option. *Confirm the treatment of care-management fees in the PY2026 benchmark methodology with the KCE.*

2.3 Connective tissue: one infrastructure, every lever

The same enrollment engine, connected-device logistics, 24/7 monitoring, nurse triage, billing-grade documentation, eClinicalWorks integration and analytics serve every strategic lever the practice faces.

That is the argument for building the service line once, centrally, rather than assembling a separate response to each problem.

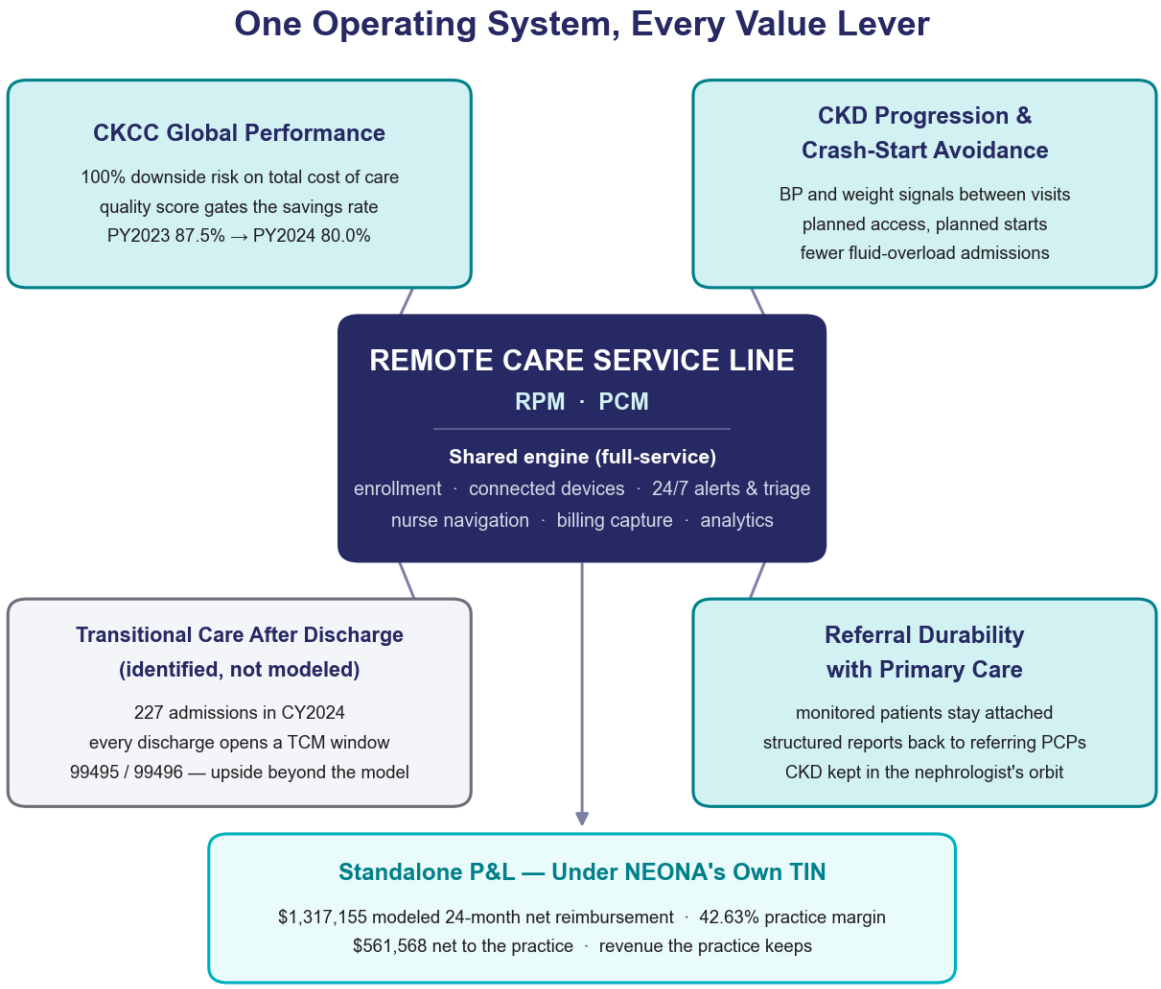

Figure 1. The Remote Care Service Line as connective tissue: one operating system powering CKCC Global performance, CKD progression and crash-start avoidance, transitional care after discharge (identified, not modeled), referral durability with primary care, and the standalone P&L.

Value lever	What is at stake in 2026–27	How the shared infrastructure powers it
CKCC Global performance	100% risk on total cost of care; the model runs through PY2027; Total Quality Score fell 87.5% → 80.0%	A monitored CKD/ESRD census reduces admissions and unplanned dialysis starts, and the monthly touch produces the documentation the quality measures are scored from
CKD progression & crash-start avoidance	Progression happens between quarterly visits; an unplanned start is the most expensive and worst-outcome pathway into ESRD	Daily blood-pressure and weight signals with 24/7 triage turn deterioration into a same-week outpatient intervention: planned access, planned modality, planned start
Transitional care after discharge *(identified, not modeled)*	227 admissions in CY2024, no TCM billed	The same enrollment and monitoring engine covers the 30-day post-discharge window; short-window RPM is billable today via 99445, and TCM remains a separate decision the practice can take on its own merits

