COACHCARE | SERVICE LINE STRATEGY

Williamson Health & Wellness Center

A HRSA-funded Federally Qualified Health Center in Williamson, West Virginia, serving Mingo County and the Tug Fork valley from fifteen sites, with a CMS-certified acute-care hospital in the same organization

Remote Care Service Line Performance & Optimization

2026 Strategy Report

A chronic-disease service line for the health center's 2,965 Medicare patients: remote physiologic monitoring, chronic care management and advanced primary care management, billed under the CY2026 rules that pay a health center for those codes individually, on top of the PPS encounter, and built on the care-management model the health center published years before Medicare paid for it

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the leadership of Williamson Health & Wellness Center. It brings together the health center's own HRSA record, the Medicare structure of Mingo County, the CY2026 billing rules for health centers, a 24-month Value Analysis for a remote care service line on the Medicare panel, the clinical governance that would run it, the Azalea Health integration it lives in, the fit with the health center's ACO, and the state funding now moving in West Virginia.

The argument is short. The health center built the human layer of chronic care management years before Medicare paid for it. Since January, a health center bills that month of care as its own codes, at national rates, on top of every visit. The state is now funding the devices. And every one of these patients is already in a two-sided ACO, where fewer admissions pay twice.

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Executive Summary

Williamson Health & Wellness Center is a HRSA Section 330 Federally Qualified Health Center in Williamson, West Virginia, the county seat of Mingo County, serving southern West Virginia and the Tug Fork valley of eastern Kentucky from fifteen HRSA-listed sites: adult medicine, pediatrics, dental, behavioral medicine, a substance-use clinic, vision, an in-house pharmacy, four school-based health centers, a mobile medical unit, and a clinic inside the hospital the organization operates.[1] Its 2025 Uniform Data System report counts 10,819 patients, of whom 2,965 are on Medicare, a 27% share that is roughly double the health-center norm; 2,591 are aged 65 or older; 538 are dually eligible; 3,371 carry a hypertension diagnosis and 1,348 a diabetes diagnosis.[2] It holds a HRSA Patient Centered Medical Home badge and two 2026 National Quality Leader badges, in diabetes health and in behavioral health, and it keeps blood pressure controlled in 71.8% of its hypertensive patients.

That is an unusual record for a health center in one of the poorest counties in Appalachia, and it is not the whole of it. From 2012 to at least 2019 the health center ran community-health-worker-led chronic care management under a CMS Health Care Innovation Award, a HRSA care-coordination grant and foundation funding. It published the results in a peer-reviewed journal: among patients followed for six to twelve months, average A1c fell 2.4 points.[3] What the record does not yet show is a Medicare revenue line for that month of work. Across every clinician billing under the health center, CY2024 Medicare fee-for-service claims show **no remote monitoring, chronic care management or advanced primary care management program at meaningful scale**; CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on a health-center claim is not visible in that file either, so that is the precise claim.[4] The careers page lists no care-manager or remote-monitoring role. Whether the community-health-worker team still operates is the first thing to confirm together.

Mingo County's Medicare population is **69.5% Medicare Advantage** (September 2026), and 27% of its beneficiaries are dual-eligible.[5] That mix shapes the revenue math in one specific way. Medicare Advantage plans must reimburse at no less than the Medicare rate, 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.

[1] HRSA Health Center Program: awardee H80CS26637 (Section 330 grantee, not a look-alike). HRSA Health Center Service Delivery and Look-Alike Sites file, pulled September 22, 2026: fifteen active records for the awardee, including one with setting 'Hospital' at 859 Alderson Street inside Williamson Memorial, one mobile van and four school-based sites.

[2] HRSA Uniform Data System, awardee H80CS26637, reporting year 2025: total patients 10,819; Medicare 2,965 (27.41%); aged 65 and over 2,591 (23.95%); dually eligible 538; Medicaid/CHIP 3,799 (35.11%); hypertension 3,371 (51.67% of medical patients); diabetes 1,348 (22.96%); controlling high blood pressure 71.79%.

[3] Preventing Chronic Disease, 2020, volume 17, evaluation of the health center's community-health-worker-based chronic care management model (data May 2017 to September 2019): 729 enrolled; among 446 with six to twelve months of follow-up, mean HbA1c fell 2.4 percentage points and 63% lowered their A1c. Earlier phases: CMS Health Care Innovation Award (2012–2015) and HRSA rural care-coordination network grant (2015–2018). Cited by journal and program, not by author.

[4] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024 (released May 2026), queried per National Provider Identifier across every clinician resolving to the health center's billing organization for codes 99453, 99454, 99457, 99458, 99445, 99470, 99091, 99490, 99439, 99491, 99487, 99489, G0556–G0558, G0511, 99495, 99496, 99484 and G0323. No lines returned. FQHC visits and care management billed on the FQHC claim do not appear in this professional-claims file.

[5] CMS Medicare Advantage State/County Penetration, September 2026: Mingo County, 6,486 eligibles, 4,510 enrolled in Medicare Advantage (69.53%). CMS Medicare Monthly Enrollment, CY2024: 6,571 beneficiaries, 1,797 dual-eligible (27.3%; 1,144 full).

The observation this report is built on

The health center built the human layer of chronic care management years before Medicare paid for it. Since January, a health center bills that month of care as its own codes, at national rates, on top of every visit. The state is now funding the devices. And every one of these patients is already in a two-sided ACO, where fewer admissions pay twice.

G0511, the bundled code health centers used for care management, has been retired. For 2026 dates of service a Federally Qualified Health Center bills chronic care management, remote physiologic monitoring and advanced primary care management as individual codes at national non-facility Physician Fee Schedule amounts, in addition to the PPS encounter.[6] The new short-window RPM codes (99445, 99470) fit post-discharge monitoring exactly. On July 30, 2026, West Virginia opened about $9.1 million of outpatient remote-monitoring funding under its Rural Health Transformation Program for connected blood-pressure cuffs and glucose monitors, aimed at diabetes, hypertension and obesity.[7] And every clinician on the health center's Medicare roster is a Qualifying APM Participant for 2026 in the health center's two-sided Medicare Shared Savings Program ACO on the ENHANCED track.[8]

What the Value Analysis returns

The forecast prices a service line for the health center's own Medicare panel, 2,965 patients as reported to HRSA for 2025, traditional Medicare and Medicare Advantage together, referred by the fourteen physicians, nurse practitioners and physician assistants who bill medical services under the health center, and delivered by CoachCare under the health center's clinical direction.[9]

	Year 1	Year 2	24 months
Net reimbursement	**$658,391**	**$1,338,451**	**$1,996,842**
CoachCare fees	$381,718	$762,467	$1,144,185
Net to the health center	**$276,673**	**$575,984**	**$852,657**
Margin to the health center	42.02%	43.03%	**42.70%**

CoachCare Value Analysis. CY2026 non-facility Physician Fee Schedule, West Virginia locality 16 (Rest of West Virginia), a deliberately conservative basis; health-center claims pay national amounts (Section 2.2). 2,965 Medicare patients in scope; RPM + CCM + APCM. Margin is 24-month net to the health center divided by net reimbursement.

1. **The program funds itself from the second month.** Month 1 nets −$2,153 to the health center, because implementation lands before enrollment revenue does. The first positive month is M2, at $4,072. From M19 the service line runs at $114,802 in monthly net reimbursement and $49,271 net to the health center.
2. **Nobody is hired.** CoachCare delivers 14,240 hours of care-team work over 24 months, about 6.8 full-time-equivalent years, including an on-site enrollment specialist carried at CoachCare's expense. No capital outlay, and no recruiting in a county where the health center already competes for every nurse.

[6] CY2025 Physician Fee Schedule Final Rule (CMS-1807-F, 89 FR 97710): Rural Health Clinics and Federally Qualified Health Centers report the individual CPT and HCPCS codes for care management in place of G0511, paid at national non-facility Physician Fee Schedule amounts in addition to the PPS encounter; advanced primary care management adopted on the same basis. CY2026 Final Rule (CMS-1832-F) for 2026 dates of service.

[7] West Virginia Office of the Governor, July 30, 2026: about $14 million of Rural Health Transformation Program funding for remote patient monitoring under the Connected Care Grid, about $9.1 million outpatient (connected blood-pressure cuffs and glucose monitors; diabetes, high blood pressure and obesity) and about $4.9 million inpatient.

