

OVP Health

A physician-owned rural health organization operating ten Rural Health Clinics across Kentucky, West Virginia and Virginia, with primary-care clinics in Mason and Spencer, West Virginia, and emergency-department and hospitalist staffing for seven rural hospital partners

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 — delivered across ten Rural Health Clinics, under the CY2026 rules that pay RHCs for those codes individually, at national rates, on top of the per-visit all-inclusive rate

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the leadership of OVP Health. It brings together the network's site and certification record, the chronic-disease burden and Medicare structure of its nine clinic counties, the CY2026 billing rules for Rural Health Clinics, a 24-month Value Analysis for a remote care service line at the clinic sites, the clinical governance that would run it, and the state funding now moving in West Virginia and Kentucky.

The argument is short. This organization built survey-ready rural clinics across three states. Chronic disease between visits is the one service line the network does not deliver yet — and the billing rail for it switched on in January.

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Table of Contents

Executive Summary.....	3
1. The Network and Its Counties.....	5
1.1 Ten Rural Health Clinics across three states.....	5
1.2 The operating discipline is already in place.....	5
1.3 The counties: chronic disease made visible.....	6
1.4 The Medicare market is two-thirds Medicare Advantage.....	6
1.5 The gap: no between-visit infrastructure.....	7
2. The CY2026 Billing Change for Rural Health Clinics.....	8
2.1 G0511 is gone; the individual codes pay on top of the visit rate.....	8
2.2 What the codes pay here.....	8
2.3 The work the change creates, and who carries it.....	9
3. The Service Line: RPM, CCM and APCM on the Medicare Slice.....	10
3.1 The clinical and billing stack.....	10
3.2 The Medicare slice it runs on.....	10
3.3 Built the way the codes work: nurse-practitioner-led care.....	11
3.4 Staffing: nobody is hired.....	11
4. Value Analysis: The 24-Month Forecast.....	12
4.1 Headline economics.....	12
4.2 Program economics by year.....	12
4.3 The ramp: every ceiling reached by month eight.....	13
4.4 What the program produces.....	14
5. Clinical Governance and Escalation.....	15
5.1 One shared escalation engine.....	15
5.2 The emergent pathway.....	15
5.3 Qualification, device assignment and routing.....	15
5.4 The post-discharge cadence.....	15
5.5 Discharge governance and continuity.....	15
6. State Momentum: Rural Health Transformation Funding.....	16
7. Implementation and the First 90 Days.....	17
7.1 Who runs what.....	17
7.2 Epic integration: the program lives in the record.....	17
7.3 Devices and patient materials.....	17
7.4 Model inputs.....	18
7.5 The 90-day plan and the operating dashboard.....	18
8. Recommendations.....	19
References and Data Sources.....	20

Executive Summary

OVP Health is a physician-owned rural health organization operating ten Medicare-certified Rural Health Clinics across Kentucky, West Virginia and Virginia — six in eastern Kentucky, three in West Virginia, one in southwestern Virginia — plus primary-care clinics in Mason and Spencer, West Virginia, that are not yet certified as RHCs. The clinic network has doubled since 2020.¹ Seven of the ten RHCs hold Joint Commission Rural Health Clinic accreditation, earned between September 2024 and January 2025.² The clinical roster at the clinic sites is 19 adult primary-care clinicians — 4 physicians and 15 nurse practitioners.³ The company also staffs emergency departments and hospitalist programs for seven rural hospital partners, which is where its multi-site operating muscle comes from.

The nine clinic counties describe the clinical work better than any strategy memo could. In the American Community Survey 2024 five-year estimates, **24–38% of all residents in the core coalfield counties live with a disability** — roughly double the national rate — and poverty runs 18–30%.⁴ Chronic disease concentrates exactly where distance and terrain make between-visit care hardest to deliver.

The Medicare market around the clinics is two-thirds Medicare Advantage: **66.2% of eligible beneficiaries across the nine RHC counties** as of August 2026, against roughly 51% nationally.⁵ That mix shapes the revenue math in one specific way. MA plans must pay at least the Medicare rate for covered services — a floor; individual contracts set their own terms for the care-management code families. This report prices everything at the fee schedule and makes the contract check a first-week discovery item.

The observation this report is built on

You built survey-ready rural clinics across three states. Chronic disease between visits is the one service line the network does not deliver yet — and the billing rail for it switched on in January.

An organization that runs Joint Commission survey-readiness across a ten-clinic rural network already has the operating discipline a care-management program needs. What the network does not have is the between-visit layer. Across all of its clinicians, CY2024 Medicare fee-for-service claims show no billed remote-care program at meaningful scale — CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed institutionally under an RHC certification is not publicly observable, so that is the precise claim: no billed remote-care program at meaningful scale, and no observable care-management operation.⁶ There is no care-management staffing in the organization's current hiring, and telemedicine at the clinics is virtual visits, not monitoring. Monitoring replaces windshield time.

The opening is live and dated. G0511, the single bundled code RHCs used for care management, has been retired. From January 2026, Rural Health Clinics bill chronic care management, remote physiologic monitoring and advanced primary care management as **individual codes at national non-facility Physician Fee Schedule rates, in addition to the per-visit all-inclusive rate (42 CFR 405.2464(c)).**⁷ New revenue arrives on the same claim — along with per-code documentation work that Section 7

¹ CMS Rural Health Clinic Enrollments file, July 17, 2026 vintage (ten RHC certifications under one CMS associate identifier; six Kentucky, three West Virginia, one Virginia), cross-checked against the CMS Provider of Services file, Q2 2026, which records the network's clinics as independent (freestanding) Rural Health Clinics. Certification dates: 2012, 2016, two in 2019, 2020, 2021, 2022, two in 2023, and 2025. The Mason and Spencer, West Virginia clinics appear in federal registry records as primary-care clinics without RHC certification.

² The organization's published accreditation announcements: one RHC accredited September 2024, one surveyed October 2024, and five more announced January 2025 — seven of ten in total, under the Joint Commission's Rural Health Clinic accreditation program.

³ NPPES practice-location records and PECOS reassignment records, retrieved August 2026, matched to the network's clinic addresses and filtered to adult primary-care clinicians. Registry addresses lag reality; the 19-clinician count is a floor.

⁴ U.S. Census Bureau American Community Survey 2024 five-year estimates, profiles DP02, DP03 and DP05, for the nine RHC counties. Disability among all ages runs from 22.1% (Jackson County, WV) to 37.7% (Buchanan County, VA); poverty from 18.5% to 30.5%.

