Proposed CY 2027 Physician Fee Schedule

Tuesday, August 18, 2026 | 2:00 p.m. ET

Partnership to Align Community Care

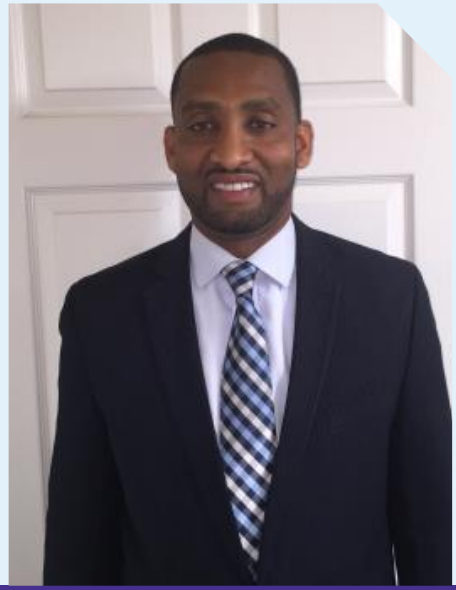
Reimbursement Pathways for Whole Person Health

Today we'll hear from...

June Simmons

Co-Chair, **Partnership to Align Community Care**

CEO, **Partners in Care Foundation**



Tim McNeill

Co-Chair, **Partnership to Align Community Care**

CEO, **Freedmen's Health Consulting**

Today's Agenda

Link to Resource Brief: https://bit.ly/4vUfkA2

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Welcome	**Proposed CY 2027 Medicare Physician Fee Schedule**	**Opportunities for Advocacy**	**Hearing from You**
Updates from the Partnership and Current Resources	What's new and why is it important for CBOs, CCHs and their partners	Why your voice matters and next steps	Q & A Upcoming opportunities to get involved

Who is the Partnership to Align Community Care?

The *Partnership to Align Community Care* (Partnership) is a learning, sharing, and cross-sector change collaborative advancing and scaling sustainable community care delivery systems leveraging community care hubs (CCHs) to promote whole-person health.

Co-Designing Solutions Leveraging CCHs to Promote Whole-Person Health

Building Awareness

Engage cross-sector stakeholders to increase formal endorsement and promotion of the CCH model nationally.

Advancing CCH Maturity

Accelerating the adoption of core CCH functions, aligning service standards, and testing shared measures to strengthen cross-sector collaboration

Increasing CCH Network Readiness

Increasing the readiness of CBOs to become contracted CCH Network partners

Expanding Clinical Integration

Addressing billing and coding pathways and advancing alternative payment arrangements to support CCH-delivered services

Learn | Share | Verify

PARTNERSHIP STEERING COMMITTEE
Guide coalition strategy, annual goals, governance, work groups, and Partnership staff.

PARTNERSHIP LEARNING & PRACTICE COLLABORATIVE
Cross-sector collaborative to co-design and scale aligned, sustainable care delivery through CCHs.

CCH MATURITY ADVANCEMENT
Expand the national CCH Collaborative to adopt core functions, align standards, test measures, and strengthen cross-sector scale.

NETWORK PARTNER READINESS
Prepare CBOs for CCH contracts with risk and readiness tools, technical assistance, and workforce-informed supports.

HEALTH & CCH INTEGRATION ALLIANCE
Secure formal endorsement of the CCH model through public commitments, aligned funding, referrals, policy, and procurement.

CLINICAL BILLING STRATEGY TEAM
Advance billing and coding pathways, CMS code use, and alternative payment models for CCH services.

ADVANCED CCH TASK FORCE
Provide practical guidance to make core CCH services scalable and sustainable and inform Health @ Home expansion.

Longstanding Leadership Informing Reimbursement Opportunties to Promote Whole-Person Health

- Leading advocacy and comment responding to payment policy updates for whole-person health services addressing upstream drivers of health since 2023.
- Developing and promoting implementation resources and peer learning opportunities
- Coordinating with federal leaders and partners to inform annual policy updates and identify technical assistance needed

Resources Available: https://www.partnership2acc.org/resources

More than 150 Individual and Organization Members to Date!