Value lever	What is at stake in 2026–27	How the shared infrastructure powers it
Referral durability with primary care	CKD patients arrive by primary-care referral and are easily lost back to it	A monitored patient stays attached to the nephrologist between visits, and structured monthly reporting back to the referring physician makes the relationship visible rather than assumed
Whole-panel coverage	Summit County is 63.14% Medicare Advantage; CKCC attribution reaches traditional Medicare only	One workflow covers fee-for-service, Medicare Advantage, commercial and Medicaid patients alike — including every CKD patient not attributed to the KCE
Standalone P&L	CY2026 code expansion (99445, 99470); durability after the model's runway ends	$1,317,155 of modeled 24-month net reimbursement at a 42.63% practice margin — revenue that does not depend on any shared-savings determination

3. 2026 Policy & Payment Environment

3.1 CKCC: extended runway, tighter math

CMS terminated the Kidney Care First track of the Kidney Care Choices model effective December 31, 2025, but extended the CKCC options by one year — to the end of PY2027. PY2026 has 74 participants, all on CKCC: 35 on the Global option and 39 on Professional. NEONA's KCE, Integrated Kidney Care of Ohio, LLC, is on the **Global option** — the fullest risk position the model offers: 100% of savings and 100% of losses against a total-cost-of-care benchmark, with the shared-savings rate gated by the Total Quality Score, and all eight benefit enhancements elected.

Two implications follow. **The window is defined:** two more performance years, so a service line launched in late 2026 contributes to the final and largest reconciliation years of the model. And **the margin has to come from operations.** Benchmark methodology tightens over a model's life; hospitalization reduction and planned dialysis starts — the levers a monitored census moves directly — are where the next increment of performance lives. Verify the KCE's PY2026 amendment terms and benchmark-reduction schedule with the KCE and its actuaries.

The quality score deserves particular attention. A 7.5-point decline in a single year is not a rounding error in a Global arrangement: the quality score multiplies the rate at which savings are shared, so the same gross savings produce materially less distributable result at 80.0% than at 87.5%. The measures a remote care program moves are set out in Section 5.

3.2 The CY2026 fee schedule: remote care gets more billable

The CY2026 Physician Fee Schedule expanded the remote-monitoring toolkit in ways that suit nephrology populations. **99445** pays the monthly device-supply amount for 2–15 days of data, where 16 or more days were previously required — which had made short post-discharge and dialysis-transition windows effectively unbillable. **99470** pays for the first 10 minutes of monthly management time, where the floor had been 20. Together they convert the two highest-value nephrology windows — the 30 days after a kidney-related discharge, and the transition around dialysis initiation — from unfunded care into billable events. PCM (99424–99427) remains the monthly chassis for single-condition specialty management, and RPM and PCM stack in the same month with discrete documentation.

3.3 The market: one of the most MA-saturated in the country

County	Medicare eligibles	MA enrolled	MA penetration
Summit — the practice's county	128,512	81,146	**63.14%**
Stark	94,078	64,921	69.01%
Portage	37,391	24,031	64.27%
Cuyahoga (Cleveland, for reference)	281,327	162,750	57.85%

CMS Medicare Advantage State/County Penetration, July 2026 file.

Northeast Ohio is one of the most Medicare-Advantage-saturated markets in the United States. Two consequences follow. First, a business case built only on fee-for-service rates understates the opportunity here — which is why the modeled panel in this report is **total Medicare**: fee-for-service plus Medicare Advantage at the local 63.14% penetration. Second, and more important strategically: **CKCC attribution covers traditional-Medicare beneficiaries only, while the remote care service line bills across fee-for-service and Medicare Advantage alike**. The value-based vehicle the practice already participates in reaches a minority of its own Medicare panel. The service line reaches all of it.

4. Performance Snapshot: The Starting Position

4.1 The panel: 3.5× national acuity

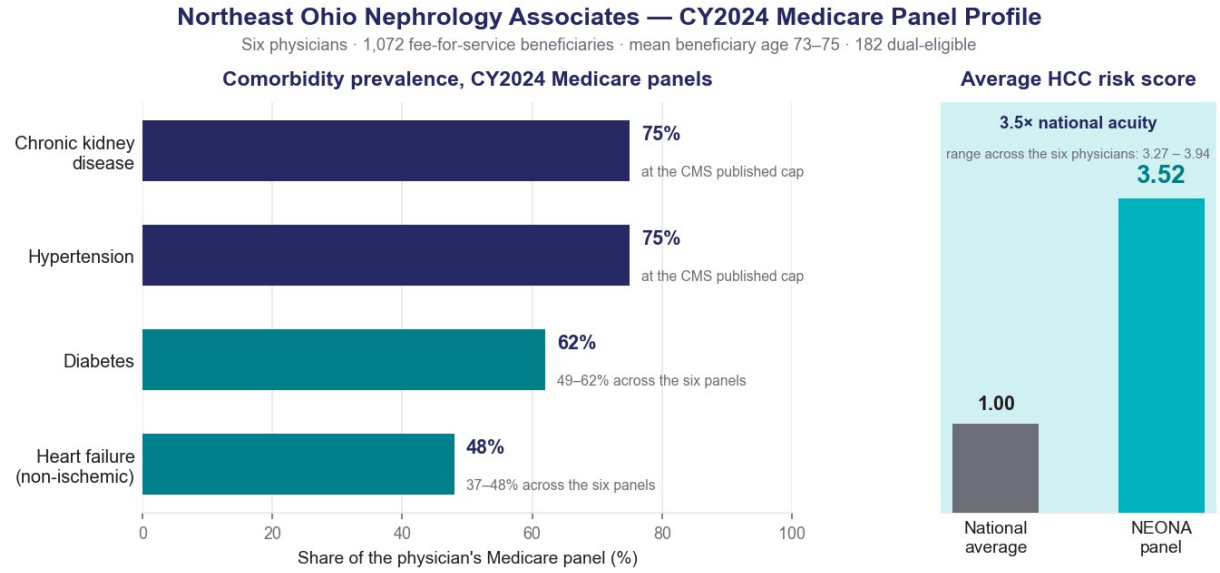

Figure 2. NEONA's own CY2024 Medicare panel. Comorbidity prevalence and average HCC risk score, from the CMS Medicare Physician & Other Practitioners file by provider (CY2024, dataset released May 21, 2026). CMS caps published prevalence values at 75%, so the CKD and hypertension figures are floors rather than point estimates.