⁵ CMS Medicare Advantage State/County Penetration file, August 2026, eligible-weighted across the nine RHC counties (66.2%); CMS Medicare Monthly Enrollment, May 2026 (67,382 beneficiaries; 23.4% dual-eligible). The national MA share is roughly 51% of Medicare.

⁶ CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released May 2026), queried per National Provider Identifier across every clinician reassigning Medicare billing to the organization, for all remote monitoring, remote therapeutic monitoring, care-management and transitional-care codes. Query mechanics were validated against a known-positive control, so the nulls are absences rather than query failures.

assigns to CoachCare, inside Epic, where the network's clinicians already work. The state money is moving on the same clock: West Virginia has designated roughly \$14 million of its Rural Health Transformation award for remote patient monitoring, and Kentucky's \$212.9 million plan leads with rural chronic-care hubs. Section 6 covers both.

What the Value Analysis returns

The forecast prices a service line for the Medicare slice of the clinic panels — an estimated 1,500 patients, traditional Medicare plus Medicare Advantage at the local penetration — referred by the 19 clinicians and delivered by CoachCare under the network's clinical direction.⁸

	Year 1	Year 2	24 months
Net reimbursement	\$511,230	\$691,680	\$1,202,911
CoachCare fees	\$297,895	\$390,904	\$688,799
Net to OVP Health	\$213,335	\$300,776	\$514,112
Margin to the network	41.73%	43.48%	42.74%

CoachCare Value Analysis. CY2026 non-facility Physician Fee Schedule, West Virginia locality — a deliberately conservative basis; RHC claims pay national amounts (Section 2.2). ≈1,500 Medicare patients in scope; RPM + CCM + APCM.

- 1. The program funds itself from the second month.** Month 1 nets −\$4,889 to the network, because implementation lands before enrollment revenue does. The first positive month is M2. From M9 the service line runs at \$57,640 in monthly net reimbursement and \$25,065 net to the network.
- 2. Nobody is hired.** CoachCare delivers 8,823 hours of care-management work over 24 months — about 4.24 full-time equivalents — including an on-site enrollment specialist carried at CoachCare's expense. No capital outlay, and no recruiting in counties where clinical recruiting is the standing constraint.
- 3. The Medicare-eligible pool enrolls inside eight months.** APCM reaches its ceiling in M4, CCM in M6, RPM in M8. At M24 the program holds 679 active enrollments across 443 unique patients. The binding constraint is the size of the Medicare slice, not enrollment capacity — chart counts above the estimate, Medicare Advantage growth, and RHC certification of the Spencer and Mason clinics are the three ways the ceiling moves.
- 4. The rate basis is deliberately conservative.** The forecast prices at West Virginia locality rates. RHC claims actually pay national non-facility amounts — 7.4% more on this code basket, worth \$92,546 over 24 months, all of it net to the network and none of it in the headline.
- 5. The clinical return is concrete.** The model projects 45.3 avoided hospitalizations over 24 months — roughly \$680,000 at \$15,000 per admission — from 71,393 device readings worked through one escalation protocol.
- 6. No shared-savings mechanism is required.** The organization participates in no Medicare accountable-care arrangement in PY2026, verified against the live participant files.⁹ The case stands on fee-for-service RHC billing alone.

⁷ 42 CFR 405.2464(c), and the CMS CY2025 Physician Fee Schedule Final Rule fact sheet: Rural Health Clinics report the individual CPT and HCPCS codes for care coordination in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the per-visit all-inclusive rate; advanced primary care management coding was adopted for RHC payment on the same basis.

⁸ CoachCare Value Analysis for OVP Health, 2026. Basis: CY2026 non-facility Physician Fee Schedule at West Virginia locality 11402-16; ≈1,500 Medicare patients in scope; 19 referring clinicians; RPM, CCM and APCM.

⁹ 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 or any clinic address in either file. Known-positive controls were run against both files first.

1. The Network and Its Counties

1.1 Ten Rural Health Clinics across three states

OVP Health has run rural clinical services since 1999. The primary-care arm is ten independent, Medicare-certified Rural Health Clinics in nine counties, built out over thirteen years and accelerating: the first site was certified in 2012, and half the network has been added since the end of 2020, with the newest RHC certified in 2025.¹⁰ Two more primary-care clinics — Mason and Spencer, West Virginia — operate outside the RHC program today. The rest of the company is workforce: emergency-department and hospitalist staffing for seven rural hospital partners, a line of business that has kept the organization fluent in multi-site clinical operations for over two decades.

Site	County	State	Medicare RHC since	Joint Commission RHC accreditation
Millard (Pikeville)	Pike	KY	2012	Accredited — Jan 2025
Ravenswood	Jackson	WV	2016	—
Logan	Logan	WV	2019	Accredited — Oct 2024
Williamson	Mingo	WV	2019	Accredited — Jan 2025
Louisa	Lawrence	KY	2020	Accredited — Jan 2025
Paintsville	Johnson	KY	2021	Accredited — Jan 2025
Inez	Martin	KY	2022	Accredited — Sept 2024
Pikeville (Thacker Rd)	Pike	KY	2023	Accredited — Jan 2025
Grundy	Buchanan	VA	2023	—
Eastern	Floyd	KY	2025	—

CMS Rural Health Clinic enrollment and certification records, July 2026 vintage; accreditation dates from the organization's announcements.

1.2 The operating discipline is already in place

Seven of the ten RHCs earned Joint Commission Rural Health Clinic accreditation in a five-month sweep between September 2024 and January 2025.¹¹ That is not a plaque program. Survey-readiness across ten rural sites requires standard operating procedures, documentation discipline and quality review held to an external audit — the same muscle a care-management program runs on. Most rural networks considering remote care have to build that discipline alongside the program. This one already exercises it.

The clinical roster at the clinic sites is 19 adult primary-care clinicians: 4 physicians and 15 nurse practitioners, anchored across the ten RHCs and the two non-RHC clinics in federal registry records as of August 2026.¹² Section 3.3 takes up why a nurse-practitioner-led roster is the right shape for this service line rather than a limitation.

¹⁰ CMS Rural Health Clinic Enrollments and Provider of Services certification dates (see note 1): four of the ten certifications date from 2012–2019, a fifth from December 2020, and the remaining five from 2021 through May 2025. The two non-RHC clinics appear in NPPES with 2023–2024 enumerations; one carries a rural-health clinic taxonomy with no Medicare RHC certification to date.