Learn More and Sign Up! https://www.partnership2acc.org/join-the-partnership

- 211 LA
- A.B.L.E Community Development Foundation
- A2 Associates
- Access Health
- ADKL Consulting
- Age Well at Home
- ARCHI (Atlanta Regional Collaborative for Health Improvement)
- Area Agency on Aging, Region X
- Aroostook Agency on Aging
- Bay Aging/VAAACares
- C3 Consultancy Services LLC
- Camden Coalition
- Care First Education LLC
- CB Health Strategies
- Cedars-Sinai
- Center for Health and Research Transformation
- Comagine Health
- Combined Entity – Finger Lakes Performing Provider System (FLPPS), Common Ground Health, Rochester RHIO
- Community Ally Services
- Community Care of the Lower Cape Fear
- Community ConneXor
- Community Well California
- Constellation Quality Health
- Creighton University – Center for Promoting Health and Health Equity
- Florida Community Health Worker Coalition
- FMMS Association of Empowered Healthcare Professionals
- Food Bank Council of Michigan
- Geisse Collaborative
- Good Seed Community Development Corporation
- HC2 Strategies Inc.
- Health and Welfare Council of Long Island
- HealthierHere
- High Country Area Agency on Aging
- ILS
- Inclusive Alliance IPA Inc
- Juniper
- Kalaya's Destiny
- Mid-America Regional Council (MARC)
- Mission Analytics Group
- Myers Consulting, LLC
- NACHC
- National Association of ACOs
- Ohio Assoc of Area Agencies on Aging
- Open REferral
- Pathways Community HUB Institute
- Phyllis Gunning, LLC
- Southwest Colorado Cares
- Southwest Community Care Partners
- Spotlight Hope Project
- SquareOne Affordable Housing Advocacy and Consultant
- Stratis Health (Rural Health Value)
- Susan Buell Consulting LLC
- Tabor Children's Services, inc.
- The Arc of Evansville
- The Health Collaborative – Cincinnati, OH
- UCPCOG AAA
- Uncommon Solutions Inc.
- University of Iowa (Rural Health Value)
- Western New York Integrated Care Collaborative

Discussion...

CY2027 Medicare Physician Fee Schedule Proposed Rule – Health Coaching Codes Overview

Timothy P. McNeill, RN, MPH

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Health Coaching Benefit Overview

- CMS proposes to establish the first-of-its-kind Medicare Part B pathway for health coaching.
- Eligible Medicare providers can deliver health coaching if there has been an initiating visit with a Medicare beneficiary.
- Medicare Providers can contract with Community Care Hubs and CBOs to delivery health coaching, incident-to general supervision of the provider.
- Training to provide ACL Title III-D evidence-based programs is a qualifying credential for a health coach.

What the Proposed Rule Establishes

Codes, valuation, workforce, supervision, and explicit recognition of CBOs and CCHs.

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Three Health & Well-Being Coaching Codes

0591T

Individual — Initial Assessment

60–90 minutes

Face-to-face or telehealth; billed per session

0592T

Individual — Follow-Up

At least 30 minutes

Repeatable within the month; no frequency cap

0593T

Group (2+ individuals)

At least 30 minutes

Billed once per participant in the group

Category III CPT codes. CMS is proposing national pricing and conditions of payment — and is soliciting comment on converting them to HCPCS G-codes for CY 2027.

Key Advocacy Issue: Codes

- CMS is requesting input as regarding the use of the temporary CPT codes or establishing a new permanent HCPCS codes for Health Coaching.
- Risk:
  - Using a temporary code established by AMA runs the risk of the benefit considered temporary by payers.
  - Some payer systems cannot reimburse claims submitted with temporary codes.
  - Use of a temporary code as a final rule will disqualify some Medicare Advantage plans from reimbursing the service.
- Recommendation:
  - Strongly recommend creating a new set of HCPCS codes for Health Coaching.

How the Services Are Valued

PROPOSED CODE		CROSSWALKED TO		WORK RVU
0591T	→	99490	Chronic Care Management (base)	1.00
0592T	→	99439	CCM — each additional 20 min	0.70
0593T	→	G0109	Group Diabetes Self-Management Training	0.23

No frequency limits
Multiple sessions in a calendar month are billable when reasonable and necessary.

Telehealth-eligible
All three codes are on the Medicare Telehealth Services List.

Like CCM
Valued as visit-based services performed under general supervision.

Key Advocacy Issue: Relative Value Unit (RVU) Analysis

- CMS proposes to crosswalk the value the health coaching individual codes to the chronic care management codes (99490 & 99439).
- Group Health Coaching cross walked to the group DSMT (diabetes self-management training – G0109)
- Recommendation:
  - Strongly advocate for the crosswalk of the health coaching codes to the chronic care management codes.
  - Strongly advocate for the crosswalk of the group health coaching to the group DSMT code RVU.
  - This crosswalk value adequately assesses the true cost to implement health coaching relative to the cost of implementing chronic care management.

Key Advocacy Issue: Frequency Limits

- CMS proposes that there should be no frequency limits or caps on health coaching sessions, if the services are reasonable and necessary.
- Recommendation:
  - Strongly advocate for no frequency limits or caps on services as long as reasonable and necessary.