A national-average Medicare beneficiary carries an HCC risk score of 1.00. Across the six physicians' CY2024 panels, average risk runs from 3.27 to 3.94 — a weighted average near 3.52, which is roughly three and a half times national acuity and among the higher figures seen anywhere in ambulatory medicine. Mean beneficiary age is 73 to 75, and 182 beneficiaries across the group are dual-eligible.[10]

The comorbidity mix is the more actionable finding. Three-quarters of the panel carries CKD and three-quarters carries hypertension — both at the value CMS publishes as its cap, meaning the true prevalence is at least that high. Diabetes runs 49–62% across the six panels and heart failure 37–48%. **Kidney, pressure, and volume in the same patient is exactly the physiology that daily home blood-pressure and weight data resolve** — and exactly the physiology that a quarterly office visit cannot. The interstitial period between nephrology visits is where progression actually happens, and at present nothing in the practice observes it.

4.2 The service record: twelve codes

Every HCPCS line billed by the group in CY2024 was screened against the full remote-monitoring and care-management code set — RPM, remote therapeutic monitoring, chronic care management, principal care management, self-measured blood pressure, and transitional care management. **Not one code from that set appears.** The complete published service mix is twelve distinct codes:

HCPCS	Beneficiaries	Services	Description
99214	535	796	Established office visit, moderate medical decision-making
99232	190	506	Subsequent hospital care, moderate complexity
99233	117	307	Subsequent hospital care, high complexity
90961	43	223	ESRD monthly capitation, 2–3 visits per month

[10] CMS Medicare Physician & Other Practitioners — by Provider, CY2024: average HCC risk score, chronic-condition prevalence, dual-eligible counts and mean beneficiary age, per rendering NPI, for the six physicians.

HCPCS	Beneficiaries	Services	Description
99223	129	141	Initial hospital care, moderate complexity
99215	88	111	Established office visit, high medical decision-making
99222	81	86	Initial hospital care
90935	25	49	Hemodialysis with physician evaluation
99213	38	47	Established office visit, low medical decision-making
99204	32	32	New patient office visit
90962	12	28	ESRD monthly capitation, 1 visit per month
99231	16	25	Subsequent hospital care, low complexity

What the data proves, stated precisely

CMS suppresses any provider / HCPCS / place-of-service line with fewer than 11 beneficiaries. A pilot-scale program — eight patients on a blood-pressure cuff, say — would not appear in this file. What the CY2024 record therefore establishes is that

no remote-monitoring or care-management program at meaningful scale existed at NEONA in CY2024. It does not establish that literally zero patients were ever monitored. For the same reason the per-code counts above are lower bounds: the six physicians' total CY2024 service volume is 3,207 services across 1,072 fee-for-service beneficiaries, and the suppressed remainder sits below the publication threshold.

Two further absences are worth naming. There are no telehealth codes in the CY2024 record. And there are no transitional-care codes — despite 227 hospital admissions initiated by these physicians in the same year, each of which opened a billable 30-day window.

4.3 The KCE record: quality, savings, and where they went

Measure	PY2023	PY2024
Total Quality Score	**87.5%**	**80.0%**
Net shared savings	$0	$1,491,352
Allocated to investments (incl. infrastructure & care resources)	100%	89.2%
Distributed to participants & preferred providers	**0%**	**10.8%**
KCE structure	Integrated Kidney Care of Ohio, LLC — CKCC Cohort 2, Global option, performance from January 1, 2023; active in PY2026; all eight benefit enhancements elected	NEONA an aligning provider with all six physicians listed by name; Darryl P. Anderson, MD a Governing Body Designee; VillageHealth DM LLC the named Preferred Provider Group for care management

Integrated Kidney Care of Ohio, LLC — public disclosure current to July 2026, corroborated by the CMS Kidney Care Choices PY2026 participants and affiliations notices dated February 4, 2026. Refresh against the KCE's PY2025 results when published.

There are two readings of that table, and both are load-bearing for this report.

First, the quality trajectory. A 7.5-point decline in a single year, in an arrangement where the quality score gates the savings rate, is a concrete and citable problem — and it is the kind of problem that structured monitoring and monthly documented management is the standard operational answer to. Hospitalization rates, blood-pressure control, planned dialysis starts, and the completeness of the documentation the measures are scored from all move with a monitored census.

Second, the distribution. NEONA carries 100% of the downside on aligned patients. In the year the KCE generated savings, 89.2% of the result was allocated to investments including infrastructure and care resources, and 10.8% was distributed to participants and preferred providers. In the prior year the distribution was zero. That is a factual disclosure made by the KCE itself, and it is not a criticism of DaVita or of the care VillageHealth delivers. The argument this report makes is narrower and purely structural: **a service line billed under NEONA's own TIN produces revenue the practice keeps**, on a schedule the practice controls, on a population far larger than the aligned sub-panel — and it does so whether or not any given performance year reconciles favourably.