[8] CMS Medicare Shared Savings Program PY2026 participant file: the health center is a participant in an ACO on the ENHANCED track (low-revenue). CMS Quality Payment Program eligibility records, 2026: every clinician resolving to the health center's billing organization carries Qualifying APM Participant status through that ACO.

[9] CoachCare Value Analysis for Williamson Health & Wellness Center, 2026. Basis: CY2026 non-facility Physician Fee Schedule at West Virginia locality 16; 2,965 Medicare patients in scope; 14 referring clinicians; RPM, CCM and APCM.

3. **All three programs reach their ceilings inside the 24 months.** APCM reaches its ceiling in M6, CCM in M11, RPM in M18. At M24 the program holds 1,342 active program enrollments across 875 unique patients. The binding constraint is the size of the Medicare panel, not enrollment capacity. The top of the health center's own five-year Medicare range, the hospital's discharges and the behavioral-health arm are the three ways the ceiling moves.
4. **The rate basis is deliberately conservative.** The forecast prices at West Virginia locality 16. Health-center claims pay national non-facility amounts, and locality 16 sits 4% to 13% below the national amount on every code in the basket. Repriced on the national rail, the same census adds $137,250 of 24-month net reimbursement, all of it net to the health center, and lifts the margin to 46.39%. None of that is in the headline.
5. **The clinical return is concrete.** The forecast projects 68.8 avoided hospitalizations over 24 months, roughly $1.03 million at $15,000 per admission, from 108,314 device readings worked through one escalation protocol, with the Williamson Memorial discharge as one trigger. Under a two-sided ACO, each of those admissions counts twice.
6. **The staffing shape already fits the codes.** Ten of the fourteen referring clinicians are nurse practitioners and physician assistants. CCM, APCM and RPM are general-supervision code families; a care team led by advanced-practice clinicians with a physician layer is the configuration they were written for.

1. The Health Center and Its County

1.1 A health center that grew from 8,960 to 10,819 patients in four years

Williamson Health & Wellness Center is a HRSA Health Center Program awardee (grant H80CS26637), a facility Health Professional Shortage Area with a score of 19, and a Medicare FQHC enrolled under twelve CMS certification numbers, one PECOS associate identifier and one board.[10] Between the 2021 and 2025 Uniform Data System reports its patient count rose from 8,960 to 10,819. Over the same four years it opened four school-based health centers, three of them enrolled with Medicare between September and December 2025, added a vision service line, grew its behavioral-health census from 411 to 1,147 patients, and put a primary-care clinic inside the hospital it operates.[11]

UDS 2025	Count	What it means for the service line
Total patients	10,819	Up from 8,960 in 2021
Medicare patients	**2,965** (27.41%)	The panel this forecast runs on; Medicare Advantage and the 538 duals are inside it
Aged 65 and over	2,591 (23.95%)	Roughly double the health-center norm
Dually eligible	538	18% of the Medicare panel; the APCM level-3 tier
Medicaid and CHIP	3,799 (35.11%)	Outside the forecast: West Virginia Medicaid does not cover the code families (Section 2.3)
Hypertension	**3,371** (51.67% of medical patients)	The RPM cohort; blood-pressure control 71.79%
Diabetes	**1,348** (22.96%)	Glucose monitoring; A1c poorly controlled in 18.18%
Patients by service	Medical 8,922 · dental 1,337 · mental health 1,147 · SUD 289 · vision 486 · school-based 447	Fifteen sites, one record, one board

[10] HRSA UDS awardee page (grantee status); HRSA primary-care HPSA file (facility designation, score 19, designated November 2013, updated September 2025); CMS Federally Qualified Health Center Enrollments, July 17, 2026 vintage: twelve CCNs under PECOS associate identifier ending 2996, main site CCN 511032 enrolled December 2013.

[11] HRSA UDS 2021–2025: total patients 8,960 (2021), 9,295, 8,789, 10,242, 10,819 (2025); mental-health patients 411 (2021) to 1,147 (2025); vision patients 486 (2025, new line); school-based patients 0 (2021) to 447 (2025). CMS FQHC Enrollments: three school-based CCNs enrolled September 15, October 21 and December 17, 2025.

HRSA Uniform Data System, awardee H80CS26637, reporting years 2021–2025 (2025 is the latest).

The site list matters for the service line because every one of the fifteen is a referral source and a place a device can be handed over: the two adult-medicine floors and pediatrics on East Second Avenue, the dental clinic, the behavioral medicine and substance-use clinic on Logan Street, the Tug Fork and Gilbert clinics, the four school-based centers in Williamson, Matewan and Delbarton, the mobile medical unit, and the clinic at 859 Alderson Street inside Williamson Memorial.[12]

1.2 Quality the record can verify

HRSA's 2026 recognitions for the health center include the Patient Centered Medical Home badge and two National Quality Leader badges, one in diabetes health and one in behavioral health, alongside badges for improving access, advancing health information technology for quality, and preventive health.[13] The measures behind the badges are the ones a monitoring program is built to move: blood pressure controlled in 71.79% of hypertensive patients, diabetes A1c poorly controlled or untested in only 18.18%, depression screening and follow-up at 97.64%, tobacco screening and cessation at 92.62%. A health center that already sits in the top quartile on diabetes control has more to gain from documented monthly care management than one starting from the middle, because the remaining gap is exactly the between-visit gap.

Clinical quality measure, UDS 2025	Health center	HRSA quartile
Controlling high blood pressure	**71.79%**	2
Diabetes: A1c above 9% or untested (lower is better)	**18.18%**	2
Statin therapy for cardiovascular prevention	79.49%	2
Depression screening and follow-up	97.64%	1
Tobacco use screening and cessation	92.62%	1
Adult BMI screening and follow-up	89.62%	1
Substance-use treatment initiation / engagement	67.74% / 44.35%	1 / 1

HRSA Uniform Data System clinical quality measures, 2025, with HRSA's adjusted quartile ranking (1 is best).

1.3 Williamson Memorial: an acute-care hospital in the same organization

Williamson Memorial is a CMS-certified acute-care hospital (CCN 510094) licensed for 76 beds and certified by Medicare in August 2024. It runs an 18-bed inpatient unit, a laboratory and imaging, with physicians on site through weekday evenings, and the health center's own primary-care clinic occupies its first floor.[14] For a remote care service line the hospital is the discharge loop: a patient leaving the inpatient unit walks into a health-center clinic in the same building, which is the highest-yield moment to place a device and open a transitional care episode. The hospital is not the revenue base of this forecast. Its inpatient volume is small, and most acute care for Mingo County residents still happens at the regional referral hospitals across the river and up the valley. Section 3.3 treats transitional care accordingly: named, priced at the local rate, and carried at zero dollars.

[12] HRSA sites file (see note 1) and the health center's locations page, retrieved September 2026.

[13] HRSA UDS awardee page, 2026 Community Health Quality Recognition badges as displayed: National Quality Leader (Diabetes Health), National Quality Leader (Behavioral Health), Health Center Quality Leader (Bronze), Improving Health Care Access, Advancing Health Information Technology for Quality, Preventive Health, Patient Centered Medical Home, and operational site visit certification. The same badges appear on the health center's own website.

[14] CMS Hospital Enrollments (July 31, 2026): Williamson Memorial, CCN 510094, Part A hospital, general acute care. CMS Provider of Services file, Q2 2026: short-term acute-care hospital, 76 certified beds, voluntary non-profit, certified August 28, 2024. Community Health Needs Assessment 2026–2029 (December 30, 2025) and the hospital's website: 18-bed inpatient unit, laboratory, radiology; physicians on site weekdays and after hours to 10 p.m.; the health center's integrated care clinic on the first floor.