Key Advocacy Issue: Telehealth Eligible

- The health coaching codes are currently listed in the Medicare Telehealth Services List. However, the Medicare Telehealth Services list includes the temporary CPT codes for Health Coaching.
- Recommendation:
  - Strongly endorse the need for health coaching to be an allowable telehealth service.
  - Recommend that CMS create new permanent HCPCS codes for health coaching and list the new HCPCS codes in the Medicare Telehealth Services list.

Who May Deliver: The ACL Training Credential

Coaches (auxiliary personnel) may qualify through recognized standards:

- National Board for Health & Wellness Coaching (NBHWC)
- NCHEC — Certified Health Education Specialist (CHES)
- AHNCC — Certified Nurse Coach standards

— OR —

Training received through ACL-overseen Older Americans Act evidence-based programs qualifies coaches.

Your CDSMP, DSMP, Stepping On, Matter of Balance, and EnhanceFitness delivery infrastructure becomes a **coach-credentialing engine.**

Key Advocacy Issue: Training Requirement

- CMS proposes that one pathway to deem a Health Coach qualified to provide health coaching is completion of training for an ACL-Evidence-based program.
- Recommendation:
  - The formal recognition of training to deliver ACL evidence-based programs is a monumental achievement. We highly endorse this decision and want this to become final.
  - This decision also deems ACL evidence-based programs as qualifying programs for a Health Coaching intervention.

ACL Title III-D Evidence-Based Program Definition

- The definition we use for Title IIID is here:

https://acl.gov/programs/health-wellness/disease-prevention.

- **ACL Definition of Evidence-Based Programs**
  - Demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability and/or injury among older adults; *and*
  - Proven effective with older adult population, using Experimental or Quasi-Experimental Design;* *and*
  - Research results published in a peer-review journal; *and*
  - Fully translated** in one or more community site(s); *and*
  - Includes developed dissemination products that are available to the public.

**Experimental designs use random assignment and a control group. Quasi-experimental designs do not use random assignment.*

***For purposes of the Title III-D definitions, being "fully translated in one or more community sites" means that the evidence-based program in question has been carried out at the community level (with fidelity to the published research) at least once before. Sites should only consider programs that have been shown to be effective within a real-world community setting.*

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Community-Based Delivery & Explicit Recognition

General supervision for CBO-employed coaches

Permits delivery in homes, senior centers, and over telehealth — the only model that is operationally viable for aging-services delivery, and a departure from the direct-supervision default.

Watch: the rule is internally inconsistent on supervision — a priority comment point.

CMS names your constituency

- Community care hubs
- Area agencies on aging
- Centers for independent living
- Aging & disability resource centers
- Other non-profits receiving ACL grants

Key Advocacy Issue: General Supervision

- General Supervision: Under the Centers for Medicare & Medicaid Services (CMS), general supervision means a procedure or service is furnished under a physician's overall direction and control, but the physician's physical presence is not required during the performance of the procedure.
- CMS proposes General Supervision but makes reference to Direct Supervision.
- Recommendation:
  - Strongly advocate for General Supervision in the Final rule.
  - General Supervision will allow for the delivery of group health coaching services in community setting in alignment with Title III-D evidence-based program delivery.

The Reimbursement Economics

What the crosswalks and the proposed CY 2027 conversion factor imply for your programs.

The Reimbursement Economics

~$65

per initial session

0591T · 60–90 min

~$50

per follow-up session

0592T · repeatable, no cap

~$16

Per person in the group

0593T · once per person

The group code is where the EBP model scales. A six-session workshop delivered to 10–12 participants converts a single grant-funded class into a stack of individually reimbursable encounters — the geometry that makes Title III-D delivery self-sustaining.

Figures are illustrative — based on the proposed crosswalks and CY 2027 conversion factor (~$33) in current-year terms. Confirm against the published final rule and GPCI before financial planning.

Anywhere CCH CDSMP Program Revenue (Potential Collected from Medicare for Services: 2027)

Program	Code	Reimbursement	Qty	Total	Medicare Collection
CDSMP (Ind)	0591T	$65.00	Ea/30 min (1 Units)	$65.00	80% = $52.00
CDSMP (Ind. Follow-up)	0592T	$50.00	Ea/30 min (1 Unit)	$50.00	80% = $40.00
CDSMP (Group 15 hrs)	0593T	$16.00	Ea/30 min (30 Units)	$480.00	80% = $384.00
Grand Total (Ind.)				***$595.00***	***$476.00***
Total for Group (12)				***$7,140.00***	***$5,712.00***

Opportunities, Barriers, & the Path Forward

Opportunities for Community Care Hubs and the Aging Network.