4.4 Position in the market

Organization	Position	Relevance to NEONA
Akron Nephrology Assoc Inc	Crosstown eight-nephrologist group at 224 W. Exchange St; a legally distinct entity in a different DaVita Kidney Contracting Entity	The direct local competitor, and larger. Also in a Global-option KCE, so operating under the same incentives with a bigger clinical bench
Co-participants in Integrated Kidney Care of Ohio	Kidney & Hypertension Consultants (whose Dayanand Makey, MD is the KCE's Clinical Leader), Advanced Nephrology & Hypertension, Adult Hypertension and Kidney Specialists, Mid Ohio Nephrology and Hypertension, and others	Co-participants rather than competitors — they share NEONA's risk pool, governing body and quality score. That makes NEONA's own directly-controllable levers more important, not less: they are the part of a shared result the practice can actually move
Summa Health	The practice's densest hospital tie — three Summa facilities among its affiliations; Summa's ACO has 13 participants, all primary care	Primary referral funnel, and a system relationship held directly by a NEONA partner (Dr. Gayomali, Division Chief of Nephrology)
Cleveland Clinic Akron General	Second major inpatient tie; part of a large MSSP accountable care organization	Hospital affiliate and, through employed nephrology, a competitor for the same referrals
DaVita VillageHealth DM LLC	The KCE's named Preferred Provider Group for care management	Partner rather than competitor — but attribution and care-plan coordination must be explicit before the first enrollment (Sections 2.1 and 9.3)

5. Powering CKCC Global Performance

CKCC pays on total cost of care against a benchmark, adjusted by a quality score. Under the Global option NEONA's KCE takes 100% of both sides of that calculation. A monitored CKD and ESRD census moves both terms — the cost term directly, and the quality term through the measures below. The practice already does this clinical work; what it lacks is continuous data between visits and the hours to act on it.

Lever	How the Remote Care Service Line moves it
Hospitalizations and total cost of care	Daily blood-pressure and weight signals catch fluid overload, hypertensive crisis and decompensation days earlier, and 24/7 triage converts them into same-day outpatient interventions. Modeled at approximately 63 avoided admissions (≈$945,000) over 24 months — value that lands in the KCE reconciliation on top of RPM and PCM fees
Optimal (planned) dialysis starts	Monitored CKD 4–5 patients progress along a managed glide path: timely access placement, modality education while there is still time to choose, and a planned outpatient or home start instead of a crash start through the emergency department. This is simultaneously a scored measure, a cost saver, and a materially better patient outcome
Home modality and post-start stability	The model explicitly rewards home dialysis. Weight, blood-pressure and symptom monitoring gives home patients a safety net between training touches, and the local receiving infrastructure already exists — Dr. Kayani is medical director of DaVita Summit Renal Home Therapies
Blood-pressure control and slowed progression	Hypertension prevalence in this panel sits at the CMS published cap. Home blood-pressure data with protocolized titration under the nephrologist's direction is the highest-yield intervention available in CKD, and it becomes measurable monthly rather than quarterly
Measure documentation	Every monthly PCM and RPM touch produces time-stamped, audit-ready documentation attached to the eClinicalWorks chart. Quality scores are built from documentation as much as from care, and a 7.5-point decline is partly a documentation problem in every organization that has ever had one

Where the P&L sits — stated factually, not as criticism

PY2024: shared savings **$1,491,352** · **89.2%** to Investments (including Infrastructure & Care Resources) · **10.8%** distributed to participants and preferred providers. PY2023: $0 in savings, $0 distributed. Source: the KCE's own public disclosure, current to July 2026.

Two observations follow, neither of which is a judgment about the quality of care delivered inside the KCE. First, NEONA carries 100% of the downside on aligned patients while the majority of the PY2024 upside was retained upstream. Second, care management inside the KCE is delivered by DaVita's VillageHealth DM LLC, the named Preferred Provider Group.

A remote care service line under NEONA's own TIN does not replace that arrangement. It adds a layer the practice owns: **professional-fee revenue that does not depend on a shared-savings determination**; **device-based physiologic data rather than telephonic navigation**; and **coverage of the whole panel rather than the attributed sub-panel**. The two run best together — one shared care plan, explicit task ownership, no duplicated billing (Section 9.3).

6. CKD Progression, Crash Starts, and the Value of a Planned Start

6.1 The interstitial layer

A patient with stage 4 chronic kidney disease sees a nephrologist perhaps four times a year. The disease does not observe that schedule. Between visits, blood pressure drifts; volume accumulates; a non-steroidal anti-inflammatory gets taken for a knee; a diuretic gets skipped because of a trip; a contrast study happens somewhere else in the system; an intercurrent illness dehydrates someone for a week. Each of those is a small, recoverable event when someone sees it within days. Compounded and unobserved for three months, they are how a managed patient becomes an admitted one.

This is the wedge, and it is worth stating plainly: the interstitial layer of care between quarterly nephrology visits is where progression actually happens — and at NEONA that layer is currently neither staffed nor billed. The practice is not failing to do something it decided to do. It has six physicians covering an office, six inpatient facilities and four dialysis directorships, with no advanced practice providers of its own and two administrative staff. Nobody in that structure has hours available for between-visit population management. The question this report answers is what happens if that layer is supplied rather than built.