¹¹ The organization's accreditation announcements, September 2024 – January 2025 (see note 2). The Joint Commission's Rural Health Clinic program surveys against its published RHC standards; accreditation is voluntary and audit-based.

¹² NPPES and PECOS registry match, August 2026 (see note 3): 4 physicians and 15 nurse practitioners in adult primary-care roles anchored at the clinic sites.

1.3 The counties: chronic disease made visible

The ten clinics sit in nine counties strung along the Kentucky–West Virginia–Virginia coalfields. The burden in these counties shows up as disability, not age: county disability rates run 22–38% of all residents, against a national rate near 13%, and every clinic county's Medicare population carries a high disabled share.¹³ Poverty runs 18–30%. Household broadband subscription runs 76–90% across the service counties — a fact that decides the device strategy in Section 7.3.

County	State	Medicare benes (May 2026)	MA share (Aug 2026)	Disability, all ages	Poverty	Broadband
Pike	KY	15,614	66.7%	29.8%	25.2%	83.2%
Johnson	KY	5,981	65.8%	26.1%	26.3%	89.1%
Lawrence	KY	4,010	63.5%	24.0%	26.9%	83.7%
Martin	KY	2,607	68.6%	32.1%	30.5%	83.6%
Floyd	KY	9,780	68.3%	28.4%	27.4%	84.7%
Logan	WV	8,487	65.5%	29.6%	23.3%	90.4%
Mingo	WV	6,496	69.7%	31.9%	27.5%	86.0%
Jackson	WV	7,618	61.9%	22.1%	18.5%	77.1%
Buchanan	VA	6,789	65.1%	37.7%	25.2%	77.2%
Nine counties		67,382	66.2%			

CMS Medicare Monthly Enrollment, May 2026; CMS MA penetration, August 2026 (eligible-weighted); American Community Survey 2024 five-year estimates. The 66.2% is the eligible-weighted average across the nine RHC counties.

Three design consequences follow. Chronic-disease management here is not a convenience offer; it is the response to a population whose disability rates are roughly double the national norm. Distance does clinical damage — when the round trip to a clinic takes half a day, blood pressure gets checked quarterly instead of daily, and decompensation is discovered in an emergency department. And the broadband numbers rule out any deployment that assumes home WiFi.

1.4 The Medicare market is two-thirds Medicare Advantage

Every one of the nine RHC counties has a majority-MA Medicare population — the range is 61.9% to 69.7%, and the eligible-weighted average is **66.2%** (August 2026), roughly fifteen points above the national share.¹⁴ The nine counties hold 67,382 Medicare beneficiaries (May 2026), 23.4% of them dual-eligible. Total Medicare at the clinics is therefore traditional Medicare plus Medicare Advantage at that local penetration, and the service line is designed for both.

¹³ American Community Survey 2024 five-year estimates (table sources in note 4). The comparison rate: roughly 13% of the U.S. population reports a disability on the same ACS measure.

¹⁴ CMS Medicare Advantage State/County Penetration, August 2026, and CMS Medicare Monthly Enrollment, May 2026 (see note 5). County MA shares range from 61.9% (Jackson, WV) to 69.7% (Mingo, WV).

What 66.2% Medicare Advantage does to the revenue model

Medicare Advantage plans are required to cover Part B services and to pay at least the Medicare rate — that is the floor under two-thirds of this panel. What the floor does not settle is whether each plan pays the care-management code families on the same terms and cadence as traditional Medicare; that is set contract by contract.

The forecast in Section 4 prices the whole panel at the fee schedule. The corresponding operational move is early: confirm RPM, CCM and APCM payment terms with the dominant local MA plans during discovery, contract by contract (Recommendation 3).

1.5 The gap: no between-visit infrastructure

A control-validated sweep of CY2024 Medicare fee-for-service claims across every clinician who reassigns billing to the organization returns zero lines on every remote-monitoring code, and no chronic-care-management volume attributable to the organization's own billing.¹⁵ CMS suppresses any provider-and-code line under 11 beneficiaries, and bundled care-management volume billed institutionally under an RHC certification is not publicly reported — so the precise finding is that there is **no billed remote-care program at meaningful scale, and no observable care-management operation**.

Everything else agrees with the claims data. The organization's hiring carries no care-manager, chronic-care, population-health or monitoring roles (August 2026). Telemedicine at the clinics is a virtual-visit platform — synchronous video encounters, not device-based monitoring.¹⁶ The clinics' own service pages already treat long-term condition management as part of the offer; what is missing is the staffing, device and billing construct underneath it. That is the whole gap, and it is a buildable one: monitoring replaces windshield time, for patients and for the clinics.

¹⁵ CY2024 Medicare Physician & Other Practitioners sweep (see note 6). Codes swept: 99453, 99454, 99457, 99458, 99091, 98975–98978, 98980, 98981, 99445, 99470; 99424–99427; 99490, 99439, 99487, 99489; G0556–G0558; G0511; 99495, 99496. The small chronic-care-management volume that does appear in the file attributes to other billing organizations, not to this one.

¹⁶ The organization's public careers board and telemedicine service page, retrieved August 2026. Thirteen open postings; none for care-management, chronic-care, population-health or monitoring roles. The telemedicine page describes virtual visits conducted through a remote-exam platform.

2. The CY2026 Billing Change for Rural Health Clinics

2.1 G0511 is gone; the individual codes pay on top of the visit rate

Rural Health Clinics are paid an all-inclusive rate per qualifying visit. For years, everything a clinic did for chronic patients between those visits was compressed into one bundled monthly code, G0511 — one flat payment regardless of how many services, minutes or programs a patient carried. That code has been retired. From January 2026, RHCs report the individual CPT and HCPCS codes — the CCM, RPM and APCM families among them — and Medicare pays each at the **national non-facility Physician Fee Schedule amount, in addition to the all-inclusive rate** (42 CFR 405.2464(c)).¹⁷

CY2026 also added two codes that matter for a rural deployment: 99445 pays the device-supply month at the full rate when a patient transmits 2–15 days of readings rather than 16 or more, and 99470 pays the first 10 minutes of monthly management time where 20 minutes is not reached. Months that used to go unbilled now bill at reduced-threshold codes.

The structural consequence is the point: between-visit care stops being a flat bundled payment and becomes a per-service revenue line that scales with enrollment and delivered work — which is what makes a staffed, managed program worth running.

