COACHCARE | SERVICE LINE STRATEGY

OVP Health Care

OVP Health Care, Inc. · a federally qualified health center look-alike operating seven sites in approved scope across five counties and three states — Cabell County West Virginia, Boyd County Kentucky, and Gallia, Lawrence and Scioto Counties Ohio

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line — remote physiologic monitoring, chronic care management and advanced primary care management — built on the between-visit engine this health center already runs, and billed under the CY2026 rules that pay health centers for those codes separately from the encounter rate

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the leadership of OVP Health Care, Inc. It brings together the organization's published clinical quality record, its federal payment position, the chronic-disease burden of the panel it serves, the market its Medicare patients sit in, the CY2026 rules governing how health centers bill care management, and a 24-month financial forecast.

The argument is short. OVP Health Care runs one of the highest-touch care models in its region, and it has the national quality scores to prove it. That model has never been pointed at chronic disease. The payment change that makes pointing it there worth doing arrived on 1 January 2026.

Table of Contents

Executive Summary **3**

1. The Quality Gap, and What It Costs **5**

1.1 The footprint the gap sits in 5
1.2 What this organization has already proven it can do 5
1.3 The gap: bottom national quartile on every chronic-disease measure 6
1.4 Why those two facts belong in the same sentence 7
1.5 The market the Medicare panel sits in 7

2. The CY2026 Billing Change for Health Centers **9**

2.1 One bundled code became a set of individual ones 9
2.2 The national rate rail, and what it is worth in this footprint 9
2.3 The work the change creates, and who carries it 10

3. The Service Line: RPM, CCM and APCM on the Medicare Slice **11**

3.1 The clinical and billing stack 11
3.2 The starting position, verified across two years 12
3.3 Staffing: nobody has to be hired 12
3.4 Devices: cellular, not app-dependent 12
3.5 Epic integration: the programme lives where the care team already works 13

4. Value Analysis: The 24-Month Forecast **14**

4.1 The headline economics 14
4.2 The ramp, month by month 15
4.3 Ceilings: the whole Medicare panel enrolls inside one quarter 15
4.4 What the programme produces clinically and operationally 16

5. Clinical Governance & Escalation **17**

5.1 One shared escalation engine 17
5.2 The emergent pathway 17
5.3 Three-way routing 18
5.4 The post-discharge three-touch cadence 18
5.5 Continuity and discharge governance 18

6. Medicaid as Act Two — and Why Ohio Is the One That Works **19**

6.1 The scale argument 19
6.2 Ohio: monitoring is paid outside the encounter rate 19
6.3 Kentucky and West Virginia 19
6.4 What would have to be true 20

7. Implementation and the First 90 Days **21**

7.1 Who runs what 21
7.2 The 90-day plan 21
7.3 The operating dashboard 21

8. Recommendations **22**

References & Data Sources **23**

Executive Summary

OVP Health Care, Inc. is a HRSA-designated federally qualified health center look-alike with seven sites in approved scope, six live Medicare health center certifications under a single CMS associate identifier, and 340B participation dating to April 2025 with an organization-owned pharmacy in Ashland and no contract pharmacies. The footprint covers five counties and three states from a base in Proctorville, Ohio.[1]

The organization is very good at something that is genuinely hard. CY2025 Uniform Data System reporting places it in the **top national quartile on substance-use treatment initiation at 77.6% and engagement at 57.9%**, and in the top quartile on childhood immunization. Holding a hard-to-reach population in treatment over months is the defining capability of a modern health center, and OVP Health Care does it better than three-quarters of the health centers in the country.[2]

The same reporting year places the organization in the **bottom national quartile on every chronic-disease measure it reports**. Controlling high blood pressure sits at 47.3% and has fallen in each of the last three reporting years, from 54.1% in CY2023 and 50.0% in CY2024. The hypertensive cohort behind that rate is 901 patients, of whom 426 are at goal and **475 are not**. Diabetes runs to 556 patients and 38.3% of them carry an HbA1c above 9%, which is 213 people.[3]

The observation this report is built on

You already run the highest-touch care model in the region. It has never been pointed at chronic disease.

Substance-use treatment initiation and engagement are longitudinal measures. They are won between visits, by repeated contact with people who are hard to keep in contact with. Controlling high blood pressure and HbA1c control are also won between visits, by the same kind of contact. The organization has the engine. It has never been aimed at the chronic-disease panel, and there is no between-visit infrastructure for that panel to aim it with.

The reason to act on that now is a payment change that is already live. Under **42 CFR 405.2464(c)(7)**, Medicare pays a health center the **national non-facility physician fee schedule amount** for the individual care-management and remote-monitoring codes, **in addition to** the health center prospective payment system encounter rate. The single bundled care-coordination code G0511 has been retired and health centers now report the individual CPT and HCPCS codes instead. This is separate revenue on the same claim, and it arrives with new per-code time-capture and documentation work. The health center runs **Epic**, and CoachCare's Epic integration is built to carry exactly that work: enrollment flags in the clinical workflow, device readings written back as discrete vitals, audit-ready documentation in the record, and claims generated automatically rather than assembled by hand each month. Section 3.5 sets it out.[4]

OVP Health Care bills none of it today. A sweep of all 25 clinicians who reassign Medicare benefits to the organization, across both the CY2023 and CY2024 Medicare Part B files, returns zero lines on all thirteen remote monitoring codes, zero on principal care management, zero on advanced primary care

[1] HRSA Health Center Service Delivery and Look-Alike Sites file, retrieved 7 August 2026 (look-alike designation, health center number LALCS49936, seven active sites in approved scope); CMS Federally Qualified Health Center Enrollments file, vintage 17 July 2026 (six live health center certifications under CMS associate identifier 648694596, incorporation state and date, non-profit status); HRSA 340B Office of Pharmacy Affairs Information System, retrieved 7 August 2026 (entity type FQHCLA, identifier FQHCLA483 and five child site identifiers, participation start 1 April 2025). Look-alike status is confirmed independently by three federal sources: the HRSA scope file, CMS provider enrollment, and the HRSA automatic shortage-area designation file.

[2] HRSA Uniform Data System, CY2025 clinical quality measures with national quartile ranking, retrieved 7 August 2026 through the HRSA Health Center Program data reporting tool and cross-checked against the HRSA Uniform Data System mapping service. Quartile 1 is the best-performing quartile nationally and quartile 4 the worst. CY2025 is the most recent published reporting year; CY2026 reporting will not publish until 2027.

[3] Same source. Controlling high blood pressure: 54.1% in CY2023, 50.0% in CY2024, 47.3% in CY2025. Diabetes HbA1c poor control, defined as greater than 9% and reported so that a lower figure is better: 39.3%, 34.0% and 38.3% across the same three years. Cohort denominators are the CY2025 Uniform Data System chronic-condition counts, 901 patients with hypertension and 556 with diabetes; the patient counts at goal and above threshold are those denominators applied to the reported rates.

[4] 42 CFR 405.2464(c)(7), and the CMS Calendar Year 2025 Medicare Physician Fee Schedule Final Rule fact sheet, which states that health centers report the individual CPT and HCPCS codes for care coordination in place of the single bundled code, that the add-on codes are billable, that advanced primary care management coding and payment was adopted for health center payment, and that payment is made at the national non-facility physician fee schedule amounts in addition to the health center prospective payment system rate.

management and zero on transitional care management. CMS suppresses any provider and code line under 11 beneficiaries, so the defensible statement is that there is no billed remote-care programme at meaningful scale. G0511 itself bills institutionally under the health center certification and does not appear in the physician file at all, which makes that particular number open rather than zero.[5]

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	**$220,911**	**$254,014**	**$474,925**
CoachCare fees	$130,985	$141,917	$272,902
Net to the health center	**$89,926**	**$112,097**	**$202,023**
Margin to the health center	40.71%	44.13%	**42.54%**

CoachCare Value Analysis, CY2026 national non-facility fee-schedule rates, 510 Medicare-primary patients, RPM + CCM + APCM.