1.4 Mingo County: older, poorer, and mostly Medicare Advantage

Mingo County has 22,542 residents, 21.9% of them aged 65 or older, against a poverty rate of 32.4% and a disability rate of 31.9%; median household income is $38,119 and 67.2% of residents have public coverage.[15] Adult COPD prevalence is 13.3%, more than three times the national rate, and the nearest tertiary care can be four hours away by road.[16] The county's 6,486 Medicare eligibles were 69.5% enrolled in Medicare Advantage in September 2026; Pike County, Kentucky, across the Tug Fork, runs 66.6%. Of Mingo County's 6,571 beneficiaries in CY2024, 1,797 (27.3%) were dual-eligible and 27.3% qualified through disability rather than age.[17]

Mingo County	Value
Population (ACS 2024 five-year)	22,542
Aged 65 and over	4,929 (21.9%)
Poverty rate (all residents / aged 65 and over)	32.4% / 28.8%
Residents with a disability	31.9%
Median household income	$38,119
Households speaking a language other than English	0.7%
Adult COPD prevalence	13.3% (national 3.8%)
Medicare eligibles (September 2026)	6,486
Medicare Advantage penetration (September 2026)	**69.5%**
Pike County, Kentucky, MA penetration	66.6%
Dual-eligible share of beneficiaries (CY2024)	**27.3%** (1,797 of 6,571)

U.S. Census Bureau ACS 2024 five-year estimates; CMS Medicare Advantage State/County Penetration, September 2026; CMS Medicare Monthly Enrollment, CY2024; Williamson Memorial Community Health Needs Assessment 2026–2029.

What 69.5% 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 more than 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; individual contracts set their own terms for those families.

The forecast in Section 6 prices the whole panel at the fee schedule. The matching operational move is early: confirm RPM, CCM and APCM payment terms with the dominant local plans during discovery, contract by contract (Recommendation 3).

The dual share works the other way. Advanced primary care management pays its highest tier, G0558 at $111.44 a month here, for Qualified Medicare Beneficiaries, and 538 of the health center's 2,965 Medicare patients, 18%, are dually eligible.

1.5 The gap: the month between visits

Between-visit chronic care has no Medicare revenue line here yet. A sweep of CY2024 Medicare fee-for-service claims across every clinician billing under the health center returns no lines on any remote-

[15] U.S. Census Bureau American Community Survey 2024 five-year estimates, profiles DP02, DP03 and DP05, Mingo County, West Virginia: population 22,542; 4,929 aged 65 and over (21.9%); poverty 32.4% (28.8% among those 65 and over); 31.9% with a disability; median household income $38,119; public coverage 67.2%; uninsured 6.8%; 0.7% speaking a language other than English at home.

[16] Williamson Memorial Community Health Needs Assessment 2026–2029 (December 30, 2025), citing CDC and County Health Rankings: adult COPD 13.3% against 3.8% nationally; residents travel up to four hours one way to the nearest urban center with tertiary care.

[17] CMS Medicare Advantage State/County Penetration, September 2026 (see note 5); Pike County, Kentucky, 15,424 eligibles, 10,271 enrolled (66.59%). CMS Medicare Monthly Enrollment, CY2024, county file: Mingo County 1,796 beneficiaries qualifying through disability (27.3%).

monitoring code, any chronic-care-management code, any advanced-primary-care code, any transitional-care code or any behavioral-health-integration code.[18] CMS suppresses any provider-and-code line under 11 beneficiaries, and care management billed on the health center's own claim does not appear in that professional-claims file at all, so the precise finding is that there is **no remote-care or care-management program at meaningful scale in CY2024 claims**.

The rest of the record points the same way, and it is a structural observation rather than a criticism. The website's locations page still lists a referral and community health worker office, and the careers page, June through August 2026, advertised for a phlebotomist, a billing specialist, a licensed practical nurse, medical assistants and a receptionist, and no care manager, care coordinator or remote-monitoring role.[19] Three thousand three hundred and seventy-one patients with hypertension and 1,348 with diabetes are seen in person a few times a year, in a county where a third of residents live with a disability and a third live in poverty. The month in between is where the readings go unread. The gap is buildable, and the health center has already shown it knows how to fill it.

2. The CY2026 Billing Change for Health Centers

2.1 G0511 is gone; the individual codes pay on top of the PPS encounter

Federally Qualified Health Centers are paid a prospective payment per qualifying encounter. For years, everything a health center did for chronic patients between those encounters was compressed into one bundled monthly code, G0511, one flat payment regardless of how many services, minutes or programs a patient carried. That code was retired during 2025. For 2026 dates of service a health center reports 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 PPS encounter**.[20]

CY2026 also added two codes that matter for an organization with an inpatient unit: 99445 pays the device-supply month when a patient transmits 2 to 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. A patient discharged from Williamson Memorial on the 20th of the month used to produce an unbillable partial month; now it bills. In this forecast the two codes carry $165,855 of gross reimbursement over 24 months, about 8.3% of net reimbursement, revenue that did not exist two years ago.[21]

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, and what makes the community-health-worker model of a decade ago fundable without a grant.

2.2 What the codes pay here

The Value Analysis prices every code at the CY2026 non-facility Physician Fee Schedule for West Virginia locality 16, Rest of West Virginia, the Palmetto GBA jurisdiction that covers ZIP 25661.[22]

Code	What it pays for	Cadence	CY2026 rate, WV locality 16
99453	RPM setup and patient education	One-time	$19.24

[18] CY2024 Medicare Physician & Other Practitioners sweep (see note 4).

[19] The health center's locations page (a 'Referral and Clinical Health Workers' location at 180 East Second Avenue) and careers page with its job-post feed, retrieved September 2026: postings dated June 26 to August 19, 2026.

[20] CMS-1807-F (see note 6): G0511 retired with a transition period during 2025; for 2026 dates of service the individual codes are the standing requirement. CMS-1832-F added the APCM behavioral-health add-on codes for health centers effective January 1, 2026.

[21] CoachCare Value Analysis, Financial Value detail: 99445 and 99470 together carry $165,855 of gross reimbursement over 24 months against $1,996,842 of net reimbursement (8.3%), on this forecast's code frequencies.

[22] CY2026 Physician Fee Schedule non-facility amounts, carrier 11402 locality 16 (Rest of West Virginia), Palmetto GBA Jurisdiction M; ZIP 25661 maps to this locality in the CMS ZIP-to-locality crosswalk (April 2026). Conversion factor $33.4009; GPCIs work 1.000, practice expense 0.869, malpractice 1.431. These are the rates priced into the Value Analysis.

Code	What it pays for	Cadence	CY2026 rate, WV locality 16
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
99495	Transitional care management, moderate complexity	Per discharge	$207.01 (named, not in the forecast)
99496	Transitional care management, high complexity	Per discharge	$280.58 (named, not in the forecast)
99484	Behavioral health integration, first 20 minutes	Monthly	$55.12 (named, not in the forecast)

CY2026 non-facility Physician Fee Schedule, West Virginia locality 16 (Rest of West Virginia), the Value Analysis basis. The APCM tier blend in the forecast (15% level 1, 60% level 2, 25% level 3) yields $60.83 per patient-month, with the level-3 weight set to the 18% of the Medicare panel that is dually eligible.

The national rail runs in the health center's favor

A health center bills these codes at national non-facility amounts, and West Virginia locality 16 prices below the national amount on every code in the basket, by 4% to 13%, most of all on the device-supply codes.[23]

Repriced at the national amounts, the same census adds $137,250 over 24 months, every dollar of it net to the health center: $1,996,842 of net reimbursement becomes $2,134,092, $852,657 net becomes $989,907, and the margin moves from 42.70% to 46.39%. The forecast keeps the conservative locality basis; the national rail is quantified upside.

These are traditional-Medicare amounts. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. With 69.5% of the county's Medicare in Medicare Advantage, that contract check belongs in the first week of 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 32,910 claims over 24 months. A health-center billing office absorbing that by hand would resent every one of them. In the operating model of Section 10, CoachCare carries the load: enrollment, device logistics, monitoring documentation and billing-ready claim generation inside Azalea Health. The health center's own billing team files the FQHC claims with the care-management codes, and the clinicians keep the clinical decisions.

[23] CY2026 national non-facility amounts (CMS RVU26A, GPCI 1.000) against West Virginia locality 16: 99454 and 99445 $52.11 national versus $45.47 (−12.7%); 99453 $21.71 versus $19.24 (−11.4%); 99490 $66.13 versus $63.16 (−4.5%); G0558 $117.24 versus $111.44 (−4.9%). Locality 16 ranks between 4th and 18th lowest of 109 localities on every code in the basket. Health centers bill the care-management codes at the national amount.