2.2 What the codes pay here

The Value Analysis prices every code at the CY2026 non-facility Physician Fee Schedule for the West Virginia locality — the modeled rates below.¹⁸

Code	What it pays for	Cadence	Modeled CY2026 rate
99453	RPM setup and patient education	One-time	\$19.24
99454	Device supply, 16–30 days of readings	Monthly	\$45.47
99445	Device supply, 2–15 days of readings (new 2026)	Monthly	\$45.47
99457	RPM management, first 20 minutes	Monthly	\$48.41
99470	RPM management, first 10 minutes (new 2026)	Monthly	\$24.37
99458	RPM management, each additional 20 minutes	Monthly	\$39.41
99490	CCM, first 20 minutes of clinical staff time	Monthly	\$63.16
99439	CCM, each additional 20 minutes	Monthly	\$47.83
G0556	APCM, level 1 — one chronic condition	Monthly	\$15.69
G0557	APCM, level 2 — two or more chronic conditions	Monthly	\$51.04
G0558	APCM, level 3 — Qualified Medicare Beneficiary	Monthly	\$111.44

CY2026 non-facility Physician Fee Schedule, West Virginia locality 11402-16 — the Value Analysis basis.

¹⁷ 42 CFR 405.2464(c) and the CY2025 PFS Final Rule fact sheet (see note 7). CMS allowed a transition period for billing-system updates; individual-code reporting is the standing requirement for 2026 dates of service.

¹⁸ CY2026 Physician Fee Schedule non-facility amounts, West Virginia locality 11402-16 (Palmetto GBA jurisdiction). These are the rates priced into the Value Analysis.

The national rail runs in the network's favor

On RHC claims these codes pay national non-facility amounts — and every fee-schedule locality in this footprint prices below national. The modeled West Virginia basket sits 7.4% under the national basket (the RPM family 10.3% under, CCM 5.0%, APCM 5.2%), and the Kentucky locality 7.6% under.¹⁹

Re-priced at the national amounts, the same forecast adds \$92,546 over 24 months, every dollar of it net to the network: \$514,112 becomes \$606,658, and the margin moves from 42.74% to 46.83%. The forecast keeps the conservative locality basis; the national rail is quantified upside.

These are traditional-Medicare amounts. Medicare Advantage — 66.2% of the counties' Medicare — owes at least the Medicare rate; whether each MA contract pays these code families on the same terms is a contract question, settled in discovery rather than on a rate schedule.

2.3 The work the change creates, and who carries it

Individual-code billing pays more and asks more. Each code carries its own eligibility test, consent, time capture and documentation standard, and the claim volume is real: this forecast generates 20,464 claims over 24 months. An RHC billing office absorbing that by hand would resent every one of them. In the operating model of Section 7, CoachCare carries the load — enrollment, device logistics, monitoring documentation and automated claim generation inside Epic — and the clinics keep the clinical decisions.

One structural note on Medicaid, because the deal design has to respect it. West Virginia Medicaid does not pay for RPM or CCM — of the care-management families, only transitional care management is covered. Kentucky Medicaid lists RPM and CCM on its RHC wrap-pay schedule, which places them inside the encounter architecture rather than paying new fee-for-service dollars. Virginia Medicaid covers RPM through its telehealth program, and its interaction with RHC payment is unconfirmed.²⁰ The service line in this report is therefore built on the Medicare slice, where the individual-code rail is explicit.

¹⁹ CY2026 national non-facility amounts measured against the modeled locality basket, revenue-weighted on this forecast's code mix: +7.4% overall; RPM family +10.3%, CCM +5.0%, APCM +5.2%. The Kentucky locality (15102-00) prices 7.6% below national on the same basket, so the West Virginia basis is representative of the footprint.

²⁰ West Virginia Medicaid RBRVS fee schedule effective April 1, 2026 – March 31, 2027 (remote monitoring and chronic-care-management codes carry not-covered status; transitional care management is covered); Kentucky Department for Medicaid Services wrap-pay and zero-pay procedure-code workbook, January 2025 (RPM and CCM on the RHC wrap-pay sheet — payable inside the encounter architecture); Virginia DMAS telehealth bulletins covering remote patient monitoring, with the RHC payment interaction not yet specified in a published transmittal.

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

3.1 The clinical and billing stack

Three programs, one infrastructure. Remote physiologic monitoring supplies the daily signal; chronic care management and advanced primary care management supply the monthly coordination wrapper. Enrollment, devices, monitoring, escalation, documentation and claims run on the same CoachCare engine for all three.

Program	Who qualifies	What it is	Billing
RPM	975 of the ≈1,500 Medicare patients (est.) — hypertension, diabetes, heart failure, COPD	Cellular-connected devices (blood-pressure cuff, glucose meter, scale, pulse oximeter); readings monitored against clinical thresholds; monthly management time	99453 setup; 99454/99445 supply; 99457/99470/99458 management
CCM	600 — two or more chronic conditions expected to last twelve months or more	Monthly non-face-to-face coordination: comprehensive care plan, medication reconciliation, referrals, outreach	99490 + 99439
APCM	525 — ongoing primary-care relationship; level set by condition count and Qualified Medicare Beneficiary status	Monthly bundle of thirteen practice-capability elements; no minute tracking	G0556 / G0557 / G0558

Eligible-pool counts from the Value Analysis eligibility model; pools overlap, billing does not (see the coordination rule below).

One coordination rule, set at enrollment

APCM and CCM never bill for the same patient in the same month — a patient carries one care-management wrapper, not two. RPM stacks with either. The enrollment workflow assigns each patient a wrapper (CCM or APCM) plus RPM where clinically indicated, so the code families never collide on a claim.

The service line pays the network four ways. First, additive professional-fee revenue: every care-management dollar lands on top of the all-inclusive rate, not inside it. Second, it is the answer to geography — a daily blood-pressure reading from a kitchen table in Martin County reaches a nurse the same morning, without anyone driving. Third, fewer unmonitored decompensations keeps chronic patients out of the emergency departments of the seven rural hospitals the company staffs. Fourth, the staffing model is recruiting-proof: CoachCare's clinical staff deliver the monitoring layer, so the program's growth does not depend on hiring nurses in the coalfields.

3.2 The Medicare slice it runs on

The forecast is built on an estimated **1,500 Medicare patients** across the 19 clinicians — traditional Medicare plus Medicare Advantage at the local ~66% penetration. It is a discovery-stage estimate, triangulated from the network's FY2024 Medicare cost-report utilization and August 2026 county Medicare data, and the first implementation step validates it against actual chart counts.²¹ From that panel, the eligibility model carves the program pools: 975 patients RPM-eligible (65%), 600 CCM-eligible (40%), 525 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.