1. **The service line pays for itself from the first quarter.** Month 1 nets −$5,109, because implementation and integration land in that month. The first positive month is M2. From M6 the programme runs at $9,341 a month net to the health center.
2. **Nobody is hired.** CoachCare delivers 3,245 hours of care-management labour over 24 months, about 1.56 full-time equivalents, including an on-site enrollment specialist carried at CoachCare's expense. There is no capital outlay and no new headcount.
3. **The national rate rail is worth real money here.** Health center care-management and monitoring lines pay at national rates with no geographic adjustment. Every fee-schedule locality in this footprint pays below national on the code basket, so the correct rail runs in the organization's favour: 7.4% above the Huntington locality, 7.6% above Ashland, 5.6% above the southern Ohio locality.
4. **The binding constraint is the size of the Medicare slice, not enrollment capacity.** All three programmes reach their ceiling inside one quarter — advanced primary care management in M2, chronic care management in M4, remote monitoring in M5. At M24 the programme holds 231 active enrollments across 151 unique patients, which is every patient the three programmes can take.
5. **Which is why Medicaid is act two.** Medicare is 510 of 5,242 patients. Medicaid is 2,510 — five times larger. Ohio pays remote monitoring as a non-encounter service billed separately from the encounter rate, and four of the seven sites are in Ohio. That arm is scoped separately and is not in the forecast above.
6. **There is no shared-savings mechanism in play, and the case does not need one.** The organization participates in no Medicare accountable-care arrangement in PY2026, verified against the live participant files for both programmes. The business case here stands on fee-for-service billing alone, which makes it a cleaner argument than most.

[5] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2023 and CY2024 (CY2024 released May 2026), queried per National Provider Identifier across all 25 clinicians reassigning to CMS associate identifier 648694596. Codes swept: 99453, 99454, 99457, 99458, 99091, 98975, 98976, 98977, 98978, 98980, 98981, 99445, 99470; 99424 through 99427; G0556, G0557, G0558; 99495, 99496; 99490 and 99439. Query mechanics were validated against a known-positive control in both years, so the nulls are absences rather than query failures. The chronic care management lines that do appear belong to one clinician whose remaining codes are initial and subsequent nursing facility care and nursing facility discharge management.

1. The Quality Gap, and What It Costs

1.1 The footprint the gap sits in

Seven sites, five counties, three states. The organization added a site, a certification or a programme every few months for three straight years, and the most recent additions were all revenue infrastructure: a 340B pharmacy stood up in a single quarter, a chiropractic line at Gallipolis, and a seventh site in Huntington that entered approved scope in December 2025 and now runs the longest hours in the network.[6]

Site	County	In approved scope	Hours/week
Proctorville, Ohio	Lawrence, OH	August 2023	40
Wheelersburg, Ohio	Scioto, OH	August 2023	40
Huntington, West Virginia — dentistry	Cabell, WV	August 2023	40
Ashland, Kentucky	Boyd, KY	March 2024	40
Gallipolis, Ohio	Gallia, OH	March 2024	40
Proctorville mobile unit	Lawrence, OH	**March 2024**	40
Huntington, West Virginia — primary care	Cabell, WV	**December 2025**	**47**

HRSA Health Center Service Delivery and Look-Alike Sites file, retrieved August 2026.

Two of those rows deserve a sentence each. The **Proctorville mobile unit** has been in approved scope since March 2024 and appears nowhere on the organization's website or in any press. A mobile unit that already travels to patients is the single cheapest enrollment channel a remote-care programme can have, and this one is currently idle for that purpose. The **601 20th Street primary care site in Huntington** entered scope in December 2025, was Medicare-certified in March 2026, and runs 47 hours a week. It is the newest and fastest-moving site in the network and the natural first site for a pilot cohort.

Two structural facts about the payment position sit underneath everything that follows. First, all seven sites sit on the same federal payment rail, so there is no site-by-site rate complication to model. Second, a look-alike carries the health center payment rail without a Section 330 operating grant, so a new service line has to pay for itself out of claims revenue from the start. Section 4 shows that this one does, from the second month.

340B has been live since 1 April 2025 under entity type FQHCLA, identifier FQHCLA483 plus five child sites, with an organization-owned pharmacy in Ashland and no contract pharmacies registered. That last detail matters for a chronic-disease programme: medication adherence gains show up in the organization's own dispensing volume rather than leaking to a contract pharmacy.[7]

1.2 What this organization has already proven it can do

Substance-use treatment initiation and engagement are the two hardest longitudinal measures in the Uniform Data System. Initiation asks whether a patient with a new substance-use diagnosis started treatment within 14 days. Engagement asks whether they were still in treatment after that. Both are won by contact between visits with a population that is difficult to reach and easy to lose.

[6] HRSA Health Center Service Delivery and Look-Alike Sites file, retrieved 7 August 2026, for site names, addresses, counties, scope-entry dates and weekly hours; CMS Federally Qualified Health Center Enrollments file, vintage 17 July 2026, for the certification dates. The 601 20th Street Huntington site entered approved scope on 17 December 2025 and was Medicare-certified on 2 March 2026. The Proctorville mobile unit entered scope on 11 March 2024.

[7] HRSA 340B Office of Pharmacy Affairs Information System covered-entity detail record for FQHCLA483, retrieved 7 August 2026: registration 14 January 2025, participation approval 6 February 2025, participation start 1 April 2025, recertification 2 February 2026, and no contract pharmacies registered. The dispensing National Provider Identifier at the Ashland site is registered to the organization itself with community and clinic pharmacy taxonomies, enumerated 24 February 2025.

OVP Health Care reports **77.6% initiation** and **57.9% engagement** for CY2025, both in the top national quartile. Substance-use disorder patients are 41.3% of the panel — 2,166 of 5,242 — and that volume tripled in two reporting years. Mental health nearly quintupled over the same period. The organization built a longitudinal engagement capability because its mission required one, and the national comparison says the capability is real.[8]

1.3 The gap: bottom national quartile on every chronic-disease measure

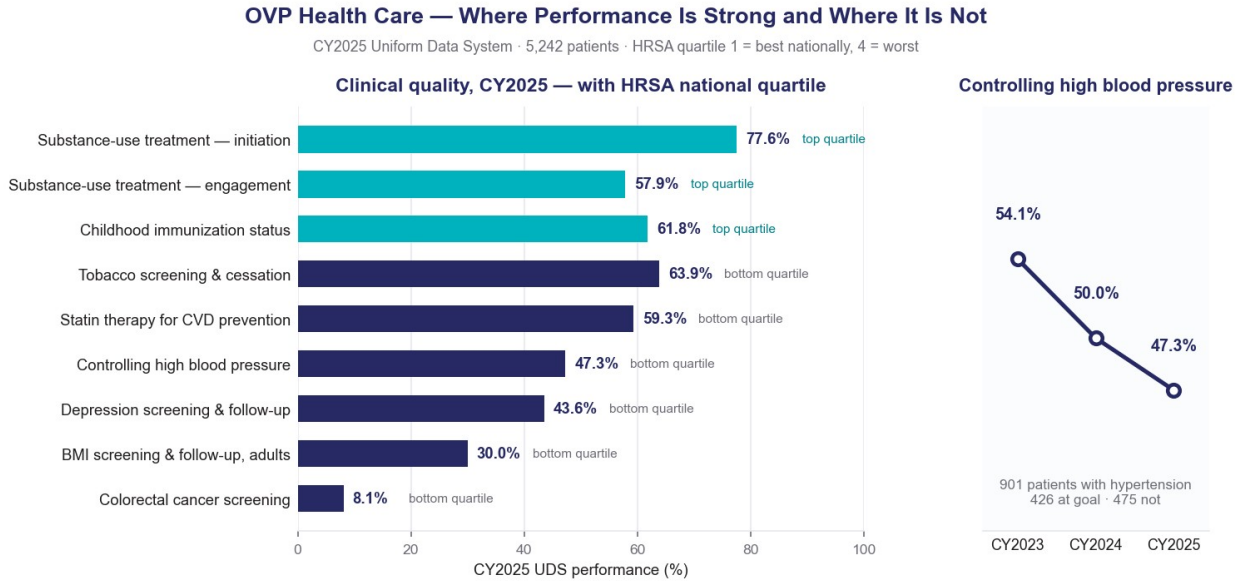

Figure 1 — CY2025 Uniform Data System clinical quality with HRSA national quartile position. Quartile 1 is the best-performing quartile nationally; quartile 4 is the worst. Inset: controlling high blood pressure across three reporting years against the 901-patient hypertensive cohort.

The organization sits in the bottom national quartile on ten CY2025 measures. Every chronic-disease measure it reports is among them.