One structural note on Medicaid, because the deal design has to respect it. The West Virginia Medicaid physician fee schedule effective April 1, 2026 lists remote physiologic monitoring, chronic care management, principal care management, behavioral health integration and advanced primary care management as not covered; transitional care management is covered.[24] Medicaid and CHIP cover 35% of the health center's patients, and none of that population is in this forecast. The service line is built on the Medicare panel, where the individual-code rail is explicit, and carries no Medicaid dollars.

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

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. Principal care management is off: a family-medicine panel bills CCM or APCM, not the single-condition specialist code.

Program	Who qualifies	What it is	Billing
RPM	1,927 of the 2,965 Medicare patients (65%): 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	1,186 (40%): 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	1,038 (35%): 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
TCM	Any inpatient discharge home from Williamson Memorial	Contact within two business days, medication reconciliation, a face-to-face visit within 7 or 14 days	99495 / 99496, named and not in the forecast

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. A transitional care episode runs for 30 days after a discharge and does not overlap APCM for that patient in that month. 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 health center four ways. First, additive revenue: every care-management dollar lands on top of the PPS encounter, not inside it. Second, it is the answer to geography. A morning blood-pressure reading from a kitchen table in Matewan reaches a nurse the same morning, without anyone driving to Williamson. Third, avoided admissions: a patient whose fluid weight climbs for four days is treated by phone and in clinic, not admitted three weeks later. That is where the forecast's 68.8 avoided

[24] West Virginia Bureau for Medical Services, Physician's (RBRVS) Fee Schedule, rates effective April 1, 2026 through March 31, 2027 (released December 29, 2025, revised June 15, 2026): status 'Not Covered' for 99453, 99454, 99457, 99458, 99091, 99490, 99439, 99491, 99487, 99489, 99424, 99426, 99484, 99492 and G0556–G0558; 99495 and 99496 covered. HRSA UDS 2025: Medicaid/CHIP 3,799 patients (35.11%).

hospitalizations come from, and under a two-sided ACO each of them is also a cost that never reaches the benchmark. Fourth, the staffing model does not depend on recruiting: CoachCare's clinical staff deliver the monitoring layer, so the program's growth does not wait on hiring nurses in Mingo County.

3.2 The Medicare panel it runs on

The forecast is built on **2,965 Medicare patients**, the health center's own count as reported to HRSA for 2025, traditional Medicare and Medicare Advantage together; Medicare Advantage and the 538 duals are already inside it, with no gross-up. The first implementation step compares it with chart counts by payer.[25] From that panel, the eligibility model carves the program pools: 1,927 patients RPM-eligible (65%), 1,186 CCM-eligible (40%), 1,038 APCM-eligible (35%). The pools overlap; the coordination rule keeps the billing disjoint.

3.3 Transitional care at the Williamson Memorial discharge, named and not in the forecast

Each discharge home from the hospital's 18-bed inpatient unit opens a transitional care management episode: an interactive contact within two business days, medication reconciliation, and a face-to-face visit within 14 days (99495, $207.01 at this locality) or 7 days (99496, $280.58). The health center's clinicians can bill those codes today because the discharging hospital and the follow-up clinic sit in the same organization and the same building, and West Virginia Medicaid pays transitional care as well.[26] TCM is on the recommended stack for that reason, and it carries no dollars anywhere in this forecast: the inpatient census, the share of discharges that go home to a health-center patient, and visit-scheduling capacity are all discovery items. What TCM does in the forecast is clinical. A discharge is the highest-yield moment to enroll a patient in monitoring, and the three-touch post-discharge cadence in Section 5.5 runs on the same contact the TCM code requires.

3.4 Behavioral health integration: the next arm, named

A health center that holds a 2026 National Quality Leader badge in behavioral health, screens 97.64% of its patients for depression, and runs a behavioral medicine clinic with 1,147 patients has an obvious fourth program waiting: behavioral health integration, 99484, $55.12 a month at this locality for the first 20 minutes of care-manager time under a treating clinician's plan. It is the same infrastructure, the same monthly cadence and the same billing engine, applied to a population the health center already treats well. This forecast carries it at zero dollars and names it once, here, as the natural next arm once the three Medicare programs are at ceiling.

3.5 Built the way the codes work: a care team led by nurse practitioners and physician assistants

Of the fourteen clinicians who bill medical services under the health center on the CMS Quality Payment Program roster for 2026, four are physicians and ten are nurse practitioners and physician assistants.[27] 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 care team led by advanced-practice clinicians with a physician layer is the configuration these codes were designed to pay. The referral motion is one step, a clinician flags a qualifying patient in the chart, and the program runs from there.

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[25] HRSA UDS 2025 (see note 2). CoachCare Value Analysis eligibility model: RPM 65%, CCM 40%, APCM 35% of the in-scope panel; the 538 dually eligible patients are 18.1% of the 2,965.

[26] CPT 99495 and 99496 requirements (interactive contact within two business days of discharge; face-to-face visit within 14 or 7 days; moderate or high medical decision-making); CY2026 non-facility amounts at West Virginia locality 16: $207.01 and $280.58. West Virginia Medicaid RBRVS fee schedule (see note 24): 99495 and 99496 covered. TCM is carried at zero dollars in every figure in this report.

[27] CMS Quality Payment Program eligibility records, 2026: 22 clinicians resolve to the health center's billing organization; the forecast's 14 are the 4 physicians and 10 nurse practitioners and physician assistants billing medical services, excluding the four behavioral clinicians, the three dental and vision clinicians, and one physician assistant whose Medicare work is outside primary care.

3.6 Staffing: nobody is hired, and the model the health center built stays

CoachCare delivers 14,240 hours of care-team work across the 24 months, about **6.8 full-time-equivalent years**, without the health center hiring anyone. The on-site enrollment specialist is CoachCare's expense, not a program cost. In a county where every growth plan eventually stalls on clinical recruiting, the service line adds the working capacity of nearly seven hires and zero requisitions.

This is a build-on, not a replacement. From 2012 to at least 2019 the health center ran a community-health-worker model for diabetes, heart failure and COPD: an initial home assessment, weekly home visits for up to six months, weekly care conferences, blood pressure and pulse measured in the kitchen, with a nurse and a nurse practitioner behind the workers. By September 2019 it had enrolled 729 high-risk patients, and the 2020 evaluation in Preventing Chronic Disease reported an average A1c reduction of 2.4 percentage points among the 446 followed for six to twelve months.[28] That program was grant-funded because Medicare had no code for it. This plan puts cellular devices, structured documentation and a Medicare revenue line under the model the health center built. Where community health workers still operate, they are the referral and trust layer; CoachCare's staff carry the recurring work of monitoring review, outreach, documentation and escalation handling. The health center's clinicians contribute the two things only they can, the referral flag that starts each enrollment and clinical judgment at the escalation points. The in-house pharmacy is where the readings and the refills meet: a glucose trend that points to non-adherence is a pharmacy conversation, two doors down.

4. The ACO Fit: One Panel, Paid Twice

The health center is a participant in a two-sided Medicare Shared Savings Program ACO on the ENHANCED track for performance year 2026, and every clinician on its Medicare roster is a Qualifying APM Participant for 2026.[29] That changes what a monitoring program is worth in three specific ways, none of which requires the ACO to do anything.

- **Attribution runs on primary-care services.** Beneficiaries are assigned to the ACO on the primary-care services they receive, and documented monthly care management is primary care delivered every month, not a few times a year. A panel under CCM or APCM is a panel that stays assigned.
- **Fewer admissions count twice.** The RPM, CCM and APCM revenue stays with the health center as fee-for-service, on top of the PPS encounter. The 68.8 avoided hospitalizations in this forecast are also expenditure that never reaches the ACO's benchmark. Under a two-sided track, that matters in both directions.
- **The quality measures are the same measures.** The ACO's quality scoring runs on electronic clinical quality measures that include diabetes A1c control, controlling high blood pressure and depression screening, the same measures the health center already leads on in its UDS report. A daily reading and a monthly care-management contact are how those numbers hold at scale.