²¹ CoachCare Value Analysis eligibility model. The panel estimate triangulates the network's FY2024 Medicare cost-report utilization with August 2026 county Medicare Advantage penetration; program eligibility shares: RPM 65%, CCM 40%, APCM 35% of the in-scope panel.

3.3 Built the way the codes work: nurse-practitioner-led care

Fifteen of the nineteen clinicians at the clinic sites are nurse practitioners. For this service line that is the right shape, not a gap to apologize for. CCM, APCM and RPM are general-supervision code families: qualified clinical staff deliver the monthly work under a billing clinician's overall direction, without that clinician in the room. A nurse-practitioner-led network with a small physician layer is the configuration these codes were designed to pay. The referral motion is one step — a clinician flags a qualifying patient in Epic — and the program runs from there.

3.4 Staffing: nobody is hired

CoachCare delivers 8,823 hours of care-management work across the 24 months — about **4.24 full-time equivalents** — without the network hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. In counties where every growth plan eventually stalls on clinical recruiting, the service line adds the working capacity of four hires and zero requisitions.

That division of labor is the design, not a side effect. CoachCare's staff carry the recurring work — monitoring review, patient outreach, documentation, escalation handling — while the network's clinicians contribute the two things only they can: the referral flag that starts each enrollment, and clinical judgment at the escalation points. Section 4 prices what that arrangement produces.

4. Value Analysis: The 24-Month Forecast

4.1 Headline economics

Over 24 months the service line produces **\$1,202,911 in net reimbursement** to OVP Health. CoachCare's fees total \$688,799. Net to the network is **\$514,112 — a 42.74% margin** on the program (41.73% in Year 1, 43.48% in Year 2).²²

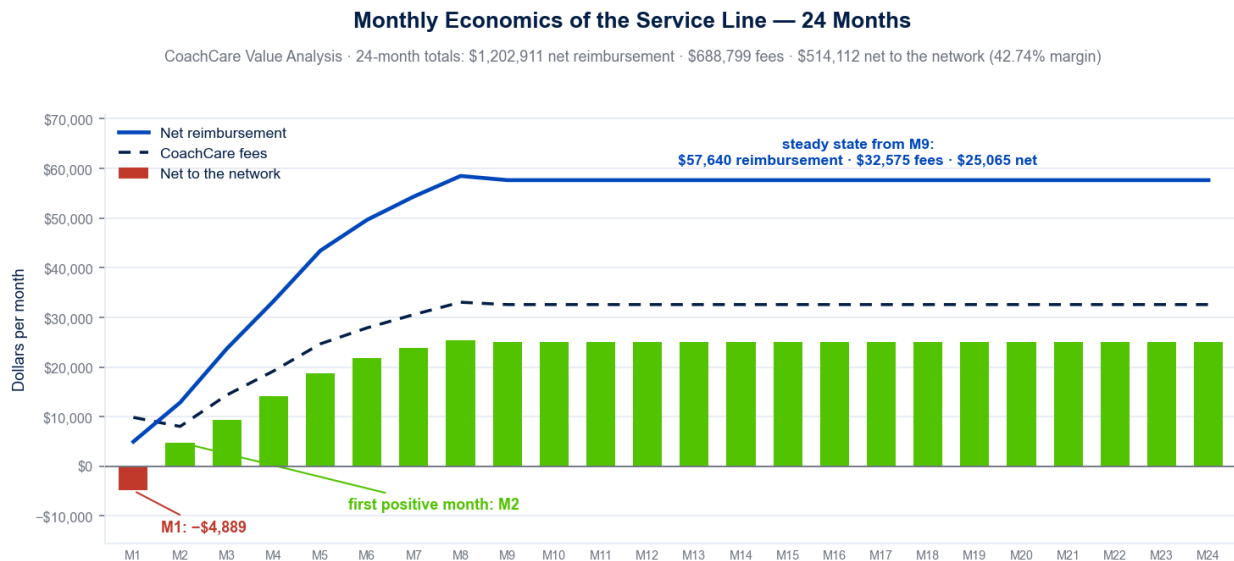


Figure 1. Monthly net reimbursement, CoachCare fees and net to the network across the 24-month forecast. Month 1 nets – \$4,889; the first positive month is M2; steady state from M9 is \$25,065 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative — $-\$4,889$ — because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at \$4,816, and the line compounds as the three programs fill: by M8, the peak enrollment-plus-setup month, net reimbursement reaches \$58,480, settling at \$57,640 a month from M9 onward once setup codes fall away and the census holds at ceiling.

4.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement
RPM	\$245,562	\$362,763
CCM	\$176,554	\$227,701
APCM	\$89,114	\$101,216
All programs	\$511,230	\$691,680

CoachCare Value Analysis, per-program net reimbursement by contract year.

Across the full 24 months, RPM contributes \$608,325 of net reimbursement, CCM \$404,256 and APCM \$190,330. RPM is the volume engine — 6,799 patient-months. CCM is the yield engine at \$105.42 of net reimbursement per patient-month, against \$89.47 for RPM and \$53.55 for APCM. APCM earns its place a different way: no minute-tracking, a bundled monthly payment, and the level-3 tier for Qualified Medicare

²² CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-network series; Year 1 margin 41.73%, Year 2 margin 43.48%, 24-month margin 42.74%.

Beneficiaries — a quarter of these counties' Medicare population is dual-eligible — pays \$111.44 a month.