Measure	CY2023	CY2024	CY2025	Quartile	Cohort
Controlling high blood pressure	54.1%	50.0%	**47.3%**	**4 — bottom**	**901 patients**
Diabetes: HbA1c above 9%	39.3%	34.0%	**38.3%**	**4 — bottom**	**556 patients**
Depression screening and follow-up	0.0%	53.6%	43.6%	4 — bottom	—
Tobacco screening and cessation	19.6%	70.6%	63.9%	4 — bottom	—
BMI screening and follow-up, adults	22.5%	25.2%	30.0%	4 — bottom	—
Statin therapy for cardiovascular prevention	71.6%	53.7%	59.3%	4 — bottom	—
Colorectal cancer screening	16.0%	7.7%	8.1%	4 — bottom	—

HRSA Uniform Data System, CY2023–CY2025. Lower is better on HbA1c above 9%. Cohort counts are the CY2025 UDS chronic-condition denominators.

The blood-pressure line is the one to look at hardest. It is the only measure in the table that has moved in the same direction for three consecutive years, and the direction is down. Behind the 47.3% are 901 patients with a hypertension diagnosis, of whom **475 are not at goal**. Hypertension prevalence in the

[8] HRSA Uniform Data System, CY2025: substance-use treatment initiation 77.6% and engagement 57.9%, both first-quartile nationally; childhood immunization status 61.8%, first quartile. Service mix for CY2025 records 2,166 substance-use disorder patients against a total panel of 5,242, up from 578 in CY2023, and 1,077 mental health patients against 222 in CY2023.

panel jumped from 246 reported patients in CY2024 to 901 in CY2025, which is a diagnosis-capture improvement rather than an epidemic. The organization got better at finding the patients and the control rate went down, which is what happens when a registry grows faster than the capacity to work it.

1.4 Why those two facts belong in the same sentence

Blood-pressure control is not decided in the exam room. It is decided by what happens in the 89 days between one visit and the next: whether the patient takes the medication, whether anyone sees a reading that says the dose is wrong, whether the titration happens in March or at the next scheduled appointment in June. HbA1c control works the same way. Both measures reward the same capability that substance-use initiation and engagement reward, which is contact between visits.

The acuity behind those measures is not in doubt. In the CY2024 Medicare Part B file, hypertension runs at **72% to 75% of every full panel** among the clinicians who surface in it, diabetes at 29% to 54%, chronic kidney disease at 25% to 49%, with average risk scores of 1.13 to 2.11 against a national 1.00.[9] The census says the same from another direction: across the five counties **19.4% to 23.1% of the whole population reports a disability**, rising to 41.3% to 47.6% among people 65 and over, and poverty runs 16.4% to 21.8%. Of the organization's own patients, 87.8% live at or below 200% of the federal poverty level.[10]

What the gap costs, stated three ways

Clinically. 475 hypertensive patients are not at goal and 213 diabetic patients carry an HbA1c above 9%. Both cohorts are known, counted and already in the registry.

In quality position. Ten measures in the bottom national quartile, against three in the top. The organization's published quality profile does not currently reflect what it is actually good at.

In revenue. The care-management and monitoring codes have been separately payable to health centers since 2025 and none of them is billed here. At the steady-state run rate in Section 4, that is $21,168 a month of net reimbursement the organization is eligible for and does not currently collect.

1.5 The market the Medicare panel sits in

Two market facts shape how the Medicare arm should be sold internally and to plans.

Market fact	Figure	What it means for this service line
Medicare Advantage is the majority payer	**54.0%** of the footprint's Medicare enrollment, against 51.2% nationally (April 2026)	More than half of the Medicare beneficiaries in these five counties are in a Medicare Advantage plan. Plans pay at least the Medicare rate as a floor. Whether a given contract pays the care-management families on the same terms is a plan-by-plan question, and it belongs in the first contracting conversation
The organization's Medicare share of the market is small	**510** of 71,928 Medicare beneficiaries in the footprint — about **0.7%**	The county Medicare market is large and OVP Health Care's share of it is negligible. That is a growth statement rather than a weakness: the service line is a reason for Medicare patients to attach to the health center, and there are 71,000 of them

[9] CMS Medicare Physician & Other Practitioners by Provider, CY2024, for the six roster clinicians who appear in the file. Chronic-condition prevalence and average risk score are reported per rendering clinician rather than per organization, and several of these clinicians carry more than one employer association, so the figures establish the acuity of the shared population rather than the organization's own volume.

[10] U.S. Census Bureau American Community Survey 2024 five-year estimates, profiles DP02, DP03 and DP05, for Cabell County West Virginia, Boyd County Kentucky, and Gallia, Lawrence and Scioto Counties Ohio. Disability among all ages runs 19.4% in Cabell to 23.1% in Lawrence; among those 65 and over, 41.3% in Cabell to 47.6% in Lawrence. Poverty runs 16.4% in Gallia to 21.8% in Scioto. The 87.8% figure is the CY2025 Uniform Data System share of patients with known income at or below 200% of the federal poverty level, against a known-income denominator of 3,496.

Market fact	Figure	What it means for this service line
Dual eligibility runs above national	21.4% of footprint Medicare enrollment against 17.1% nationally; 148 of the organization's own 510	Dual eligibility sets the advanced primary care management tier mix, and it is the bridge to the Medicaid arm in Section 6

CMS Medicare Monthly Enrollment, April 2026, five-county footprint; CY2025 UDS payer mix.

One design consequence from the census data, worth settling before enrollment starts. Household broadband subscription runs from 78.9% in Gallia County to 87.1% in Boyd County. Better than one household in five in Gallia has no broadband. Any device design that depends on home WiFi or a patient smartphone app fails on 13% to 21% of this panel, which is the point Section 3.4 addresses. English proficiency, by contrast, is a non-issue at 0.3% to 0.9% across the five counties.[11]

[11] Same American Community Survey source: household broadband subscription 78.9% in Gallia, 84.7% in Lawrence, 86.3% in Scioto, 86.6% in Cabell and 87.1% in Boyd. Population speaking English less than very well runs 0.3% to 0.9% across the five counties, and the CY2025 Uniform Data System limited-English-proficiency share is 0.11%.

2. The CY2026 Billing Change for Health Centers

2.1 One bundled code became a set of individual ones

For years, a health center billed care coordination through a single bundled HCPCS code, G0511, at one blended rate regardless of what was actually delivered. CMS ended that. Health centers now report the **individual CPT and HCPCS codes** for each care-management and remote-monitoring service, the add-on codes are billable, and advanced primary care management was adopted for health center payment at the same time.[12]

> **The load-bearing sentence, from the CMS rule**
>
> Payments to health centers are made at the national, non-facility physician fee schedule amounts when the individual code is on the claim — **in addition to** the health center prospective payment system rate.
>
> **42 CFR 405.2464(c)(7)**, for chronic care management, behavioral health integration, principal care management, remote patient monitoring, remote therapeutic monitoring and advanced primary care management furnished on or after 1 January 2025.

Two consequences follow directly, and both are worth stating plainly because they are the opposite of what most health center finance teams assume.

- **Care management does not cannibalize the encounter rate.** It is paid on top of it. A patient seen for a face-to-face visit and enrolled in remote monitoring generates the encounter payment and the monitoring payment, on the same claim.
- **The two rails are adjusted differently.** The encounter rate is geographically adjusted by the health center geographic adjustment factor. The separately-billable care-management and monitoring lines are not adjusted at all — they pay at national non-facility amounts wherever the health center is. Section 2.2 shows why that asymmetry is worth money in this particular footprint.

For scale, the CY2026 health center prospective payment system base rate is $207.72, up from $202.65, on a 2.5% market basket update. The care-management lines described in this report sit alongside that rate, not inside it.[13]

2.2 The national rate rail, and what it is worth in this footprint

Because the care-management and monitoring lines pay at national non-facility amounts, the correct way to price a health center service line is off the national schedule rather than off the local Medicare Administrative Contractor locality. Measured across all 109 localities in the CY2026 schedule, every locality in this footprint pays **below** national on the relevant code basket.