The Value Analysis in Section 6 is a fee-for-service forecast and does not model shared savings. Nothing in this report depends on any decision by the ACO; the argument is that the same panel, managed monthly, is worth more to the health center under both rails than under one.

[28] Preventing Chronic Disease, 2020, volume 17 (see note 3), and the federally funded rural care-coordination network evaluation brief for 2015–2018: community health workers with a registered nurse and a nurse practitioner; initial home assessment; weekly home visits for up to six months; weekly care conferences; blood pressure and pulse measured at home; target conditions diabetes, heart failure and COPD.

[29] CMS Medicare Shared Savings Program PY2026 participant file and CMS Quality Payment Program eligibility records, 2026 (see note 8). Beneficiary assignment under the program is based on primary-care services (42 CFR 425.400–425.404). The Value Analysis does not model shared savings.

5. The Discharge Loop: Clinical Governance and Escalation

5.1 A monitoring program is a clinical operation first

Most remote care programs are bolted onto a clinic and hope the hospital tells them about admissions. Here the same organization operates the clinic visit, the inpatient unit and the discharge, and the health center's clinic sits on the hospital's first floor, which means the program learns about a Williamson Memorial discharge from the record, not from the patient's memory a month later. A monitoring program is a clinical operation before it is a revenue line. This section sets out the machinery the health center inherits on day one of the program: CoachCare's Care Management Programs standard operating procedures, March 2026 edition, rendered as seven process maps covering qualification, monitoring, escalation and discharge.[30] The argument here is not a penalty program. It is keeping a patient with heart failure or COPD out of a bed four hours from home.

5.2 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 clinic hears 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.

5.3 The emergent pathway

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

5.4 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 that the higher-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.

5.5 The post-discharge cadence

A hospitalization within the last 60 days fires a fixed three-touch follow-up sequence: a first contact on day 1 or 2, a second on days 5 to 8, and a third on days 12 to 14. 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. For a Williamson Memorial discharge the first touch is also the interactive contact a transitional care episode requires, and the day-12-to-14 touch lands inside the 14-day visit window. One workflow serves both, and it is where most of the 68.8 avoided hospitalizations in Section 6.4 are won.

[30] 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.

5.6 Discharge governance and continuity

Discharge from the program 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.

6. Value Analysis: The 24-Month Forecast

6.1 Headline economics

Over 24 months the service line produces **$1,996,842 in net reimbursement** to Williamson Health & Wellness Center. CoachCare's fees total $1,144,185, including $52,186 of ancillary items: implementation, the Azalea Health integration and telephonic outreach. Net to the health center is **$852,657, a 42.70% margin** on the program, 42.02% in Year 1 and 43.03% in Year 2.[31]

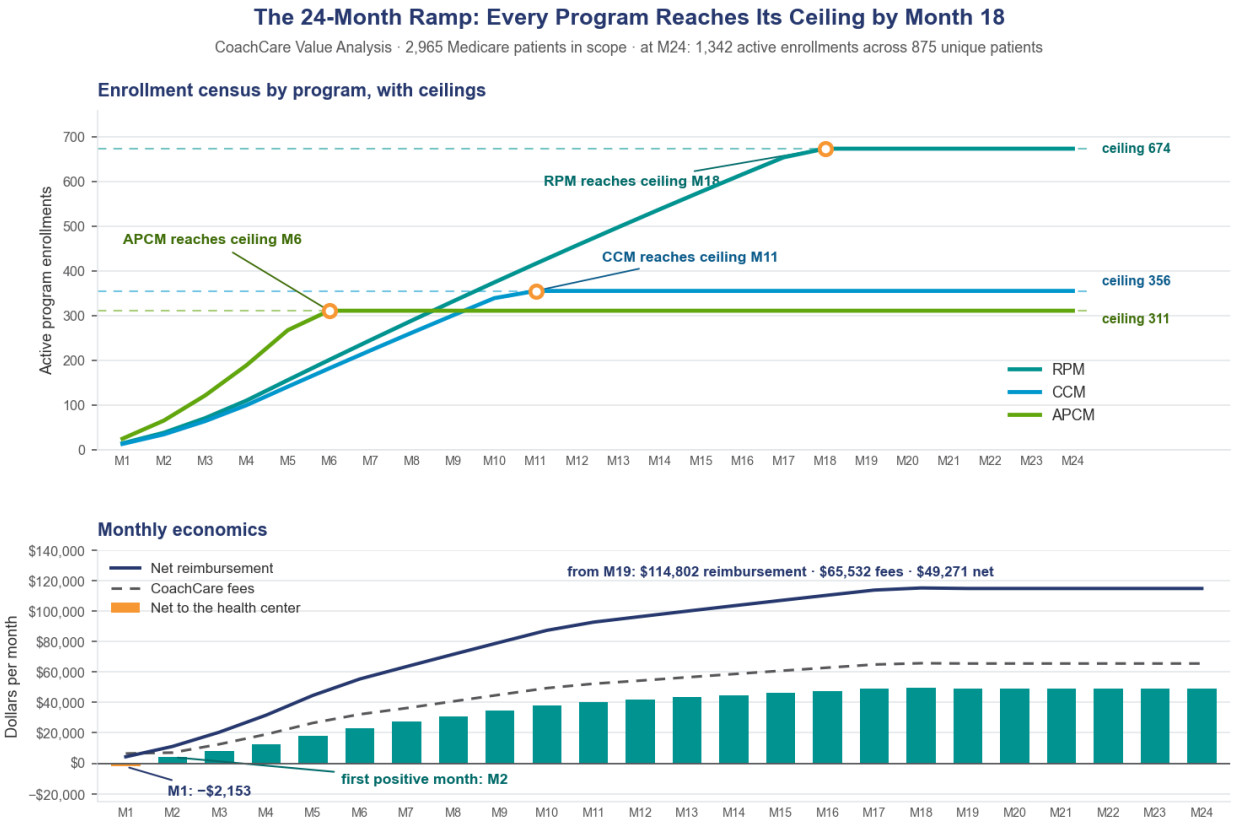

Figure 1. The 24-month ramp: enrollment census by program with ceilings (above) and monthly net reimbursement, CoachCare fees and net to the health center (below). Month 1 nets −$2,153; the first positive month is M2; from M19 the line holds at $49,271 net per month.

The shape of the curve is worth reading precisely. Month 1 is negative, −$2,153, because implementation and enrollment effort land before the first full billing months do. Month 2 turns positive at $4,072, month 3 nets $7,914, and the line compounds as the three programs fill: by M12 net reimbursement reaches

[31] CoachCare Value Analysis, 24-month forecast: monthly net reimbursement, fees and net-to-health-center series; Year 1 margin 42.02%, Year 2 margin 43.03%, 24-month margin 42.70%, each defined as net to the health center divided by net reimbursement. Ancillary fees of $52,186 over 24 months: implementation $2,500; Azalea Health integration $1,000 setup, $150 a month and $1.50 per patient; telephonic outreach.

$96,353 and net to the health center $42,036; M18, the month RPM reaches its ceiling, is the peak at $115,143 of net reimbursement and $49,420 net; from M19 the line settles at $114,802 of net reimbursement, $65,532 of fees and $49,271 net a month once setup codes fall away and the census holds at ceiling.

6.2 Program economics by year

Program	Year 1 net reimbursement	Year 2 net reimbursement	24-month net reimbursement	24-month CoachCare fees	24-month net to the health center
RPM	$247,879	$677,790	$925,669	$536,838	$388,830
CCM	$250,002	$450,089	$700,091	$348,368	$351,723
APCM	$160,511	$210,571	$371,082	$206,792	$164,290
Ancillary (implementation, integration, outreach)	—	—	—	$52,186	−$52,186
All programs	**$658,391**	**$1,338,451**	**$1,996,842**	**$1,144,185**	**$852,657**

CoachCare Value Analysis, per-program economics by contract year. Ancillary items: implementation $2,500; Azalea Health integration $1,000 setup plus $150 a month and $1.50 per patient; telephonic outreach.