6.2 What a monitored glide path changes

An unplanned or “crash” start — dialysis initiated during an inpatient stay, usually arrived at through the emergency department, usually begun with a catheter rather than a matured access — is the most expensive and worst-outcome pathway into end-stage renal disease. This report does not attach a published national prevalence or cost figure to it; that literature should be reviewed against the practice's own experience in discovery. What the model does quantify is the admission side: approximately **63 avoided hospitalizations over 24 months, about $945,000 at an illustrative $15,000 per admission**. What a monitored glide path changes clinically is more specific than a cost figure:

- **Earlier detection of progression.** Trending home blood pressure and weight surfaces the patients who are deteriorating between visits, rather than discovering it at the next scheduled lab draw.
- **Access placement ahead of need.** A patient identified as approaching start three months earlier is a patient whose fistula or graft can mature before it is required — which is the single largest determinant of whether a start is planned or a crash.
- **Modality education while there is still a choice.** Home dialysis is an explicit scoring priority in the model and, for many patients, the better life. It is also a decision that cannot be made from an inpatient bed. Local home-therapy infrastructure exists, including the DaVita Summit Renal Home Therapies unit where a NEONA physician is medical director.
- **Transplant-list stability.** NEONA has no transplant program of its own and refers candidates onward. What the practice can control is whether a referred candidate stays list-eligible: blood-pressure control, weight and volume management, medication adherence, and documented follow-through are the variables that keep a candidate active rather than suspended, and all four are exactly what a monitored program produces evidence of.
- **Resistant hypertension, comanaged.** A panel with hypertension prevalence at the published cap contains a meaningful resistant subgroup. Home blood-pressure data with protocolized titration is the appropriate response — referenced here as clinical management, not as a procedural growth line.

6.3 The transitional-care window — identified, not modeled

In CY2024 the six physicians initiated **227 hospital admissions** and delivered 954 subsequent-hospital-care services across at least six affiliated facilities. Every one of those admissions ended in a discharge,

and every discharge opened a 30-day transitional-care window billable under 99495 or 99496 — contact within two business days, face-to-face visit within 14 or 7 days depending on complexity. None was billed.

A deliberate exclusion

Transitional care management is **not included in any financial figure in this report**. Every dollar, margin percentage, enrollment count and avoided-admission estimate in Sections 2.2, 5 and 9 is modeled on RPM and PCM alone. TCM is identified here as a separate, additional opportunity — and as the clinical window where a CKD patient is at the highest risk they will face all year — so that the practice can evaluate it on its own merits rather than as an assumption baked into a forecast.

It is also where the fragmented record hurts most: the discharge happens in a hospital system the practice does not control, and the two-business-day contact requirement depends on knowing the discharge occurred (Section 8.1).

6.4 Referral durability with primary care

Chronic kidney disease arrives at a nephrology practice by primary-care referral, and it is easily lost back to it — particularly where a large share of primary care sits inside health-system accountable care organizations running their own care-management programs. Summa Health's ACO has 13 participants, all primary care, with no nephrology group among them; the relationship between Summa's primary-care base and this practice therefore runs directly, physician to physician. Dr. Gayomali's position as Division Chief of the Section of Nephrology at Summa Health is the strongest single asset in it.

A monitored program strengthens referral durability in two mechanical ways. The patient stays attached to the nephrologist between visits, because someone from the nephrology program contacts them monthly. And the referring physician receives structured monthly evidence that the patient is being managed — blood-pressure trend, weight trend, interventions taken, plan of care — which makes the value of the referral visible instead of assumed. For an independent group competing with employed nephrology inside two large systems, that visibility is a durable, low-cost competitive asset.

7. Target Populations & Clinical Pathways

Four populations, one workflow. Together they cover the modeled ~2,050 in-scope Year-1 patients, and they are ordered by how quickly each can be enrolled.

Population	Programs	Devices / cadence	Why it fits NEONA
CKD stages 3b–5 — the core panel	RPM + PCM	Cellular blood-pressure cuff and weight scale; monthly PCM management time	CKD prevalence in this panel sits at the CMS published cap. This is not a segment of the panel — it is substantially the whole panel
Uncontrolled and resistant hypertension	RPM (+ PCM where CKD is the qualifying condition)	Home blood-pressure cuff; protocolized titration under the nephrologist's direction	Hypertension prevalence also sits at the cap. Home blood-pressure data is the highest-yield signal in the disease and the fastest cohort to enroll
Approaching and transitioning to dialysis (CKD 5 / early ESRD)	RPM (+ PCM pre-start)	Weight, blood-pressure and fluid monitoring around start; short-window RPM via 99445	Planned access, planned modality, planned start — the model's optimal-start measure and the patient's outcome are the same event. Four DaVita medical directorships and a local home-therapies unit are the receiving infrastructure
Recently discharged kidney patients	Short-window RPM (99445); TCM decision separate and unmodeled	14–30 days of intensive monitoring after a kidney-related admission	227 admissions in CY2024 across at least six affiliated facilities. The physicians are already at the bedside, so enrollment at discharge is a workflow change rather than a new relationship

The enrollment engine, as modeled: six referring providers at eight referrals per provider per month with 80% patient acceptance, plus one on-site enrollment specialist at approximately 80 enrollments per month — **staffed at CoachCare's expense, embedded value, never deducted from the practice's margin**. Eligibility is modeled at 75% of the in-scope population for RPM and 85% for PCM, with acceptance of 35% and 30%. Prioritization within the funnel: recent kidney-related discharge first, then CKD 4–5 patients approaching start, then uncontrolled hypertension, then patients in their first 90 days on a home modality.

8. eClinicalWorks Integration & Technology Architecture

8.1 A record fragmented across four systems

NEONA documents office care in eClinicalWorks.[11] Its physicians document dialysis care in DaVita's and Fresenius's chain-owned systems, and hospital care in Cleveland Clinic Akron General's and Summa Health's. None of the latter belongs to the practice, and none of them talks to the others. **For a group carrying Global downside risk on total cost of care, having no single cross-setting view of a patient is a genuine exposure** — clinically, because the physician managing a patient's kidney disease cannot see the admission that just happened; and financially, because the total cost the practice is accountable for is accumulating in records it cannot read.

This is the strongest structural argument for a remote care layer, and it is worth being precise about why. The monitoring layer is not a fifth system competing with the other four. It is the one record that **follows the patient rather than the site of service** — a continuous physiologic and management record that exists whether the patient is at home, in a dialysis chair, or in a hospital bed, and that lands back in the chart the practice actually works in.