Fee-schedule locality	Sites it covers	National rail versus the locality
West Virginia 11402-16	Huntington — primary care and dentistry	**national pays 7.4% more**
Kentucky 15102-00	Ashland	**national pays 7.6% more**
Ohio 15202-00	Gallipolis, Proctorville, Wheelersburg, mobile unit	**national pays 5.6% more**

CY2026 Medicare Physician Fee Schedule, national non-facility amounts against the three localities covering the footprint, measured on the RPM, CCM and APCM code basket.

[12] CMS Calendar Year 2025 Medicare Physician Fee Schedule Final Rule fact sheet. CMS allowed a transition period of at least six months for billing-system updates, and individual-code reporting is the standing requirement for 2026 dates of service.

[13] CMS MLN Matters MM14309, related change request 14309, effective 1 January 2026, article released 8 December 2025: health center prospective payment system base payment rate $207.72 for CY2026 against $202.65 for CY2025, on a 2.5% market basket update. The same document confirms that the base rate is adjusted by the health center geographic adjustment factor while the separately-billable care-management lines are paid at national non-facility amounts.

This is not a rounding difference. It is between five and eight cents on every dollar of care-management revenue, and it applies for as long as the organization holds health center status. The forecast in Section 4 is built on the national rail throughout.

2.3 The work the change creates, and who carries it

The change gives with one hand and takes with the other. One bundled code required one time log. A set of individual codes requires per-programme time capture, per-programme documentation, per-programme consent and per-programme claim construction, each with its own minute thresholds and its own add-on rules. That work lands on whoever owns the billing system, and it landed this year.

This is where the Epic integration stops being a technical detail and becomes the reason the programme is workable at all. Per-code billing means somebody has to capture minutes against the right programme, attach the reading that justified the service, hold the consent, and build a claim for every enrolled patient every month. Done by hand across seven sites, that is a headcount question. Done through the integration, the readings land in the chart as discrete vitals, the documentation is written back into the record, and **the claims are generated automatically** — which is what makes the new rules tractable for an organization with one physician on staff and no spare billing capacity. Section 3.5 sets out the mechanics.

Put plainly: the organization does not have to build a compliance layer for a payment change it did not ask for. It inherits one that already runs inside the system its care team uses every day.

3. The Service Line: RPM, CCM and APCM on the Medicare Slice

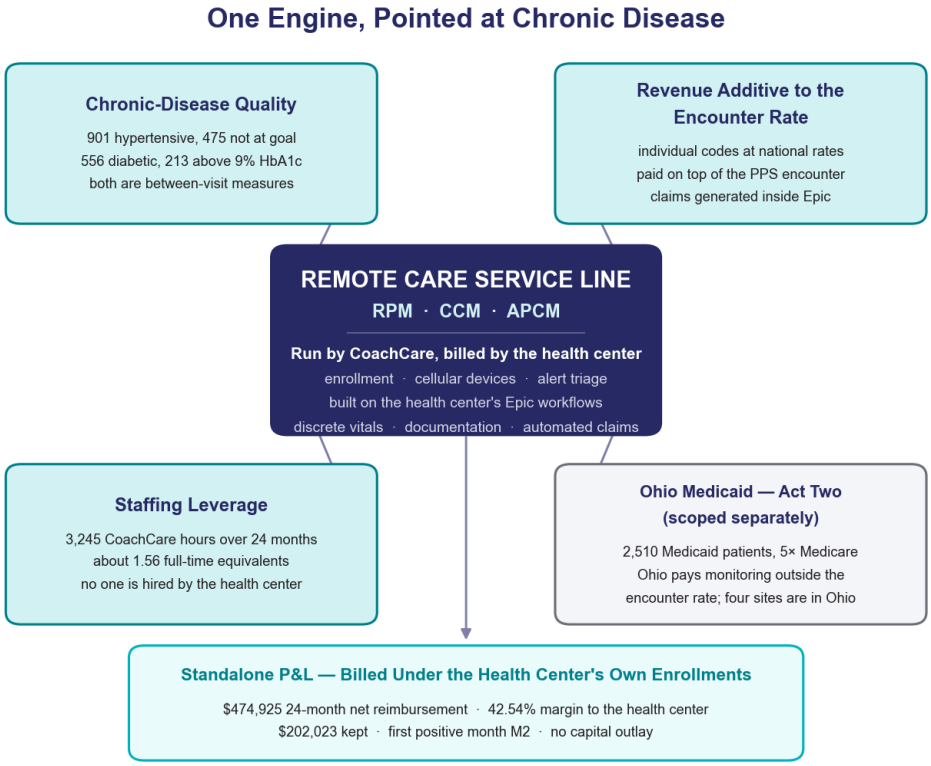

Figure 2 — one operating spine, four value layers, and the standalone profit and loss underneath it. Figures from the CoachCare Value Analysis and the CY2025 Uniform Data System.

3.1 The clinical and billing stack

Three programmes, one enrollment conversation, one care team, one billing pipeline. Each programme answers a different clinical question and each is separately payable to a health center at national rates.

Programme	What it does clinically	Who it fits in this panel
Remote physiologic monitoring (RPM)	A connected cuff, scale or glucometer transmits readings between visits, reviewed against thresholds the health center sets	The 901-patient hypertensive and 556-patient diabetic cohorts. Both failing measures are measured on exactly the values these devices transmit
Chronic care management (CCM)	A documented care plan for patients with two or more chronic conditions, with at least 20 minutes of non-face-to-face coordination each month	The multi-morbid core of the Medicare panel — given this footprint's comorbidity profile, most of it
Advanced primary care management (APCM)	A monthly per-patient payment for continuous primary care management, no minute threshold, tiered by complexity and dual-eligible status	The patients for whom a minute-counted programme is the wrong shape. Tier mix anchored to the 148 dual-eligible patients

Chronic care management and advanced primary care management draw on one care-management pool and are mutually exclusive in a given patient-month. Remote monitoring runs alongside either.

3.2 The starting position, verified across two years

Every one of the 25 clinicians who reassigns Medicare benefits to the organization was queried against thirteen remote monitoring and remote therapeutic monitoring codes, four principal care management codes, three advanced primary care management codes, two transitional care management codes and the chronic care management family, in both the CY2023 and CY2024 Medicare Part B files.

Code family	CY2023	CY2024
Remote monitoring, all 13 codes	**None**	**None**
Principal care management · advanced primary care management · transitional care management	**None**	**None**
Chronic care management	**None**	Present at one clinician, alongside nursing-facility codes — a personal nursing-home panel rather than health center work

CMS Medicare Physician & Other Practitioners by Provider and Service, CY2023 and CY2024, queried per clinician across the roster.

Two things need saying about what those zeros do and do not mean, and both are matters of accuracy rather than hedging.

- **CMS suppresses any provider and code line under 11 beneficiaries.** A code billed to ten patients by one clinician is invisible in this file. The claim the evidence supports is that there is no billed remote-care programme at meaningful scale, not that no patient has ever been billed.
- **G0511 is structurally absent from this dataset.** The bundled code billed institutionally under the health center certification, and the physician file contains no institutional claims at all. Whatever G0511 volume the organization ran is open rather than zero, and settling it needs the health center cost report. It is the first number to ask for.

For the monitoring line, though, the zero is close to conclusive. Six of the clinicians surfaced 3,479 services in CY2024 and cleared the suppression threshold on other codes in the same file. A monitoring programme of any real size would have shown up beside them.

3.3 Staffing: nobody has to be hired

This is an advanced-practice-led organization: one physician, a pediatrician, alongside 12 nurse practitioners in the Medicare reassignment roster, plus eleven behavioral health clinicians and a chiropractor. Chronic care management and advanced primary care management are built for exactly that shape, because both operate under general supervision and both are routinely delivered by clinical staff under a supervising practitioner.

The labour comes from CoachCare. Over 24 months the forecast carries **3,245 hours of care-team time — about 1.56 full-time equivalents** — covering enrollment calls, monthly outreach, alert triage, documentation and claim preparation, with an on-site enrollment specialist included at CoachCare's expense. The health center adds no headcount and the 12 nurse practitioners keep their schedules.

3.4 Devices: cellular, not app-dependent

Broadband runs from 78.9% to 87.1% across the five counties, and the population skews older, poorer and more disabled than national norms. Devices for this panel are cellular-connected and pre-paired, transmitting without home WiFi, a router password or a smartphone app. Getting that wrong would fail on roughly one patient in six, and it is expensive to retrofit. The 340B position gives the decision a second payoff: with an organization-owned pharmacy and no contract pharmacies, the adherence a monitoring programme produces shows up in the organization's own dispensing volume.