RPM is the volume engine at 10,316 patient-months and $925,669 of net reimbursement. CCM is the yield engine at $105.42 of net reimbursement per patient-month across 6,641 patient-months, against $89.73 for RPM and $56.35 for APCM over its 6,585. APCM earns its place a different way: no minute-tracking, a bundled monthly payment, and the level-3 tier for Qualified Medicare Beneficiaries, $111.44 a month, on a panel where 18% of Medicare patients are dually eligible. Year 2 outruns Year 1 by $680,060 of net reimbursement because Year 1 carries the ramp and Year 2 runs two programs at ceiling from its first month and the third from its sixth.

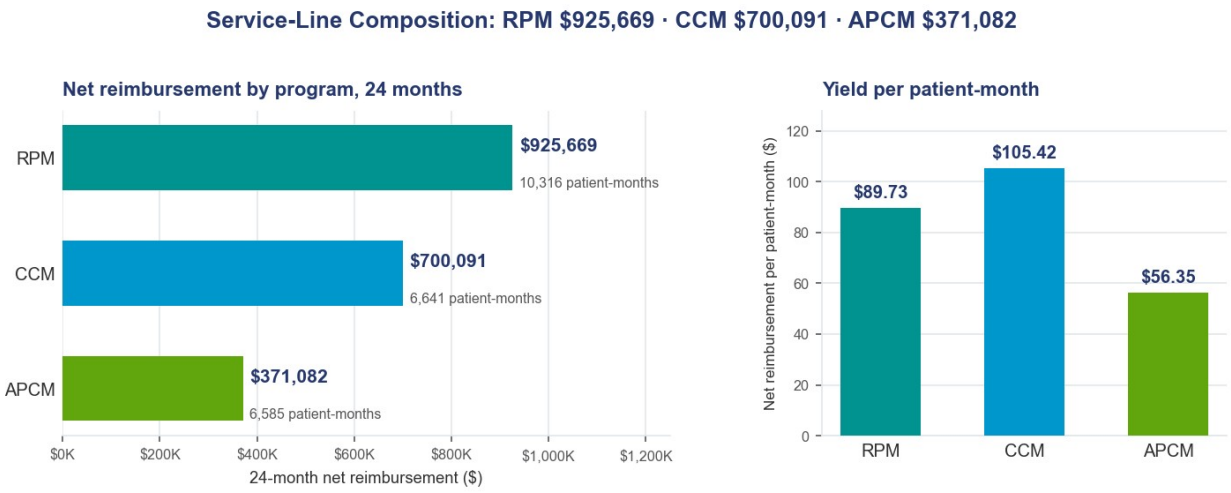

Figure 2. Service-line composition: per-program 24-month net reimbursement and net reimbursement per patient-month.

6.3 The ramp: every ceiling reached by month 18

This account is ceiling-limited in all three programs inside the 24 months. APCM reaches its ceiling of 311 enrollments in month 6, CCM its 356 in month 11, and RPM keeps climbing until month 18, when it

reaches 674. From M19 the forecast is flat because there is no one left to add.[32] The first 90 days move fast: 52 enrollments across the three programs in month 1, 138 by month 2, 256 by month 3.

Program	Eligible pool	Ceiling	Ceiling reached	Active enrollments at M24
RPM	1,927	674	Month 18	674
CCM	1,186	356	Month 11	356
APCM	1,038	311	Month 6	311
All programs		**1,342**		**1,342 enrollments · 875 unique patients**

Enrollment counts are program enrollments, not unique patients; the 1,342 enrollments at M24 belong to 875 unique patients (667 at M12), because a patient may carry a monitoring enrollment and a care-management enrollment at the same time.

Say the constraint out loud: what binds this program is the size of the Medicare panel, not enrollment capacity. That cuts two ways. It caps the forecast, and it de-risks it, because the model asks the clinicians to produce no heroic enrollment performance, only a panel that exists. Three things move the ceiling upward: the top of the health center's own five-year Medicare range rather than the 2025 count, the hospital's discharges feeding enrollment at the bedside, and the behavioral-health arm in Section 3.4 once the first three programs are full. The on-site enrollment specialist cannot raise a ceiling, but it reaches every ceiling months sooner, and Section 11 prices what that is worth.

6.4 What the program produces

24-month output	Volume
Claims generated, billing-ready	32,910
Device readings monitored	108,314
Care-management tasks completed	65,819
Chart updates written to Azalea Health	16,455
Patient conversations held	9,873 (548 hours of call time)
Care-team hours delivered	14,240 (≈ 6.8 FTE-years)
Hospitalizations avoided	**68.8 · ≈ $1.03 million at $15,000 per admission**

CoachCare Value Analysis operational and clinical outputs, 24 months.

The avoided-admission line deserves its own sentence. 68.8 avoided hospitalizations over 24 months is roughly $1.03 million of cost that never lands on anyone: not on Medicare, not on the plans that cover 69.5% of the county, not on the ACO's benchmark, and not on a bed in a referral hospital hours from home.[33]

[32] CoachCare Value Analysis enrollment model: program ceilings 674 (RPM), 356 (CCM), 311 (APCM); ceilings reached in months 18, 11 and 6; 1,342 active enrollments across 875 unique patients at month 24 (667 at month 12). Dedup: the care-management enrollments plus the RPM enrollments not already carrying a wrapper.

[33] CoachCare Value Analysis clinical-outcomes module: 68.8 avoided hospitalizations over 24 months, valued at $15,000 per avoided admission (≈$1.03 million).

7. Azalea Health Integration: The Program Lives in the Record

The health center runs on Azalea Health, and the forecast prices CoachCare's Azalea Health integration ($1,000 setup, $150 a month and $1.50 per patient), with the integration scope set in the workplan.[34] The program operates inside the record rather than beside it.

- **Out of the chart: eligibility flags and referral orders.** Qualifying patients are flagged and orders triggered by service inside the Azalea Health workflow; CoachCare enrolls flagged Medicare patients on the health center's behalf, and clinicians see enrollment status in real time in the chart they already use. Patients begin receiving services in under five days from the flag.
- **Back into the chart: vitals, documentation and status.** Device readings land as integrated vital reports, not attached PDFs; evidence of care, care plans and the integrated care summary attach to the chart monthly; enrollment status and time capture write back to the record.
- **Billing-ready claims.** The CoachCare billing engine assembles the monthly claim lines automatically, the step that makes individual-code billing workable at 32,910 claims over 24 months. The health center's own billing team files the FQHC claims with the care-management codes.
- **The discharge feed.** Williamson Memorial discharges reach the program from the record, which is what arms the post-discharge cadence in Section 5.5 without anyone relaying a message; the hospital's own system and the interface between the two are an integration-scope item.

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.[35]

8. State Momentum: The Connected Care Grid

All fifty states received first-year awards under the federal Rural Health Transformation Program on December 29, 2025. West Virginia's award is $199.5 million for federal fiscal year 2026, and the first of its seven flagship initiatives is the Connected Care Grid: telehealth, remote monitoring and local care coordination, aimed at diabetes, hypertension, cardiovascular disease, COPD and asthma among the named conditions.[36] On July 30, 2026, the state opened about $14 million of remote-monitoring funding under that initiative, roughly $9.1 million of it for outpatient remote monitoring of chronic conditions with connected devices such as blood-pressure cuffs and glucose monitors, targeting diabetes, high blood pressure and obesity, with applications through the state's grants portal.[37]

This section is context. No application or award is asserted here; whether the health center or the hospital has applied is a discovery item in Section 12. The permitted argument is narrower and stronger. The funding pays for devices and start-up; the Medicare codes pay for the month, every month, and they do so under fee-for-service before any application is written. An applicant already operating a monitoring program on 2,965 Medicare patients, with a published care-management model behind it, makes a stronger case than one proposing to start, and the funding is infrastructure money, not a payer change; it does not alter the Medicare billing rail this report is built on.

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[34] EHR as stated by the health center (Azalea Health), September 2026. CoachCare integration pricing for Azalea Health as carried in the Value Analysis: $1,000 setup, $150 a month, $1.50 per patient. The interface scope is set in the workplan.

[35] CoachCare company statistics, 2026: patients served, managed conditions, providers on the platform, implementations completed, claims generated and vitals recorded.

[36] CMS-published Rural Health Transformation Program state project abstract, West Virginia (January 5, 2026): seven flagship initiatives led by the Connected Care Grid; West Virginia Department of Health program FAQ (April 2026): award $199,476,098.72 for federal fiscal year 2026, funded one year at a time.