8.2 What the eClinicalWorks integration does

CoachCare's eClinicalWorks integration is a catalog capability rather than a bespoke build. What it delivers:

- **Integrated enrollment.** Enrollment flags and trigger ordering by service inside the existing clinical workflow, with enrollment status visible in real time — and patients receiving services in under five days.
- **Enrollment by services and devices.** The specific program and device set is selected at the point of order, not reconciled afterwards.
- **Exchange of health history.** Relevant clinical history flows to the care team so the monthly management conversation starts informed.
- **Integrated vital reports.** Physiologic readings return to the chart as structured, reviewable reports rather than as an external portal the practice has to remember to check.
- **Compliance documentation and an integrated care summary.** The documentation that supports the claim and the documentation that supports the clinical record are the same artifact.
- **Supporting documents attached to the chart monthly.** Evidence of Care, Vitals, and Care Plans filed to the patient's chart every month — which is also the substrate quality measures are scored from.
- **Automated claim generation via the CoachCare billing engine,** eliminating the manual per-patient monthly claim step. CoachCare is the only care management application integrated with eClinicalWorks that provides this.

> ***"…creating a seamless, intuitive experience for the patient and the provider."***
>
> That is what the eClinicalWorks integration is for. *Quotation used without individual attribution, per house convention.*

8.3 Why automated claim generation matters here specifically

In most organizations, automated claim generation reads as a convenience feature. At NEONA it is a precondition. The practice's published non-clinical staff is two people. A remote care program that

[11] eClinicalWorks is identified from the practice's own patient-portal URL (mycw8.eclinicalweb.com), the vendor's hosted-portal domain and standard portal path. First-party evidence, but single-source — confirm in contracting.

requires someone to assemble, verify and submit a claim for each enrolled patient every month is a program that will not survive contact with that staffing level. At a month-24 census of 959 active program enrollments and **25,593 modeled claims and billed units over 24 months**, manual claim assembly is not a rounding error in someone's week — it is a full job that nobody in the building currently has time to do.

The same logic applies to the threshold rules that govern whether a month is billable at all: the 16-day data requirement for 99454, the 2–15-day window for 99445, and minute-level time documentation for 99457, 99470, 99458 and the PCM codes. Tracked manually, these are where remote-monitoring programs quietly lose revenue to capture failures. Tracked automatically, they are a dashboard line.

A confirmation item, flagged honestly. The eClinicalWorks identification is high-confidence but single-source: it rests on the practice's own patient-portal URL, which is first-party evidence but the only evidence located. No secondary confirmation was obtained, and no EMR is named in the practice's job posting. *Confirm the eClinicalWorks product version and the integration path in contracting.*

9. Implementation Playbook: Building the Service Line

9.1 Goals, scope, and the modeled funnel

Goal: a chartered service line with the first billable enrollment inside 90 days and a full RPM + PCM run-rate inside 12 months — a schedule that sits entirely within the CKCC runway that extends through 2027.

Modeled scope: an estimated ~2,050 Medicare patients across six nephrologists (a discovery-stage estimate — validate against chart counts), all in scope in Year 1; six referring providers × eight referrals per month × 80% acceptance; eligibility 75% for RPM and 85% for PCM; acceptance 35% and 30%; one on-site enrollment specialist at CoachCare's expense; RPM and PCM only, with transitional care management excluded. *All figures are illustrative, modeled — verify against practice data.*

9.2 Staffing: nobody has to be hired

This is the section that matters most for a six-physician group with no advanced practice providers of its own and a two-person administrative team. The division of labor below is not a preference — it is the only version of this program that can actually run in this building.

Function	Who does it
Clinical direction, protocols, supervision, escalation	NEONA physicians — unchanged. Clinical governance stays with the practice
Patient identification and referral	NEONA physicians at the point of care; one order inside eClinicalWorks
Enrollment, consent, and the cost-sharing conversation	**CoachCare on-site enrollment specialist — staffed at CoachCare's expense: embedded value, never deducted from the practice's margin**
Device logistics — shipping, provisioning, replacement, reclamation	CoachCare
24/7 data review, alert triage, tiered escalation	CoachCare monitoring clinicians
Monthly management time and documentation	CoachCare care team working under NEONA's protocols and supervision — 12,173 modeled hours over 24 months, about 5.9 full-time equivalents
Claim generation and capture	CoachCare billing engine, integrated with eClinicalWorks (Section 8.2)
Program reporting and KPI review	Joint — the physician lead and the practice manager, monthly

The practice supplies clinical judgment and supervision. It does not supply headcount, and it does not carry the payroll for the enrollment or monitoring layer.

9.3 “DaVita already does that for us” — the answer

This objection should be expected, and it deserves a precise answer rather than a competitive one. VillageHealth DM LLC is the KCE's named Preferred Provider Group for care management, and patients aligned to the KCE are very likely already receiving some care navigation through it. Nothing in this report argues that work is unnecessary or poorly done. The distinctions are structural:

Dimension	KCE care navigation	The NEONA remote care service line
Whose P&L	Delivered by the KCE's preferred provider; PY2024 distributions to participants and preferred providers were 10.8% of $1,491,352, and PY2023 distributions were $0	Billed under NEONA's own TIN. The professional fee is the practice's revenue and does not depend on any shared-savings determination

Dimension	KCE care navigation	The NEONA remote care service line
What it measures	Telephonic outreach and care navigation	Device-based physiologic monitoring — daily blood pressure and weight, 99,044 modeled readings over 24 months — plus documented monthly clinical management time
Who is covered	Beneficiaries attributed to the KCE — traditional Medicare only	The whole panel: Medicare Advantage (63.14% of Summit County Medicare eligibles), commercial, Medicaid, and every CKD patient not attributed to the KCE
Where the record lives	The KCE's systems	The practice's own eClinicalWorks chart, with Evidence of Care, Vitals and Care Plan documents attached monthly

The two are complementary and should be run that way: one shared care plan, explicit task ownership per patient, and no duplicated billing. Write that policy before the first enrollment, not after the first denial.