3.5 Epic integration: the programme lives where the care team already works

The health center runs Epic. CoachCare uses built-in Epic workflows, so the care team enrols and monitors patients without learning a second system and without a parallel portal to check. The programme lives in the Epic environment.[14]

Integration pillar	What it does in the record
Integrated enrollment	Enrollment flags and trigger ordering sit inside the clinical workflow. The CoachCare team enrols qualified Medicare patients on the health center's behalf, and enrollment status is visible in Epic in real time rather than in a report someone has to request
Exchange of health history	Bi-directional at intake, so the care plan starts from what is already in the chart instead of from a blank form
Integrated discrete vitals	**Device readings land in the chart as discrete vitals, not as scanned PDFs. That is the difference between a blood-pressure series a clinician can trend and an attachment nobody opens**
Compliance documentation and integrated care summary	Audit-ready documentation written into the record, which is what the per-code rules in Section 2.3 now require for every programme, every month
Automated claim generation	**Claims created through the CoachCare billing engine. CoachCare is the only care management application integrated with Epic that generates claims automatically, which removes the manual per-patient, per-month claim step entirely**

Two consequences matter for the ramp in Section 4.2. Patients begin receiving chronic care management and remote monitoring services in **under five days** from the enrollment flag, which is why the census climbs as steeply as it does in the first quarter. And because claim construction is automatic, the volume in Section 4.4 — **7,530 claims over 24 months** — never lands on the billing desk as manual work.

> **On what the integration is for**
>
> *"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**

One question to settle in the first call, and it is about sequencing rather than about the system. A health center on Epic is normally either on a hosted community instance or on a **Community Connect** instance licensed from a local health system. Which of the two decides whose governance board approves the interface and whose queue the build sits in, and that determines the integration timeline in Section 7.2 — not whether the integration is available.

[14] The record system was confirmed as Epic by OVP Health Care directly, August 2026. Integration detail is from the CoachCare Epic integration overview: integrated enrollment with flags and trigger ordering in the clinical workflow and real-time enrollment status; bi-directional exchange of health history at intake; device readings written to the chart as discrete vitals; compliance documentation and an integrated care summary; and automated claim generation through the CoachCare billing engine. Patients begin receiving chronic care management and remote monitoring services in under five days from the enrollment flag.

4. Value Analysis: The 24-Month Forecast

4.1 The headline economics

The forecast models remote physiologic monitoring, chronic care management and advanced primary care management across the 510 Medicare-primary patients in the CY2025 Uniform Data System count, at CY2026 national non-facility fee-schedule rates, with a referral engine of 12 nurse practitioners and one on-site enrollment specialist.

	Year 1	Year 2	24 months
Net reimbursement	**$220,911**	**$254,014**	**$474,925**
CoachCare fees	$130,985	$141,917	$272,902
Net to the health center	**$89,926**	**$112,097**	**$202,023**
Margin to the health center	40.71%	44.13%	**42.54%**

The margin improves from year one to year two because the one-time implementation and integration cost falls out and the panel is already enrolled. Year two is the steady state: **$254,014 of net reimbursement, $112,097 of it kept, at a 44.13% margin**.

Where the revenue comes from

Programme	Active enrollments at M24	24-month net reimbursement	Share	Per enrolled patient-month
Remote physiologic monitoring	116	**$246,762**	52.0%	$97.34
Chronic care management	61	**$153,575**	32.3%	$110.75
Advanced primary care management	54	**$74,588**	15.7%	$59.31
Total	**231 enrollments**	**$474,925**	100%	—

Active enrollments are programme enrollments. The 231 enrollments at M24 belong to 151 unique patients, because a patient may hold both a monitoring enrollment and a care-management enrollment.

Remote monitoring carries just over half the revenue on the largest enrolled population. Chronic care management earns the most per patient-month. Advanced primary care management is the smallest of the three lines here — the tier mix is anchored to a dual-eligible share of 29% of the Medicare panel, which is meaningful without being the headline.

4.2 The ramp, month by month

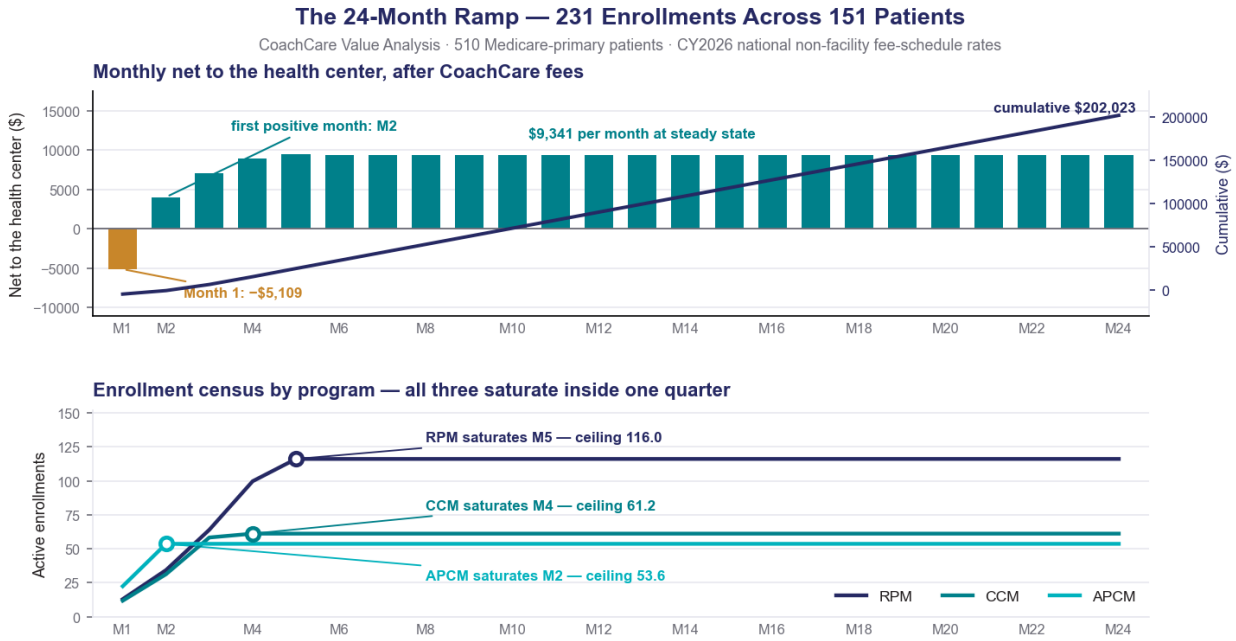

Figure 3 — monthly net to the health center after CoachCare fees, with cumulative net overlaid, and the enrollment census by programme. CoachCare Value Analysis.

Month 1 nets **−$5,109**, because implementation and integration are one-time costs that land in that month against a census that is still building. The first positive month is **M2**, at $4,054. By M6 the programme is at its steady-state run rate of $9,341 a month net to the health center, and it holds there.

Month	Net reimbursement	CoachCare fees	Net to the health center
M1	$4,148	$9,257	**−$5,109**
M2	$10,389	$6,335	**$4,054**
M3	$16,414	$9,327	$7,087
M4	$20,293	$11,292	$9,000
M5	$21,493	$11,988	$9,505
M6 onward	**$21,168**	$11,826	**$9,341**

The commercially relevant number in that table is not the 24-month total. It is the fact that the programme is cash-positive in its second month and has repaid its own start-up cost by the end of the first quarter. A service line that funds itself out of its own claims from month two does not compete with anything else for capital.

4.3 Ceilings: the whole Medicare panel enrolls inside one quarter

All three programmes hit their enrollment ceiling within five months, and it is worth being explicit about why. The referral engine alone — 12 nurse practitioners referring at 8 patients a month with an 80% completion rate — produces 77 enrollments a month, and the on-site enrollment specialist adds 80 more. That is 157 enrollments a month against a total ceiling of 231.

Programme	Eligible share of the 510	Acceptance	Ceiling	Saturates
Remote physiologic monitoring	65%	35%	**116.0**	**M5**
Chronic care management	40%	30%	**61.2**	**M4**
Advanced primary care management	35%	30%	**53.6**	**M2**

Say the constraint out loud

The binding constraint on this programme is the size of the Medicare slice, not the capacity to enrol into it. Against 510 Medicare-primary patients in a 5,242-patient panel, every patient the three programmes can take is enrolled by the end of the first quarter, after which the same infrastructure has nowhere further to go on the Medicare rail.