Service-Line Composition — RPM \$608,325 · CCM \$404,256 · APCM \$190,330

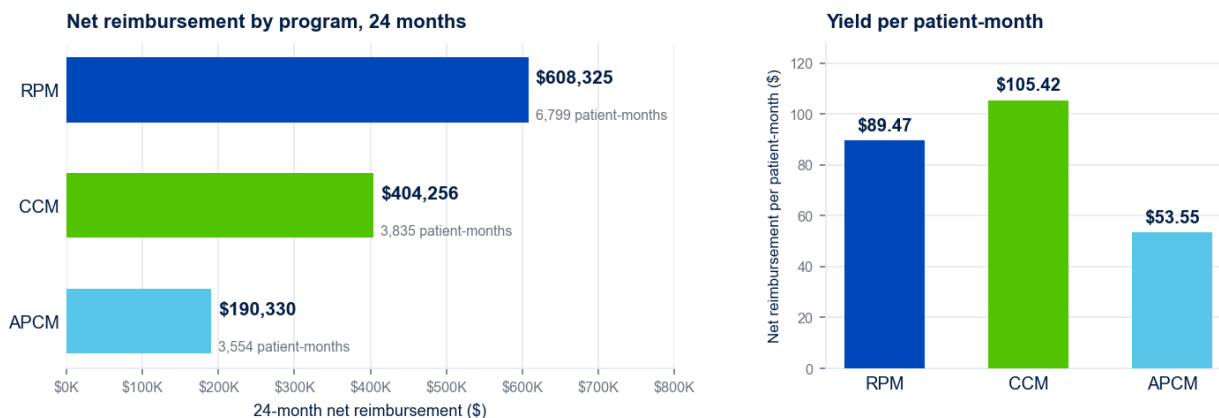


Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

4.3 The ramp: every ceiling reached by month eight

This account is ceiling-limited in all three programs — the honest version of a constraint most forecasts bury. APCM saturates in month 4 at 157.5 modeled enrollments, CCM in month 6 at 180, RPM in month 8 at 341.25. The entire Medicare-eligible pool is enrolled inside eight months, and from M9 the model is flat because there is no one left to add.²³

The 24-Month Enrollment Ramp — Every Program Reaches Its Ceiling by Month 8

CoachCare Value Analysis · ≈1,500 Medicare patients in scope · at M24: 679 active enrollments across 443 unique patients

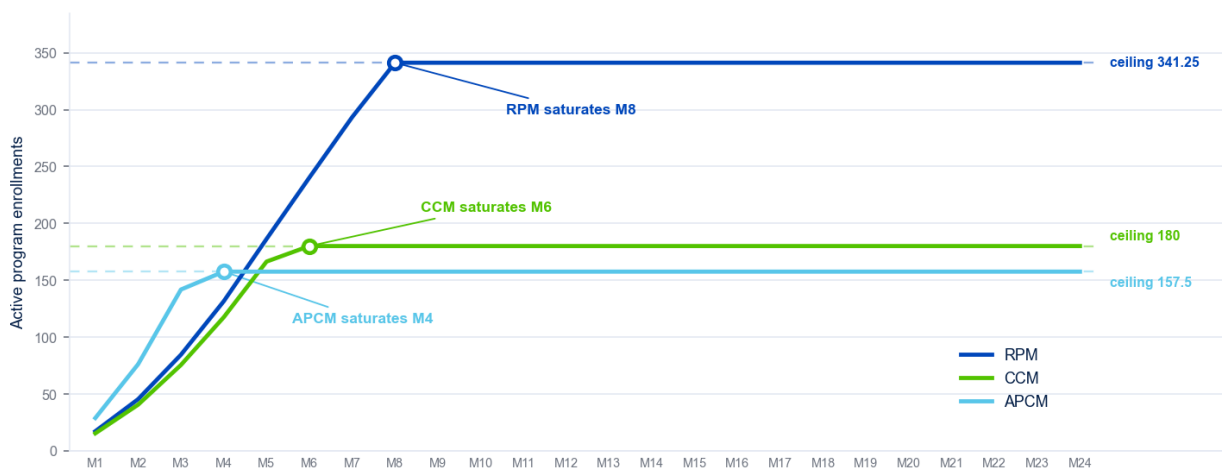


Figure 3. Enrollment census by program with modeled ceilings. All three programs reach ceiling by month 8; at M24 the program holds 679 active enrollments across 443 unique patients.

Program	Eligible pool	Modeled ceiling	Ceiling reached	Active enrollments at M24
RPM	975	341.25	Month 8	341
CCM	600	180	Month 6	180

²³ CoachCare Value Analysis enrollment model: program ceilings 341.25 (RPM), 180 (CCM), 157.5 (APCM); saturation months 8, 6 and 4; 679 active enrollments across 443 unique patients at month 24.

Program	Eligible pool	Modeled ceiling	Ceiling reached	Active enrollments at M24
APCM	525	157.5	Month 4	158

Enrollment counts are program enrollments, not unique patients; the 679 enrollments at M24 belong to 443 unique patients.

Say the constraint out loud: what binds this program is the size of the Medicare slice, not enrollment capacity. That cuts two ways. It caps the forecast — and it de-risks it, because the model asks the clinics to produce no heroic enrollment performance, only a panel that exists. Three things move the ceiling upward: chart counts above the deliberately conservative 1,500-patient estimate, Medicare Advantage growth across counties already trending that way, and RHC certification of the Spencer and Mason clinics, each of which would add its county's Medicare slice to a program already at ceiling.

4.4 What the program produces

24-month output	Volume
Claims generated and submitted	20,464
Device readings monitored	71,393
Care-management tasks completed	40,928
Chart updates written to Epic	10,232
Patient conversations held	6,139
Care-management hours delivered	8,823 (≈4.24 FTE)
Hospitalizations avoided (modeled)	45.3 — ≈\$680,000 at \$15,000 per admission

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 45.3 modeled avoided hospitalizations is roughly \$680,000 of cost that never lands on anyone — not on Medicare, not on the MA plans whose contracts the network wants to grow into, and not on the emergency departments its hospital partners run.²⁴

²⁴ CoachCare Value Analysis clinical-outcomes module: 45.3 modeled avoided hospitalizations over 24 months, valued at \$15,000 per avoided admission (≈\$680,000).

5. Clinical Governance and Escalation

A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the network inherits on day one: CoachCare's Care Management Programs standard operating procedures, March 2026 edition, rendered as seven process maps covering qualification, monitoring, escalation and discharge.²⁵

5.1 One shared escalation engine

Every program — RPM and the care-management wrappers alike — routes through one alert-and-escalation decision logic. A critical value escalates immediately, regardless of symptoms. An out-of-range reading that is not critical gets worked before it escalates: the patient retakes the reading and answers a symptom check, so the clinics hear clinical signal rather than cuff artifacts. Trend rules are explicit — three consecutive out-of-range blood-pressure or glucose readings at least an hour apart, or three abnormal heart-rate readings inside seven days, count as a trend and draw clinical review even when no single reading is critical.

5.2 The emergent pathway

An active emergent symptom reported during any outreach contact triggers the 911 pathway. That policy supersedes any client-specific escalation preference: whichever clinic the patient belongs to, the emergent floor does not move.

5.3 Qualification, device assignment and routing

Enrollment starts with the panel, not the device inventory. The population is screened by ICD-10 code and routed to the right program and device, and device assignment follows a fixed, ordered hierarchy in which the highest-priority qualifying diagnosis wins — a patient with heart failure and diabetes gets the device their highest-acuity condition needs. Once monitoring runs, escalations route three ways: emergencies to the emergent pathway, non-critical clinical items to the clinic for direction, and informational items documented to the chart.