[37] West Virginia Office of the Governor, July 30, 2026 (see note 7). Applications run through the state's grants portal; eligible applicants include local providers, hospitals, clinics and non-profit organizations. No application by the health center or the hospital is asserted.

9. The CY2027 Proposed Rule, Repriced on This Forecast

CMS published its proposed CY2027 physician fee schedule in July 2026. Comments on CMS-1848-P closed September 14, 2026; the final rule arrives in early November; the changes take effect January 1, 2027, and a statutory phase-in caps how far any code's payment can fall in a single year. The proposal that matters here is a reduction to the remote monitoring device-supply codes. Every code in this forecast was repriced at the West Virginia locality on this account's own billing mix, with enrollment held constant.[38]

Level	CY2026 basis	Proposed CY2027 effect	Why each step is smaller
Device supply, 99454 and 99445	$45.47 a month	**$36.14 a month, −20.5%**	The code CMS proposes to cut
The remote monitoring arm	$925,669 over 24 months	**−8.8%, −$81,753**	Device supply is 31% of the remote monitoring basket; management time moves little
Chronic care management	$700,091 over 24 months	−2.3%, −$15,871	Conversion-factor and relative-value churn only; the proposal does not target these codes
Advanced primary care management	$371,082 over 24 months	−0.8%, −$2,995	The same conversion-factor movement; the bundle's relative values barely move
The whole service line	$1,996,842 over 24 months	**−5.0%, −$100,619, to $1,896,223**	Remote monitoring is 46% of the line; care management is $18,865 of the total

CoachCare repricing of this forecast at the CY2027 proposed amounts, West Virginia locality 16, on the code frequencies and APCM tier weights in this Value Analysis.

Three numbers, each smaller than the last only because its base is larger. A 20.5% cut to one code is a 5.0% change to the service line, because the line is built on three programs and two of them are not the one being repriced. On the national rail a health center bills by rule, the same census carries more cushion than the locality basis shows.

10. Implementation and the First 90 Days

10.1 Who runs what

CoachCare delivers	Williamson Health & Wellness Center keeps
Telephonic and on-site enrollment; the enrollment specialist is CoachCare's expense	Referral flags in Azalea Health; clinical oversight under general supervision
Cellular device logistics: supply, shipping, replacement	Sign-off on care plans and escalation preferences per site
Monitoring, documentation and the escalation protocol of Section 5	Responses to clinic-routed escalations; the discharge feed from Williamson Memorial
Billing-ready claim generation inside Azalea Health	Filing the FQHC claims with the care-management codes; billing review; the revenue
Monthly operating reports against the dashboard in 10.4	Program governance; the community-health-worker relationship where it operates

[38] CMS-1848-P, proposed CY2027 Physician Fee Schedule (July 2026); comment period closed September 14, 2026. CoachCare repricing at West Virginia locality 16 on this forecast's code frequencies and APCM tier weights: 99454 and 99445 from $45.47 to $36.14 (−20.5%); RPM arm −8.8% (−$81,753); CCM −2.3% (−$15,871); APCM −0.8% (−$2,995); service line −5.0% (−$100,619, from $1,996,842 to $1,896,223). Enrollment held constant.

10.2 Devices and patient materials

Devices ship cellular-connected. A cellular cuff transmits the moment it is used: nothing to pair, no app, no password, no home broadband required, which matters in a county with a 32.4% poverty rate and a 31.9% disability rate. Patient-facing materials are written at a low reading level in English; fewer than one household in a hundred speaks another language at home. Enrollment happens by phone, in any of the fifteen sites, and at the bedside before a Williamson Memorial discharge, not through a portal.

10.3 Model inputs

Input	Value
Medicare panel in scope	2,965 patients, the health center's UDS 2025 Medicare count; compared with chart counts by payer in the first 30 days
Referring clinicians	14 on the CMS Quality Payment Program roster for 2026 (4 physicians + 10 nurse practitioners and physician assistants)
Programs	RPM + CCM + APCM; TCM and BHI named, not in the forecast; PCM off
Program-eligible pools	RPM 1,927 · CCM 1,186 · APCM 1,038
Enrollment ceilings	RPM 674 (M18) · CCM 356 (M11) · APCM 311 (M6)
Acceptance	RPM 35% · CCM and APCM 30% of the eligible pool
Enrollment engine	8 referrals per clinician per month at 80% acceptance; one CoachCare-funded on-site enrollment specialist at 80 enrollments a month; telephonic outreach on; 1.5% monthly attrition
Rate basis	CY2026 non-facility Physician Fee Schedule, West Virginia locality 16 (Rest of West Virginia), ZIP 25661; conservative, since health-center claims pay national amounts (+ $137,250 over 24 months, Section 2.2)
APCM tier blend	15% level 1 · 60% level 2 · 25% level 3 = $60.83 per patient-month
Medicare Advantage	69.5% of Mingo County's Medicare (September 2026). Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Care-management payment terms are confirmed contract by contract in discovery.
EMR	Azalea Health, priced at the catalog integration; integration scope set in the workplan

10.4 The 90-day plan and the operating dashboard

Days 0–30: foundation. Program agreement and the Azalea Health integration workplan. Chart counts by payer against the 2,965 UDS count, and the current care-team roster, the two inputs that move the model most. ICD-10 screening of the Medicare panel per the qualification map, device logistics staged, escalation routing localized per site, the discharge feed wired from Williamson Memorial, and clinician orientation to the general-supervision workflow. The Medicare Advantage contract check with the dominant local plans starts in week one.

Days 31–60: enrollment live. Telephonic, in-clinic and bedside enrollment running; first devices in homes; first billable service months. Month 1 nets −$2,153 as implementation lands; month 2 turns positive. The forecast carries 52 enrollments in month 1 and 138 by month 2.

Days 61–90: scale and file. Enrollment at 256 by month 3 and tracking toward APCM's ceiling in month 6. First monthly operating report against the dashboard. Decision point on the Connected Care Grid outpatient remote-monitoring application, with a live program to describe rather than a proposed one.

The operating dashboard from month one:

- Enrollment census by program against ceiling (674 / 356 / 311)
- Time from referral flag to first billable enrollment (target: under five days from flag to first service)

- Discharges captured: Williamson Memorial discharges that entered the three-touch cadence, against the hospital's own discharge count
- Device-reading days per patient-month against the 16-day 99454 threshold, with 99445 capturing 2- to 15-day months
- Escalations by pathway: emergent, clinic-routed, documented
- Claims generated against expected claims, and claims filed on the FQHC claim
- Blood-pressure control and A1c control among enrolled patients, against the UDS 2025 baseline of 71.79% and 18.18%
- Net to the health center per month against the $49,271 steady-state line

11. Recommendations

1. **Stand up the service line on the Medicare panel 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 $852,657 of 24-month net one month further out.
2. **Confirm the chart counts and the care-team roster in the first 30 days.** The 2,965-patient figure is the health center's own UDS count and drives every ceiling in the forecast. Chart counts by payer and the current community-health-worker and nursing roster are the two inputs that move the model most, and the roster decides how the build-on in Section 3.6 is staffed.
3. **Take the Medicare Advantage question to the plans early.** With 69.5% of the county's Medicare in Medicare Advantage, parity is the floor: plans owe at least the Medicare rate, and individual contracts set their own terms for the care-management code families. Confirm RPM, CCM and APCM terms with the dominant local plans in the first two weeks of discovery.
4. **Bill the health-center rail at national rates from the first claim.** The forecast prices at West Virginia locality 16; health-center claims pay national non-facility amounts, worth $137,250 more over 24 months, all of it net to the health center. Configure claims on the FQHC rail and capture it.
5. **Make the Williamson Memorial discharge the front door.** Wire the discharge feed first, enroll at the bedside, and bill transitional care on every discharge home to a health-center patient. TCM is in the forecast at zero dollars; every episode billed is upside, and every episode enrolled is a monitoring patient from the day they most need it.
6. **Keep the CoachCare-funded enrollment specialist in the plan.** The specialist cannot raise the ceilings, but reaches them months sooner, and is worth $531,629 of 24-month net reimbursement against the no-specialist case in the table below; without it, remote monitoring never fills inside 24 months.
7. **Apply for the Connected Care Grid money as an operator, not an aspirant.** Decide on the outpatient remote-monitoring application in the first 90 days, and take a running program with a published care-management history into it.
8. **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 and a transitional care episode after a discharge. One rule, set once in the enrollment workflow, prevents every double-billing collision the code families allow, and keeps the ACO's attribution clean.