That is the argument for Medicaid as act two, not a weakness in the Medicare case. The Medicare arm is the proving ground: it stands up the workflow, the escalation protocol, the documentation standard and the claim pipeline, and it pays for all of them while doing it. Medicaid is where the same machine meets a population five times larger.

4.4 What the programme produces clinically and operationally

Output over 24 months	Volume	What it represents
Readings received	**26,619**	Blood pressure, weight and glucose values arriving between visits, against a hypertension measure that is currently decided without them
Claims generated	**7,530**	Constructed, coded and submitted through the programme rather than assembled by hand
Care-management tasks completed	15,060	Outreach attempts, care-plan updates, medication reviews and follow-up actions
Patient conversations	2,259	Live contacts, across 125 hours of call time — the between-visit contact the two failing measures are decided by
Chart updates	3,765	Documentation written back for the care team to act on
Care-team hours delivered by CoachCare	**3,245**	**About 1.56 full-time equivalents of care-management labour the health center does not employ**
Hospitalizations avoided	**16.9**	At a conservative $15,000 per avoided admission, roughly $253,000 of cost the health system does not incur

CoachCare Value Analysis, 24-month totals.

The avoided-admission figure belongs to the patient and the payer rather than to the health center's income statement, and it is not part of the $202,023. It is the number that matters to a Medicare Advantage plan in a footprint where 54.0% of Medicare beneficiaries are enrolled in one, and it is the number to lead with in a plan conversation.

5. Clinical Governance & Escalation

Section 4 shows the service line pays. This section shows it is safe. Every reading a patient takes routes through one shared escalation engine with defined thresholds, a defined trend rule, defined routing and a defined documentation standard, so the health center never carries surveillance liability it did not agree to. With one physician on staff and no named medical director, the escalation protocol here is a governance document rather than a clinical formality, and it should be signed off by the people who run the organization before the first patient enrols.

5.1 One shared escalation engine

All three programmes route through the same logic. The engine is programme-agnostic and the thresholds are set with the health center's clinical leadership rather than by default.

Branch	The rule	Why it is written this way
Critical value	**Escalate immediately, regardless of symptoms**	A reading at a critical threshold escalates whether or not the patient reports symptoms. There is no wait-and-see branch on a critical value, and no client preference can suppress it
Out of range, not critical	Retake, then a structured symptom check	A non-critical out-of-range reading is worked rather than forwarded: confirm technique, request a repeat, then run the symptom check. Most out-of-range readings resolve here, which is exactly why the care team's inbox stays clean
Trend	**Three consecutive readings at least one hour apart for blood pressure or glucose; three readings within seven days for heart rate**	A trend is a definition rather than a judgment call. A confirmed trend escalates on the same footing as a single threshold breach
Patient unreachable	Document the attempt, leave a voicemail with the callback line and advice to seek care if symptoms worsen — and escalate anyway if the reading was critical or a confirmed trend	Silence never downgrades a clinical finding. This is the branch that separates a monitoring programme from a data-collection exercise
Documentation	**Six fields on every escalation: vital · findings · method · contact · outcome · follow-up**	The same six fields every time, so any episode can be reconstructed end to end. Parameter changes are documented in the same record

5.2 The emergent pathway

Non-negotiable, and stated as such

Triggers. Chest pain · new shortness of breath · signs of stroke · syncope · worst-ever headache · sudden swelling. Any of these reported during an outreach call activates the emergent protocol immediately.

Action. 911 is called with the patient still on the line. The call is not ended and handed off.

If the patient refuses. The care team is called with the patient still on the line and directs care. If the care team cannot be reached, CoachCare activates emergency services regardless. Either way the clinic is notified and the chart records the symptoms, the 911 status, the contact made and the instructions given.

The floor. CoachCare's urgent and emergent policy supersedes any client-specific escalation preference. A health center can shape routing for everything else. It cannot lower the floor on an emergency, and neither can we.

Symptoms that are recent or changing but not actively emergent — inside a 72-hour window — route as an escalation under the health center's own stated preference rather than through the 911 pathway, and are documented the same way.

5.3 Three-way routing

The failure mode of a monitoring programme inside a busy clinic is not a missed alert. It is an inbox nobody reads, because everything arrives as an alert. Escalations route three ways, and the split is agreed before the first patient enrols.

Route	What goes there	Who sees it
Emergency	Emergent symptoms, or a critical value with clinical instability	911 activated, with the care team notified
Non-critical	A confirmed out-of-range reading or trend without emergent features	The defined care team member named in the escalation matrix, within the agreed window
Stable or resolved	**Worked, retaken, resolved, patient asymptomatic**	**Documented in the record as a note rather than pushed as an alert. This is the branch that decides whether the programme is sustainable across seven sites**

Across a seven-site, three-state footprint that matrix is agreed per site rather than once centrally, because the covering clinician in Gallipolis on a Tuesday afternoon is not the covering clinician in Ashland.

5.4 The post-discharge three-touch cadence

Triggered automatically by any emergency room visit or hospitalization reported in the previous 60 days. This is the readmission-prevention spine, and it is the mechanism behind the 16.9 avoided hospitalizations in the forecast.

Touch	Window	What happens
1 · Stabilise	**Day 1–2**	Identify what precipitated the admission; reconcile discharge medications against what is actually in the house; confirm the follow-up appointment exists within 7 to 14 days; symptom assessment, documented and escalated per the engine above
2 · Detect	**Day 5–8**	The window in which post-discharge decompensation usually declares itself. Verify medication adherence; re-evaluate the original triggers; confirm the appointment was attended; verify ordered labs were completed
3 · Secure	**Day 12–14**	Medication and risk review; review the outcome of the completed visit; final symptom assessment; hand the patient into the longitudinal monitoring panel so the window closes with continuity rather than a cliff

5.5 Continuity and discharge governance

Patients do not quietly fall out of the programme, and the care team is notified at every decision point.

1. **An unreachable patient escalates on a fixed cadence.** For remote monitoring, a patient unreachable 45 days from enrollment is escalated to the care team, and non-compliance at 90 days triggers a second escalation plus 90 more days of monitoring. Care management runs on a longer clock, with the first escalation at six months.
2. **There is a hard backstop.** If no instruction comes back from the care team, discharge proceeds at 180 days for monitoring. The clinic is notified in every case and discharges process in the first week of the following month.
3. **The health center always decides.** Clinical discharge criteria, escalation thresholds and routing belong to the health center. CoachCare executes them consistently and documents the execution. It does not overrule clinical judgment, with the single exception of the emergent floor in Section 5.2.
4. **Auditable by design.** Because every escalation carries the same six documented fields, any episode can be reconstructed end to end — which is what the per-code documentation rules in Section 2.3 require in any case.

6. Medicaid as Act Two — and Why Ohio Is the One That Works

6.1 The scale argument

Medicare is 510 patients. Medicaid is **2,510** — five times larger, and 47.9% of the whole panel. The CY2025 payer split runs Medicaid and CHIP 2,510 (47.9%), other third party 1,738 (33.2%), Medicare 510 (9.7%) and uninsured 484 (9.2%), against a total of 5,242 patients, with 148 dual-eligible patients sitting inside the Medicare line. Any programme designed around Medicare economics addresses under a tenth of this organization's population.

The Medicare arm in Section 4 is still the right first move, because it is where the payment rules are settled and where the programme funds itself from month two. But the Medicaid arm is where the scale is, and its structure is unusual enough to be worth getting right before anyone starts designing.

6.2 Ohio: monitoring is paid outside the encounter rate

Ohio Administrative Code 5160-28-03(C) lets a health center structure its Medicaid enrollment so that it can submit a claim and receive separate payment for a covered service that cannot be claimed as an encounter service. The non-exhaustive list of such services names **remote patient monitoring** explicitly. Subsection (3) then states that providing a non-encounter service on the same date as an encounter service does not preclude payment for either. The Ohio Department of Medicaid's own telehealth billing guidelines for dates of service on or after 1 January 2026 confirm the mechanism operationally.[15]

Four of the seven sites are in Ohio — Wheelersburg, Proctorville, Gallipolis and the mobile unit. That is where a Medicaid monitoring arm would produce incremental margin rather than a re-labelled encounter payment.