9.4 Clinical workflow

1. **Identify.** CKD staging from laboratory results in eClinicalWorks, the uncontrolled-hypertension cohort, and discharge lists from the affiliated hospitals flag eligible patients.
2. **Refer.** One order inside eClinicalWorks, with the enrollment flag and status visible in the chart in real time.
3. **Enroll and consent.** The on-site enrollment specialist covers the program, cost-sharing and devices; the 182 dual-eligible beneficiaries in the panel carry minimal cost-sharing friction.
4. **Connect.** Cellular device activation and first readings within five days — a tracked KPI. No smartphone, app install or home Wi-Fi required, which matters for a panel with a mean age of 73 to 75.
5. **Monitor and triage.** 24/7 data review with tiered alerts: self-care prompt, nurse callback, then same-day contact with a NEONA physician.
6. **Intervene.** Protocolized titration, volume management, medication reconciliation, and access and modality planning; escalation to clinic, dialysis unit or admission only when clinically warranted.
7. **Document and bill.** Data-day and minute thresholds captured automatically; RPM and PCM claims generated by the billing engine; Evidence of Care, Vitals and Care Plans attached to the chart monthly.

9.5 KPI dashboard and expected impact

Domain	Key performance indicators
Clinical	Alert resolution under 24 hours; blood-pressure control rate in the hypertension cohort; share of the CKD 4–5 census with dialysis access planned before start; planned (non-crash) start rate; 30-day readmission rate within the monitored cohort
Operational	Enrolled census versus plan; device activation within 5 days; 16-day data-adherence rate (99454); time to first billable enrollment; care-team hours delivered
Financial	Monthly capture rate against data-day and minute thresholds; net revenue per enrolled patient per month; denial rate; actual versus Value Analysis plan; contribution to the KCE total-cost result

Expected impact (modeled)

Measure	Year 1	Year 2	24-month
Net reimbursement	$387,939	$929,216	**$1,317,155**

Measure	Year 1	Year 2	24-month
CoachCare fees (incl. setup & integration)	$229,998	$525,590	$755,587
Net to the practice	**$157,941**	**$403,627**	**$561,568**
Practice margin	**40.71%**	**43.44%**	**42.63%**
Net reimbursement by program	—	—	RPM $864,847 · PCM $452,308
Claims / billed units	—	—	25,593
Physiologic readings collected	—	—	99,044
Hospitalizations avoided (modeled)	—	—	~63 (≈$945,000 at $15,000 each)
Care-team hours delivered	—	—	12,173 (≈5.9 FTE)
Active program enrollments at month 24	—	—	959 (RPM 538 · PCM 420)
Unique patients (de-duplicated)	567 at month 12	664 at month 24	—

24-month practice margin: 42.63% of net reimbursement (Year 1 40.71%, Year 2 43.44%) — net to the practice ÷ net reimbursement. RPM reaches its modeled ceiling of 538 at month 13; PCM is still growing at month 24 (420 against a ceiling of 523), so Year 2 is a growth year rather than a steady state. *Illustrative, modeled — verify against practice data.*

9.6 Twelve-month roadmap

Phase	Months	Milestones
Contract & configure	0–1	Agreements and business associate agreement; eClinicalWorks integration turned on; coordination policy written (NEONA owns RPM/PCM · the referring PCP owns any longitudinal wrapper · KCE navigation on one shared care plan); device logistics live; physician lead and practice-manager dyad named
Launch	2–3	On-site enrollment specialist in place; CKD 3b–5 and uncontrolled-hypertension cohorts enrolled first; first billable month; alert-triage and escalation pathways tested with each of the six physicians
Scale	4–6	Pre-dialysis and post-discharge cohorts added; short-window RPM (99445) live off the hospital discharge list; structured monthly reporting back to referring primary-care physicians begins; KCE-facing reporting live
Optimize & extend	7–12	Full RPM + PCM run-rate; the transitional-care (TCM) decision taken on its own merits; quality-measure documentation audited against the KCE's PY2026 scorecard; PY2027 planning with the KCE

A note on every number in this report

All financial and clinical projections are illustrative and modeled in CoachCare Value Analysis (MAC-locality rates auto-resolved for ZIP 44304 — CGS Jurisdiction 15, Ohio statewide locality) from the stated assumptions. They are planning aids, not guarantees. Validate population counts, payer mix, eligibility and locality rates against practice data during discovery.