5.4 The post-discharge cadence

An emergency-department visit or hospitalization reported within the last 60 days triggers a fixed three-touch follow-up sequence designed to prevent readmission. Each touch is documented, and any clinical alert surfaced during a touch escalates under the same shared logic — the post-discharge window gets more contact, not a different rulebook.

5.5 Discharge governance and continuity

Discharge is governed, not ad hoc. Discharge criteria and unreachable-patient timelines are defined per program, and the clinic is notified in every case. For monitoring patients the sequence is explicit: a recommended discharge first escalates to the clinic for instructions, re-escalates every 30 days, and if the clinic has given no instruction by 180 days the discharge proceeds. Processed discharges post in the first week of the following month. Nobody quietly falls out of the program, and nobody quietly stays in it either.

²⁵ CoachCare Care Management Programs standard operating procedures, March 2026 edition, and the seven derived process maps: qualification and device assignment; the RPM patient lifecycle; the care-management lifecycle; alert-and-escalation decision logic; the emergent/urgent communication protocol; the post-discharge follow-up sequence; and the discharge decision flow.

6. State Momentum: Rural Health Transformation Funding

All fifty states received first-year awards under the federal Rural Health Transformation Program on December 29, 2025. Two of the three states in this footprint are pointing the money directly at chronic-disease monitoring.

West Virginia received \$199.5 million for the first year and has designated roughly **\$14 million of it for remote patient monitoring** under its Connected Care Grid initiative — about \$4.9 million inpatient and \$9.1 million outpatient — funding connected devices such as blood-pressure cuffs and glucose monitors and chronic-disease management support, with applications running through the state's wvOASIS portal.²⁶ OVP Health has three RHCs, two additional clinics and its headquarters in West Virginia.

Kentucky received \$212.9 million, and its plan leads with rural community hubs for chronic-care innovation — hub-and-spoke collaboratives for obesity and diabetes built around digital self-management. State guidance points to Rural Health Clinics among eligible recipients — confirm in the application cycle.²⁷ Six of the ten RHCs are in Kentucky, the network's largest state block.

Two readings follow. The grant money is infrastructure funding, not a payer change — it can buy devices and build monitoring capacity, and it does not alter the Medicare billing rail this report is built on. And timing compounds: an applicant already operating a monitoring program makes a stronger case than one proposing to start one. Launching on the Medicare slice now positions the network as the operator these state programs are looking to fund.

²⁶ CMS award announcement, December 29, 2025 (Rural Health Transformation Program, all fifty states); the West Virginia governor's announcement of the \$14 million remote-monitoring investment (~\$4.9M inpatient, ~\$9.1M outpatient) under the Connected Care Grid initiative; and the West Virginia RHTP program FAQ (applications through the wvOASIS portal).

²⁷ Kentucky's published Rural Health Transformation plan (ruralhealthplan.ky.gov), whose first flagship initiative is rural community hubs for chronic-care innovation; advisory summaries of the program name Rural Health Clinics among eligible recipients — eligibility to be confirmed directly in the application cycle.

7. Implementation and the First 90 Days

7.1 Who runs what

CoachCare delivers	OVP Health keeps
Telephonic and on-site enrollment — the enrollment specialist is CoachCare's expense	Referral flags in Epic; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences per clinic
Monitoring, documentation and the escalation protocol of Section 5	Responses to clinic-routed escalations
Automated claim generation inside Epic	Billing review and the revenue
Monthly operating reports against the dashboard in 7.5	Program governance

CoachCare runs remote care programs for more than 500,000 patients across 400+ managed conditions, with 10,000+ providers on the platform, 1,000+ implementations completed, more than five million claims generated, and over 100 million vitals recorded.

7.2 Epic integration: the program lives in the record

The network runs Epic. CoachCare's Epic integration is direct and bi-directional, and the program operates inside the record rather than beside it.²⁸

- **Integrated enrollment.** Qualifying patients are flagged and orders triggered inside the clinical workflow; CoachCare enrolls flagged Medicare patients on the network's behalf, with enrollment status visible in Epic in real time.
- **Health-history exchange.** Bi-directional at intake — the program starts from the chart, not a blank form.
- **Discrete vitals.** Device readings land in the chart as discrete vitals, not attached PDFs.
- **Compliance documentation.** Audit-ready care summaries and time documentation written to the record.
- **Automated claim generation.** The CoachCare billing engine assembles the monthly claims — the step that makes individual-code billing workable at 20,464 claims over 24 months.

Patients begin receiving CCM and RPM services within five days of the enrollment flag. CoachCare's is the only care-management application integrated with Epic that generates claims automatically, which removes the manual per-patient, per-month claim step entirely.

7.3 Devices and patient materials

Devices ship cellular-connected. Household broadband subscription runs 76–90% across the service counties, which rules out a WiFi- or smartphone-dependent deployment for a meaningful share of the panel. A cellular cuff transmits the moment it is used — nothing to pair, no app, no password. Patient-facing materials are written at a low reading level, and enrollment happens by phone and in the clinic, not through a portal.

²⁸ The record system was confirmed as Epic by OVP Health directly, August 2026. Integration detail from the CoachCare Epic integration overview: integrated enrollment with real-time status, bi-directional health-history exchange, device readings as discrete vitals, compliance documentation, and automated claim generation; first CCM and RPM services within five days of the enrollment flag.

7.4 Model inputs

Input	Value
Medicare panel in scope	≈1,500 patients — discovery-stage estimate; validate against chart counts
Referring clinicians	19 (4 physicians + 15 nurse practitioners)
Programs	RPM + CCM + APCM
Program-eligible pools	RPM 975 · CCM 600 · APCM 525
Modeled enrollment ceilings	RPM 341.25 · CCM 180 · APCM 157.5
Rate basis	CY2026 non-facility Physician Fee Schedule, West Virginia locality 11402-16 — conservative; RHC claims pay national amounts (+7.4% on the basket)
Medicare Advantage	66.2% of the nine counties' Medicare (August 2026). Plans owe at least the Medicare rate — a floor; care-management payment terms confirmed contract by contract in discovery
EMR	Epic — CoachCare direct, bi-directional integration

7.5 The 90-day plan and the operating dashboard

Days 0–30 — foundation. Program agreement and the Epic integration workplan. Panel validation against chart counts — the input that moves the model most. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing localized per clinic, and clinician orientation to the general-supervision workflow.