Two conditions attach, and both are real work rather than paperwork:

- **A second Ohio Medicaid provider number is required.** Non-encounter services bill under provider type 50, ambulatory health care clinic. Obtaining it does not change the organization's health center status, but it is a prerequisite and it takes time.
- **No wraparound applies to non-encounter services.** Ohio defines wraparound against the per-visit payment amount, and monitoring is not a visit. The payment is what the fee schedule says it is.

One complication to plan around rather than discover. Ohio retired the bundled care-coordination code effective 1 January 2026 without enabling its replacements on the Medicaid side: the chronic care management codes are not covered and principal care management is absent from the schedule entirely. Advanced primary care management is priced. Whether a health center may bill it as a non-encounter service is the open question, and it is the highest-value one to put to the Ohio Department of Medicaid in writing before anything is designed around it.[16]

6.3 Kentucky and West Virginia

The three states are structurally different from each other, and only one of them produces incremental revenue. Being precise about this is the difference between a credible second phase and a proposal that falls apart at the first billing question.

---

[15] Ohio Administrative Code 5160-28-03(C), effective 1 July 2022, subsection (2)(b) naming remote patient monitoring among services a health center may claim outside the encounter rate, and subsection (3) on same-date payment; Ohio Department of Medicaid Telehealth Billing Guidelines for dates of service on or after 1 January 2026; Ohio Administrative Code 5160-28-01(E) on the wraparound calculation.

[16] Ohio Department of Medicaid Medical Assistance Letter 688, 29 December 2025, retiring the bundled care-coordination code effective 1 January 2026; Appendix DD to Ohio Administrative Code 5160-1-60, revised 1 January 2026, for the coverage status of the chronic care management codes and the pricing of the advanced primary care management codes. Whether a health center may bill advanced primary care management as a non-encounter service is not addressed by the department in any published document located in this research.

	Ohio — 4 sites	Kentucky — 1 site	West Virginia — 2 sites
Remote monitoring	**Covered, and paid as a non-encounter service billed separately from the encounter rate**	Covered, but wrap-paid — the payment lands inside the encounter rate rather than on top of it	**Not covered — explicit exclusion on the state fee schedule**
Chronic care management	Not covered	Covered, also wrap-paid inside the encounter	Not covered
Advanced primary care management	Priced; health center eligibility is open	Not on the state schedule	Not covered
Transitional care management	Not covered	Zero-pay to a health center	**Covered**
Net effect	**Real incremental margin**	**No incremental dollar**	**No payment path for the modelled programmes**

State Medicaid fee schedules and administrative code, retrieved August 2026. Ohio Administrative Code 5160-28-03; Kentucky 907 KAR 3:170 and the Department for Medicaid Services wrap-pay and zero-pay code lists; West Virginia Medicaid RBRVS physician fee schedule effective 1 April 2026.

Kentucky covers more codes and pays a health center less for them. Monitoring and chronic care management are eligible services, but a Kentucky health center visit is defined to include telehealth-delivered services, so both roll into the encounter payment through the wrap rather than adding to it.[17] West Virginia is a flat exclusion: the state priced the relative value units for the monitoring, chronic care management and advanced primary care management codes and then set adjudication to not covered on every one of them, down to the blood-pressure monitor as non-covered equipment. Transitional care management is the exception there and is covered. Vendor material asserting that West Virginia provides comprehensive monitoring and care-management coverage is contradicted by the state's own fee schedule.[18]

One point to correct if it comes up: none of the three states requires the provider rather than a supplier to furnish the monitoring device. That rule exists in some states. It does not exist in Ohio, Kentucky or West Virginia.

6.4 What would have to be true

The Medicaid arm is scoped separately and deliberately kept out of the forecast in Section 4. Four things would have to be settled before it could be modelled:

1. Enrollment as an Ohio ambulatory health care clinic, provider type 50, alongside the existing health center enrollment.
2. A written answer from the Ohio Department of Medicaid on whether a health center may bill advanced primary care management as a non-encounter service.
3. Managed-care confirmation plan by plan. Ohio requires benefit parity from its Medicaid plans but not rate parity, so the rates are contractual.
4. The same cellular-first device design as the Medicare arm, applied to a population with a lower broadband floor.

[17] Kentucky 907 KAR 3:170 sections 4, 6 and 7 on eligible telehealth services, eligible providers and reimbursement parity; 907 KAR 1:055 section 1(37) defining a health center visit to include telehealth-delivered encounters; and the Kentucky Department for Medicaid Services wrap-pay and zero-pay procedure code lists, which place the monitoring and chronic care management codes on the wrap-pay sheet and transitional care management, principal care management and the bundled care-coordination code on the zero-pay sheet.

[18] West Virginia Medicaid RBRVS physician fee schedule effective 1 April 2026 through 31 March 2027, which carries a not-covered adjudication status on every remote monitoring, remote therapeutic monitoring, chronic care management, principal care management and advanced primary care management code, and covered status on transitional care management; Chapter 522 of the West Virginia Medicaid provider manual on services payable outside the encounter; and Appendix 506C, which lists the blood-pressure monitor and scales as non-covered durable medical equipment.

7. Implementation and the First 90 Days

7.1 Who runs what

Function	CoachCare	OVP Health Care
Patient identification	Registry query against the agreed inclusion criteria	Approves the criteria and the target list
Enrollment	**On-site enrollment specialist, at CoachCare's expense; Epic enrollment flags and trigger ordering**	Provider referral at the point of care
Devices	Sourced, configured, cellular-paired, shipped, replaced	Nothing purchased, nothing stocked
Monitoring and escalation	Reading review, monthly outreach, alert triage, post-discharge cadence, protocol execution and documentation	**Sets thresholds, routing and after-hours cover; receives escalations**
Documentation and billing	Time logs, discrete-vitals and documentation write-back to Epic, automated claim generation	**Bills under its own enrollments; keeps the revenue**
Reporting	Monthly enrollment, engagement, escalation and revenue reporting	Standing monthly operating call

7.2 The 90-day plan

Window	What happens	Result at the end of it
Days 0–15 Decide	Establish which Epic instance the health center is on and who owns its interface queue. Confirm the Medicare and dual classification behind the 510 count. Request the cost-report line for the retired bundled code. Agree the clinical target	Scope signed, target cohort defined, Epic build slotted
Days 16–30 Design	Epic interface build: enrollment flags, trigger ordering, discrete-vitals write-back. Escalation thresholds, routing and after-hours cover agreed per site. Registry run to name the target list from the 901 hypertensive and 556 diabetic cohorts	Clinical protocol signed by leadership
Days 31–60 Enrol	Enrollment specialist on site, starting at the Huntington primary care site and Gallipolis. Flags live in the clinical workflow. Devices shipped and paired. Mobile unit added as a second channel	First claims generated automatically; month 2 turns cash-positive
Days 61–90 Scale	Roll to Proctorville, Wheelersburg and Ashland. Post-discharge cadence on. Ohio provider type 50 application opened in parallel	All three programmes at or near ceiling; Medicaid track started

7.3 The operating dashboard

Metric	Why it is on the list	Where it should be by M6
Active enrollments by programme, and unique patients	The leading indicator of everything else, with enrollments and patients kept apart	**116 · 61 · 54 by programme, across about 151 patients**
Reading adherence — days transmitting per patient-month	Decides whether the monitoring codes are billable and whether the signal is real	16 or more days per patient-month
Controlling high blood pressure, and HbA1c above 9%	**The two measures the whole programme is pointed at**	**Reversal of the three-year decline from 47.3%; movement off 38.3%**
Escalations by route	Confirms the three-way split is holding and the inbox is not flooding	Stable non-critical volume
Net reimbursement and net to the health center	The finance conversation, monthly	$21,168 and $9,341 a month