The ~2,050-patient base is an estimate, not a practice-reported figure. Its credible range runs from an observed floor of **1,072** fee-for-service beneficiaries (CMS CY2024) to an upper bound of roughly **2,900** total Medicare patients. **The chart count is discovery question number one.**

References & Data Sources

- **Northeast Ohio Nephrology Associates — neonephrology.com:** home, physicians, individual physician biographies (Anderson, Chiao, Gayomali, George, Jorge Cabrera, Kayani), all-staff page, our affiliations, careers, contact, and the eClinicalWorks patient-portal link (retrieved July 29, 2026).
- **NPPES NPI Registry —** organizational NPI 1356459481 (Northeast Ohio Nephrology Associates Inc, taxonomy 207RN0300X Internal Medicine / Nephrology, single-specialty group) and the individual NPI records of the six physicians (live API, retrieved July 29, 2026).
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024** (dataset modified May 21, 2026): beneficiary counts, service counts, allowed amounts, average HCC risk scores, chronic-condition prevalence, dual-eligible counts and mean beneficiary age for each of the six physicians.
- **CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024** (dataset modified May 21, 2026): the complete published HCPCS mix, screened against the remote-monitoring and care-management code sets. CMS suppresses lines with fewer than 11 beneficiaries.
- **DaVita — Integrated Kidney Care of Ohio, LLC:** the KCE's CMS-required public transparency roster (KCE Leadership, Participants and Providers), listing Northeast Ohio Nephrology Associates Inc as an aligning provider with all six physicians by name, Darryl P. Anderson as a Governing Body Designee, VillageHealth DM LLC as a Preferred Provider Group, and the PY2023 and PY2024 quality scores and savings distributions (page datestamps April 2 and July 2, 2026; retrieved July 29, 2026).
- **CMS Innovation Center — Kidney Care Choices (KCC) Model:** PY2026 participants notice and PY2026 participants + affiliations notice, both dated February 4, 2026; PY2026 Model Update Quick Reference (Kidney Care First terminated December 31, 2025; CKCC options extended through the end of PY2027; 74 PY2026 participants — 35 Global, 39 Professional).
- **CMS — Medicare Shared Savings Program participant files, PY2025 and PY2026,** and the ACO REACH PY2024 Provider PUF (dataset modified July 20, 2026): searched in full; Northeast Ohio Nephrology Associates does not appear in any of them. The practice's only verified value-based arrangement is CKCC.
- **CMS — Medicare Advantage State/County Penetration, July 2026 file:** Summit County 63.14%, Stark 69.01%, Portage 64.27%, Medina 56.14%, Cuyahoga 57.85%.
- **CMS — Medicare Dialysis Facility listing** (updated June 16, 2026): 16 Medicare-certified dialysis facilities in Summit County; identification of DaVita Akron Renal Center, Summit Renal Center, Summit Renal Home Therapies and Coventry Dialysis.
- **U.S. Census Bureau — American Community Survey 2024 one-year estimates,** table B01001: Summit County population 538,370, of whom 20.2% are 65 or older.
- **CMS — CY2026 Medicare Physician Fee Schedule:** RPM codes 99453, 99454, 99445, 99457, 99470 and 99458; PCM 99424–99427; TCM 99495 and 99496; and the concurrency rules under which RPM and PCM stack. Locality-adjusted payment is set by CGS Administrators, Jurisdiction 15, for Ohio.
- **CoachCare — eClinicalWorks integration collateral:** integrated enrollment, enrollment by services and devices, exchange of health history, integrated vital reports, compliance documentation and integrated care summary, monthly attachment of Evidence of Care, Vitals and Care Plans to the chart, and automated claim generation via the CoachCare billing engine (CoachCare-provided; confirm scope and product version in contracting).
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 5, 6.2 and 9, including the ~2,050-patient base, 75% / 85% RPM / PCM

eligibility, 35% / 30% acceptance, the six-provider referral engine at eight referrals per provider per month with 80% acceptance, and one on-site enrollment specialist at CoachCare's expense.

Items not independently verified

The following were searched for and could not be confirmed from public sources. They are listed so that nothing in this report is mistaken for a verified fact, and they are the right discovery agenda for a first conversation.

- **How many patients are aligned to the KCE.** CMS has published provider-level Kidney Care Choices data for PY2022 only, and NEONA's cohort began in PY2023. This is the single most valuable number to obtain, because it sizes the risk-bearing sub-panel.
- **What VillageHealth already delivers, and at what cost to the practice.** No public disclosure exists. It is the central discovery question behind Section 9.3.
- **True total panel size and payer mix.** The observed floor is 1,072 fee-for-service beneficiaries; the modeled figure is ~2,050 total Medicare; the upper bound is ~2,900. Commercial and Medicaid volume is outside every public dataset and is additive to all figures in this report.
- **Whether any physician holds equity in a local dialysis joint venture.** The KCE roster's entity naming is suggestive but no ownership document was located. Equity would change who benefits from reduced dialysis utilization and is worth resolving early.
- **Advanced practice provider capacity.** One nurse-practitioner record lists the practice address, but that individual does not appear on the practice's current staff page, billed exclusively facility place-of-service in CY2024, and is reported by a third-party aggregator under a different employer. This report therefore models zero advanced practice providers, which should be confirmed.
- **Ohio Secretary of State corporate filing details** (charter number, status, statutory agent, officers). The state's business-search service blocks automated retrieval and every third-party mirror is likewise gated; this needs a manual lookup.
- **Second-source confirmation of the EMR.** eClinicalWorks is identified from the practice's own patient-portal URL — first-party but single-source. Confirm the product version and integration path in contracting.
- **Clinical research participation and awards.** Searched; nothing published was found. Treated as absent rather than confirmed-absent.
- **Referral volumes by source, and county-level CKD/ESRD prevalence.** Not pulled in this pass; the 16-facility dialysis count and the practice's own 75% CKD panel prevalence are the usable proxies.

Global verification caveat

Facts in this report reflect public sources current to July 2026 and are cited above. Items flagged “CoachCare-provided,” “stated assumption,” “estimate,” or “confirm” were not independently verifiable from public sources. Reimbursement figures are illustrative national or modeled locality magnitudes — verify against the current CY2026 Physician Fee Schedule and the applicable Ohio locality files. The KCE's PY2026 amendment terms, its benchmark treatment of care-management fees, and the practice's eClinicalWorks product version should all be confirmed in discovery. All Value Analysis outputs are illustrative, modeled — verify against practice data.

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