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Implementation Opportunities for Title III-D Grantees

1

Credential without new cost

Coaches qualify through ACL programs you already operate.

2

Community & home delivery is billable

General supervision enables the field-based model.

3

The group code fits the workshop

Multi-session EBP curricula align with per-participant billing.

4

Telehealth reach

All three codes are telehealth-eligible; audio-only is in play.

5

A defined role for the hub

Employ coaches, hold the contract, run the infrastructure.

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Structural & Financial Barriers

1

No direct CBO/CCH billing

Incident-to: an enrolled practitioner submits the claim and receives payment. Your revenue comes through a fair-market-value contract — address anti-kickback, Stark, and fee-splitting deliberately.

2

Incident-to clinical prerequisites

The beneficiary must be an established patient under a physician-established plan of care into which coaching is integrated — requiring a bidirectional referral-and-attribution workflow.

3

Braided funding & non-duplication

Title III-D dollars cannot pay for a service billed to Medicare. A clean cost-allocation methodology must segregate grant-funded from billable encounters.

4

Favorable provisions not yet final

The general-supervision carve-out and ACL credential are proposed; they must be defended during the comment period.

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Operational & Compliance Barriers

5 **Documentation & audit exposure**
Time-based codes need contemporaneous time logs, consent, and a care plan — in a high-scrutiny incident-to context. The hub must supply the infrastructure.

6 **Coach credential verification**
“Trained through an ACL program” is a category, not a roster — document each coach's qualifying training and press CMS to enumerate the programs.

7 **Beneficiary cost-sharing**
20% Part B coinsurance applies — a deterrent for low-income elders, mitigated only by dual/QMB status or Medigap.

8 **Coaching vs. EBP-delivery gap**
The code defines individualized coaching; whether a fidelity-bound workshop is billable coaching should be clarified in comment.

9 **Category III durability & MA**
Temporary codes; the G-code question is open, and Medicare Advantage recognition varies plan by plan.

Cost Sharing

- All Medicare Part B services have a cost sharing requirement (80%), with the exception of those that have specific preventive services rated "A" or "B" by the U.S. Preventive Services Task Force.
- The beneficiary is required to pay the 20% co-insurance. However, if the beneficiary has a secondary policy, then the payment can be obtained from the secondary policy.
- The 20% cost sharing requirement cannot be waived. The provider must attempt to collect. If the beneficiary is not able to pay – after being asked to pay – the provider can provide the service, and the uncollectible amount becomes bad debt.

Secondary Policy Penetration

- According to recent data from the Kaiser Family Foundation, 91% of Medicare FFS beneficiaries have a secondary insurance policy.
  - Medigap plan
  - Employer-sponsored plan
  - Retiree plans
  - Tricare for Life (Military)
  - Medicaid (Duals)

- Reference: https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/

Next Steps

- The Partnership will draft a formal response to the CMS proposed rules.
- The deadline to submit comments is September 14, 2026.
- We are compiling input from interested parties to formalize a final comment letter.
- Please share your feedback and thoughts regarding the proposed Health Coaching codes.
- Final Rules will be issued early November.
- Final Rules become active January 1, 2027.
- Begin implementing all final rules 2027.

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Thank You
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Stay tuned for updates from Partnership!

CY 2027 Medicare Physician Fee Schedule Proposed Rule

Important comment opportunity!

- CMS is proposing a Medicare Part B payment pathway for health and well-being coaching that names community-based organizations (CBOs) and community care hubs (CCHs) by role and accepts training delivered through the ACL OAA evidence-based programs as a qualifying coach credential.
- **Stay tuned for template language and a sign-on opportunity responding to CMS proposed rule from Partnership**

Download Overview of Proposed Changes: https://bit.ly/4vUfkA2

Check Out Our NEW CCH Resource Map!

- ✓ A centralized repository to help you easily locate and access critical CCH tools, templates, and guidance!
- ✓ Sourced from trusted national, state, and local partners!
- ✓ Whether you are learning the basics, building new partnerships, or managing advanced operations, you can easily find:
  - Foundational hub overviews & governance frameworks
  - Financial modeling tools
  - Implementation resources for navigating Medicare billing and coding pathways

Learn More:
https://www.partnership2acc.org/cch-journey-map

PRE-CONFERENCE OPPORTUNITY

Leading and sustaining hubs in a changing environment

Tuesday, October 13, 2026

1-4 pm PT

Oakland Marriott City Center
Oakland, CA

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THANK YOU!

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