8. Recommendations

1. **Point the existing engagement engine at the chronic-disease panel.** The capability that produces top-quartile substance-use initiation and engagement is the same capability that moves blood-pressure control. Start with the 475 hypertensive patients who are not at goal and the 213 diabetic patients above 9%, because both cohorts are already identified in the registry.
2. **Bill the codes the CY2026 rules make separately payable.** Remote monitoring, chronic care management and advanced primary care management pay at national non-facility rates on top of the encounter rate. The organization currently bills none of them. At the steady-state run rate that is $21,168 a month of net reimbursement it is eligible for.
3. **Take the programme on the national rate rail, not the local one.** Every fee-schedule locality in this footprint pays below national on the code basket. Pricing off the local locality would understate the programme by five to eight percent.
4. **Design cellular-first, and decide it once.** Broadband subscription runs as low as 78.9% in Gallia County. Cellular-connected, pre-paired devices are the only design that reaches the whole panel, and retrofitting that decision after enrollment is expensive.
5. **Turn on the two idle enrollment channels.** The Proctorville mobile unit has been in approved scope since March 2024 and appears nowhere in the organization's public material. The Huntington primary care site entered scope in December 2025 and runs the longest hours in the network. Both are enrollment channels the programme should use from week one.
6. **Agree the escalation protocol at leadership level before enrollment starts.** With one physician on staff and no named medical director, the escalation matrix is a governance decision rather than a clinical formality. Section 5 is the operating floor a protocol session starts from.
7. **Use the Epic integration as the compliance answer, not as a feature.** The CY2026 per-code rules create time-capture, documentation and claim work that has to happen for every enrolled patient every month. Discrete vitals in the chart and automated claim generation are what keep that off the billing desk. Settle the Epic instance and its interface queue in the first call so the build is slotted before enrollment starts.
8. **Ask for one number in the first meeting.** The historical volume on the retired bundled code, which is invisible in the physician file because it billed institutionally under the health center certification. It is the difference between no programme and an unmeasured programme, and it comes off the health center cost report.
9. **Open the Ohio Medicaid track in parallel, not afterwards.** Four sites are in Ohio, Ohio pays monitoring outside the encounter rate, and the second provider number takes time to obtain. Starting the application during the Medicare roll-out costs nothing and saves a quarter.

The Medicare arm is small by design, and it is small because the Medicare panel is small. What it buys is a working chronic-disease service line — protocol, staffing, documentation, claims — paid for by its own revenue from the second month, on a panel where the failing measures are already counted and the patients are already named.

References & Data Sources

- **Federal designation, certification and 340B records** (retrieved August 2026): the HRSA Health Center Service Delivery and Look-Alike Sites file, for look-alike designation, health center number, the seven sites in approved scope with counties, scope-entry dates and operating hours; the CMS Federally Qualified Health Center Enrollments file, vintage 17 July 2026, for six live Medicare health center certifications under a single CMS associate identifier, site National Provider Identifiers, incorporation and non-profit status, with the companion All Owners file establishing self-ownership and no holding company, management services company or private equity sponsor in the disclosed structure; and the HRSA 340B Office of Pharmacy Affairs Information System, for entity type, the parent and five child identifiers, participation dates, the February 2026 recertification and the absence of registered contract pharmacies.
- **HRSA Uniform Data System, CY2023 through CY2025** (CY2025 is the most recent published reporting year): total patients, age distribution, payer mix and counts, service mix, chronic-condition prevalence and counts, the full clinical quality measure set with HRSA national quartile rankings, and income distribution. HRSA quartile ranking runs 1 for the best-performing quartile nationally to 4 for the worst.
- **CMS Revalidation Clinic Group Practice Reassignment file** (vintage August 2026), rolled up on the organization's CMS associate identifier: the 25-clinician roster and its composition — one physician, 12 nurse practitioners, eleven behavioral health clinicians and one chiropractor. Roll-up on the associate identifier, rather than name matching, is what makes this an identity test rather than a string match, and it is what separates this organization from similarly named entities in the same market.
- **CMS Medicare Physician & Other Practitioners — by Provider and by Provider and Service, CY2023 and CY2024** (CY2024 released May 2026), queried per National Provider Identifier across the full roster: the negative screen on thirteen remote monitoring and remote therapeutic monitoring codes, four principal care management codes, three advanced primary care management codes, two transitional care management codes and the chronic care management family, in both years; the six clinicians who surface in CY2024 with 3,479 services; and the chronic-condition prevalence and risk scores in their panels. Query mechanics were validated with a known-positive control in both years. CMS suppresses any provider and code line with fewer than 11 beneficiaries.
- **Medicare payment rules and rates for health centers:** 42 CFR 405.2464 and the CMS Calendar Year 2025 Medicare Physician Fee Schedule Final Rule fact sheet, for the retirement of the bundled care-coordination code, the move to individual CPT and HCPCS reporting, the adoption of advanced primary care management for health center payment, and the rule that the individual codes are paid at national non-facility amounts in addition to the prospective payment system rate; CMS MLN Matters MM14309, effective 1 January 2026, for the $207.72 CY2026 base rate against $202.65 for CY2025 and the 2.5% market basket update; and the CY2026 national non-facility amounts measured against all 109 fee-schedule localities, which return the 7.4%, 7.6% and 5.6% differentials in Section 2.2.
- **CMS Medicare Shared Savings Program PY2026 participant file** (15,370 participant rows) and the **ACO REACH PY2026 participant list**: zero matches on the organization's name, any site address, or any of its seven organizational National Provider Identifiers, in either file. Known-positive controls were run against both files first to prove the queries functioned. The organization participates in no Medicare accountable-care arrangement in PY2026.
- **Market and population sources:** CMS Medicare Monthly Enrollment, April 2026, filtered to the five footprint counties, for 71,928 total Medicare beneficiaries, 38,831 in Medicare Advantage at a footprint-weighted 54.0% against 51.2% nationally, and dual eligibility at 21.4% against 17.1%; the U.S. Census Bureau American Community Survey 2024 five-year estimates, profiles DP02, DP03 and DP05, for population, age, income, poverty, disability, educational attainment, English

proficiency and household broadband subscription; and the HRSA Medically Underserved Area and Primary Care Health Professional Shortage Area files for the organization's own shortage-area designation and the low-income population designation of all five counties.

- **State Medicaid authority for Ohio, Kentucky and West Virginia:** Ohio Administrative Code 5160-28-03 and 5160-28-01, the Ohio Department of Medicaid telehealth billing guidelines for dates of service on or after 1 January 2026, Appendix DD to Ohio Administrative Code 5160-1-60 and Medical Assistance Letter 688; Kentucky 907 KAR 3:170 and 907 KAR 1:055 with the Department for Medicaid Services wrap-pay and zero-pay procedure code lists; and the West Virginia Medicaid RBRVS physician fee schedule effective 1 April 2026, Chapter 522 of the provider manual and Appendix 506C.
- **CoachCare Care Management Programs standard operating procedures, version March 2026:** The shared clinical alert and escalation decision logic, the trend definitions, the emergent and urgent communication protocol, the three-way escalation routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 5.
- **The record system, confirmed by OVP Health Care as Epic** (August 2026), and the CoachCare Epic integration overview: the five integration pillars reproduced in Section 3.5, the under-five-days interval from enrollment flag to first chronic care management and remote monitoring service, and automated claim creation through the CoachCare billing engine.
- **CoachCare Value Analysis for OVP Health Care, 2026:** Every financial, enrollment, clinical-output and operational figure in Sections 4 and 7, built on 510 Medicare-primary patients, 12 referring nurse practitioners, one on-site enrollment specialist, and CY2026 national non-facility fee-schedule rates for remote physiologic monitoring, chronic care management and advanced primary care management.
- **The organization's own website, site records and public announcements** (retrieved August 2026, with archived captures from 2024 onward): the locations page, the advertised service lines, the pharmacy service page, the chiropractic launch, and the absence of any care management, care coordination or remote monitoring service from the published service list.

A note on how this report handles counts

Enrolled patients and programme enrollments are different numbers. At M24 the programme holds 231 active programme enrollments belonging to 151 unique patients, because a patient may hold a monitoring enrollment and a care-management enrollment at the same time. Wherever this report gives a patient count it says patients; wherever it gives an enrollment count it says enrollments.

Panel counts come from the Uniform Data System, not from claims. Health center encounters bill institutionally under the health center certification rather than under the physician fee schedule by individual clinician, so the Medicare physician file systematically undercounts a health center panel. Six of 25 roster clinicians appearing in that file is the expected result for an organization of this type. The 510 Medicare-primary figure used throughout is the measured Uniform Data System count for CY2025.

No individual is named anywhere in this report. Clinician composition, board structure and leadership are described by count and role only.