What moves the number

Scenario	24-month net reimbursement	Net to the health center	Margin	Ceiling reached RPM / CCM / APCM
Base: 2,965 panel, 14 clinicians, 1 enrollment specialist	**$1,996,842**	**$852,657**	42.70%	M18 / M11 / M6
No on-site enrollment specialist	$1,465,213	$626,599	42.77%	never / M19 / M10
Second on-site enrollment specialist	$2,208,557	$941,907	42.65%	M13 / M8 / M5
12 referring clinicians	$1,936,802	$827,549	42.73%	M19 / M12 / M6
15 referring clinicians	$2,024,063	$864,074	42.69%	M17 / M11 / M6
Panel 2,736 (the health center's five-year Medicare low)	$1,892,370	$807,140	42.65%	M16 / M10 / M6
Panel 3,041 (the health center's five-year Medicare high)	$2,029,895	$867,061	42.71%	M18 / M11 / M6
National health-center rate rail, same census	$2,134,092	$989,907	46.39%	M18 / M11 / M6

CoachCare Value Analysis recalculations at the same pricing. The binding constraint is the size of the Medicare panel, not enrollment capacity; the enrollment specialist changes when each ceiling is reached, not where it sits.

12. What We Would Confirm Together

Every item below is a discovery question, not a condition. The forecast stands on the figures in Section 6; these are the inputs that would move it, in the order they matter.

1. **Chart counts by payer and the current care-team roster.** The Medicare chart count against the 2,965 UDS figure, and who on the current staff carries the community-health-worker, nursing and care-coordination roles the health center built.
2. **The traditional-Medicare and Medicare Advantage split of the panel.** The county runs 69.5% Medicare Advantage; the health center's own mix decides how much of the forecast rides on plan contracts.
3. **Medicare Advantage plan terms for the care-management code families.** RPM, CCM and APCM payment terms with the dominant local plans, contract by contract.
4. **The integration scope.** The Azalea Health modules in use and the interfaces available, and the hospital's own system for the discharge feed.
5. **The Connected Care Grid application.** Whether the health center or Williamson Memorial has applied to the July 2026 outpatient or inpatient remote-monitoring funding, and the application calendar.
6. **The Williamson Memorial discharge feed.** Inpatient discharges per month, the share that go home to a health-center patient, and how the discharge reaches the clinic today; this sizes the transitional care opportunity the report leaves at zero.
7. **The dual and Qualified Medicare Beneficiary share.** The 538 duals in the UDS report against the 27.3% county rate, which sets the APCM level-3 weight.
8. **Which clinicians bill on the FQHC claim.** The fourteen on the 2026 roster against the health center's own list, including any clinician who also bills under another organization.

References and Data Sources

- **HRSA Health Center Program records:** the Uniform Data System awardee page for H80CS26637 (reporting years 2021–2025, retrieved September 2026), the Health Center Service

Delivery and Look-Alike Sites file (fifteen active records), the 2026 Community Health Quality Recognition badges, and the primary-care Health Professional Shortage Area file (facility designation, score 19).

- **CMS Federally Qualified Health Center Enrollments (July 17, 2026 vintage):** twelve certification numbers under one PECOS associate identifier, including three school-based sites enrolled September–December 2025.
- **CMS Hospital Enrollments (July 31, 2026), Provider of Services file (Q2 2026) and Care Compare Hospital General Information:** Williamson Memorial, CCN 510094, short-term acute-care hospital, 76 certified beds, certified August 28, 2024; the hospital's Community Health Needs Assessment 2026–2029 (December 30, 2025) for the 18-bed inpatient unit, laboratory and imaging.
- **The health center's website,** retrieved September 2026: the locations, providers and careers pages and the site's brand assets; the EHR (Azalea Health) as stated by the health center.
- **CMS Quality Payment Program eligibility records, 2025 and 2026,** for every clinician resolving to the health center's billing organization: 22 clinicians in 2026, of whom 14 bill medical services (4 physicians, 10 nurse practitioners and physician assistants), with Qualifying APM Participant status through the health center's Medicare Shared Savings Program ACO.
- **CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024** (released May 2026): the sweep of every remote-monitoring, care-management, advanced-primary-care, transitional-care and behavioral-health-integration code across every clinician billing under the health center. CMS suppresses any provider-and-code line under 11 beneficiaries; care management billed on the health-center claim is not in this file.
- **CMS Medicare Shared Savings Program PY2026 participant file:** the health center's participation, the ACO's ENHANCED track and its low-revenue status; the ACO REACH PY2026 participant list, on which the health center does not appear.
- **The CY2025 Physician Fee Schedule Final Rule (CMS-1807-F) and CY2026 Final Rule (CMS-1832-F):** retirement of G0511; individual-code reporting for health-center care management; payment at national non-facility amounts in addition to the PPS encounter; APCM adopted for health-center payment; the CY2026 additions 99445 and 99470.
- **CY2026 Physician Fee Schedule rate files (CMS RVU26A, January 2026 release):** non-facility amounts for the eleven forecast codes, the two transitional care codes and the behavioral health integration code at West Virginia locality 16 (Rest of West Virginia; work GPCI 1.000, practice-expense 0.869, malpractice 1.431), and the national-rate comparison producing the +$137,250 differential.
- **CMS Medicare Advantage State/County Penetration, September 2026, and CMS Medicare Monthly Enrollment, CY2024:** Mingo County's 6,486 eligibles and 69.5% MA penetration; Pike County, Kentucky, 66.6%; 6,571 beneficiaries with 1,797 (27.3%) dual-eligible.
- **U.S. Census Bureau American Community Survey 2024 five-year estimates** (profiles DP02, DP03 and DP05), Mingo County, West Virginia: population, age, poverty, disability, income, language and insurance coverage.
- **West Virginia Medicaid:** the Bureau for Medical Services physician (RBRVS) fee schedule effective April 1, 2026 through March 31, 2027 (remote monitoring, chronic care management, principal care management, behavioral health integration and advanced primary care management not covered; transitional care management covered); Provider Manual Chapter 522 (FQHC and RHC services) and Policy 519.17 (telehealth).
- **Rural Health Transformation Program records:** the CMS fifty-state award announcement of December 29, 2025; the CMS-published West Virginia project abstract (January 5, 2026) naming the Connected Care Grid; the West Virginia Department of Health program FAQ (April 2026); and

the Governor's July 30, 2026 announcement of about $14 million of remote-monitoring funding, $9.1 million of it outpatient.

- **The published evaluation of the health center's community-health-worker chronic care management model,** Preventing Chronic Disease, 2020, volume 17, on data from May 2017 to September 2019; and the federally funded rural care-coordination program evaluation brief covering 2015–2018. Cited by journal and program, not by author.
- **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.
- **CoachCare Azalea Health integration overview:** integrated ordering and enrollment, enrollment status in the clinical workflow, integrated vital reports, monthly evidence-of-care and care-plan documents, and automated claim generation through the CoachCare billing engine.
- **CoachCare Value Analysis for Williamson Health & Wellness Center, 2026, and the CY2027 repricing of the same forecast:** every financial, enrollment, clinical-output and operational figure in Sections 2, 6, 9, 10 and 11, built on 2,965 Medicare patients in scope, 14 referring clinicians, one on-site enrollment specialist, and CY2026 non-facility fee schedule rates at West Virginia locality 16 for RPM, CCM and APCM.

How this report counts

Patients and program enrollments are different numbers. At M24 the program holds 1,342 active program enrollments belonging to 875 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 the health center's own. Health-center visits bill on the FQHC claim rather than under individual clinicians, so clinician-level Medicare claims files structurally undercount a health-center panel. The 2,965-patient figure is the Medicare count the health center reported to HRSA for 2025, and the first implementation step compares it with chart counts by payer.

No individual is named anywhere in this report. Governance, leadership, clinician composition, ACO participation and published research are described by count, role, organization and journal only.