Days 31–60 — enrollment live. Telephonic and on-site enrollment running; first devices in homes; first billable service months. Month 1 nets –\$4,889 as implementation lands; month 2 turns positive. APCM is on pace to reach its ceiling around month 4.

Days 61–90 — scale and file. Enrollment tracking toward the CCM ceiling (month 6) and RPM's (month 8). First monthly operating report against the dashboard. Decision point on the West Virginia remote-monitoring application through wvOASIS while the funding window is open.

The operating dashboard from month one:

- Enrollment census by program against ceiling (341.25 / 180 / 157.5)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2–15-day months
- Escalations by pathway: emergent, clinic-routed, documented
- Claims submitted against expected claims
- Net to the network per month against the \$25,065 steady-state line

8. Recommendations

1. **Stand up the service line on the Medicare slice now.** The individual-code rail has been live since January. The ramp is the ramp wherever it starts — each month of delay pushes the full \$514,112 of 24-month net one month further out.
2. **Validate the panel against chart counts in the first 30 days.** The ≈1,500-patient estimate is deliberately conservative and drives every ceiling in the forecast. The chart count is the single input that moves the model most, in either direction.
3. **Take the Medicare Advantage question to the plans early.** With 66.2% of the counties' Medicare in MA, parity is the floor: plans owe at least the Medicare rate, and care-management payment terms vary by contract. Confirm RPM, CCM and APCM terms with the dominant local plans in the first two weeks of discovery.
4. **Bill the RHC rail at national rates from day one.** The forecast prices at West Virginia locality rates; RHC claims pay national non-facility amounts — worth \$92,546 more over 24 months, all of it net to the network. Configure claims on the RHC rail and capture it.
5. **File for the state money on the program's timeline.** West Virginia's remote-monitoring allocation is open through wvOASIS now; Kentucky's chronic-care-hub initiative follows, with state guidance pointing to RHCs among eligible recipients — confirm in the application cycle. Apply as an operator, not an aspirant.
6. **Certify Spencer and Mason as Rural Health Clinics.** Each certification adds its county's Medicare slice to a program that will already be at ceiling — the cleanest organic growth available to this service line.
7. **Set the attribution rule at enrollment.** Each patient carries one care-management wrapper — CCM or APCM, never both in a month — plus RPM where indicated. One rule, set once in the enrollment workflow, prevents every double-billing collision the code families allow.

References and Data Sources

- **CMS Rural Health Clinic enrollment and certification records** (RHC Enrollments file, July 17, 2026 vintage; Provider of Services file, Q2 2026): the ten RHC certifications under one CMS associate identifier, their independent (freestanding) status, certification dates, counties and states; and the Mason and Spencer clinic records showing no RHC certification to date.
- **The organization's published announcements and site records** (retrieved August 2026): Joint Commission Rural Health Clinic accreditation of seven sites, September 2024 through January 2025; the locations page; the telemedicine service description; and the hospital-partner staffing line.
- **Federal clinician registries** (NPES and PECOS reassignment records, retrieved August 2026): the 19 adult primary-care clinicians — 4 physicians and 15 nurse practitioners — anchored at the clinic sites. Registry practice addresses lag reality, so the count is a floor.
- **CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024** (released May 2026): the control-validated sweep of every remote-monitoring, care-management and transitional-care code across every clinician reassigning billing to the organization. CMS suppresses any provider-and-code line under 11 beneficiaries; bundled institutional volume under RHC certifications is not publicly reported.
- **42 CFR 405.2464(c) and the CY2025 Physician Fee Schedule Final Rule** fact sheet: retirement of G0511; individual-code reporting for RHC care management; payment at national non-facility amounts in addition to the all-inclusive rate; APCM adopted for RHC payment; and the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files**: non-facility amounts for the eleven modeled codes at West Virginia locality 11402-16, and the national-rate comparison producing the +7.4% basket differential (+10.3% RPM family, +5.0% CCM, +5.2% APCM; the Kentucky locality sits 7.6% below national).
- **CMS Medicare Advantage State/County Penetration, August 2026, and CMS Medicare Monthly Enrollment, May 2026**: county MA shares, the 66.2% eligible-weighted footprint average, 67,382 Medicare beneficiaries and the 23.4% dual-eligible share across the nine RHC counties.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates** (profiles DP02, DP03, DP05): county disability, poverty and household broadband figures.
- **CMS Medicare Shared Savings Program PY2026 participant file and the ACO REACH PY2026 participant list**: zero matches on the organization's name or any site address in either file; known-positive controls run first to prove the queries functioned.
- **Rural Health Transformation Program records**: the CMS fifty-state award announcement of December 29, 2025; West Virginia's Connected Care Grid remote-monitoring designation and program FAQ (applications via wvOASIS); Kentucky's published plan and advisory summaries naming Rural Health Clinics among eligible recipients, to be confirmed in the application cycle.
- **State Medicaid authority**: the West Virginia Medicaid RBRVS fee schedule effective April 1, 2026 (remote monitoring and chronic-care codes not covered; transitional care management covered); the Kentucky Department for Medicaid Services wrap-pay and zero-pay procedure-code workbook, January 2025 (RPM and CCM on the RHC wrap-pay sheet); and Virginia DMAS telehealth bulletins covering remote patient monitoring.
- **CoachCare Care Management Programs standard operating procedures, March 2026**, and the seven process maps derived from them: the shared alert-and-escalation decision logic, trend definitions, the emergent communication protocol, three-way routing, the post-discharge three-touch sequence and the discharge decision flow reproduced in Section 5.

- **The record system, confirmed by OVP Health as Epic** (August 2026), and the CoachCare Epic integration overview: the five integration pillars, the under-five-day interval from enrollment flag to first service, and automated claim creation through the CoachCare billing engine.
- **CoachCare Value Analysis for OVP Health, 2026:** every financial, enrollment, clinical-output and operational figure in Sections 3, 4 and 7, built on ≈1,500 Medicare patients in scope, 19 referring clinicians, one on-site enrollment specialist, and CY2026 non-facility fee schedule rates at West Virginia locality 11402-16 for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 679 active program enrollments belonging to 443 unique patients, because a patient may carry 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.

The panel figure is an estimate, on purpose. RHC visits bill institutionally under each clinic's certification rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount an RHC panel. The ≈1,500-patient figure triangulates the network's FY2024 Medicare cost-report utilization with August 2026 county Medicare Advantage penetration, and the first implementation step is to replace it with actual chart counts.

No individual is named anywhere in this report. Ownership, leadership and clinician composition are described by count and role only.