Exploring Reimbursement Pathways for Whole Person Care

October 29, 2025 | 3:30-4:30 PM ET

Partnership to Align Social Care
A National Learning & Action Network

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS®

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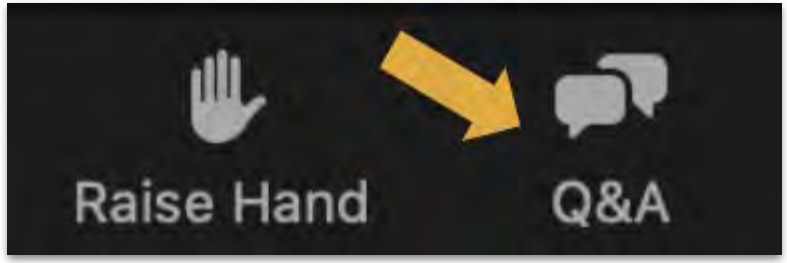
spring street exchange

Administrative Notes

- This webinar is being recorded. The recording and slides will be shared with all registrants



- Please use the Q&A tab at the bottom of your screen and we'll try address as many questions as possible at the end of the panel discussion

- Closed captions are provided for this session, can also click "Show Captions" to display automated captions

Speakers

June Simmons, CEO
Partners in Care Foundation

Tim McNeill, CEO
Freedmen's Health Consulting

Gervean Williams,
Director, Finance Training and Technical Assistance, National Association of Community Health Centers (NACHC)

David Crocker, Director, Community Care and Home Based Services,
SARCOA, Area Agency on Aging

Chris Detter, Director
Southeast Health Statera Network

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Advancing a Proven Model at a National Level

National coalition advancing scalable, sustainable systems that integrate healthcare and social care through Community Care Hubs led by trusted community-based organizations.

June Simmons

President and CEO,
Partners in Care Foundation

Co-Chair,
Partnership to Align Social Care

Federal healthcare cuts could affect coverage for millions of Californians, state officials say

SNAP recipient Rachel Dorame, 41, and her granddaughter Celeste Herrera, 4 months old, look over free clothing

Subscribers are Reading ›

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Melanie Winter, who fought for embracing nature along the Los Angeles River, dies

Why Elias Redlew is a three-sport standout at San Pedro High

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Nine concerns the Dodgers should have about facing the Blue Jays in the World Series

https://www.latimes.com/california/story/2025-10-28/federal-healthcare-cuts-will-cause-millions-of-californians-to-lose-coverage-state-officials-say

Mission

Partners in Care FOUNDATION

To improve health outcomes by bridging healthcare and community-based services- empowering people to live safely, heal fully, and thrive

$21 Million+

Through our Community Care Hub, local partners accessed reimbursement in 2024—fueling community-based care and reinvesting dollars directly into the communities they serve

The Challenge: Fragmented Social and Health Services

Resource Barriers

Smaller community-based organizations often lack the resources to contract directly with healthcare payers or manage complex billing and data requirements

Disconnected Care

Fragmented services create inefficiencies, duplication of efforts, and critical gaps in care for vulnerable populations

The Solution

Community Care Hubs create a unified, scalable infrastructure to overcome these systemic barriers

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Lessons From Partners' Experience

- Targeting high-risk populations helps make interventions more cost-neutral and reduces overall cost of care
- Changing behavior—both individual and system-level—is challenging but essential

Bridging Hope When Care Can't Wait

- The uncertainty is where Partners steps in (HCBA & the HUB)

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CHI Benefit Overview and Sample Application

Timothy P. McNeill, RN, MPH

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FREEDMEN'S MEDICINE

HEALTH IS FREEDOM

Clear Pathway to CHW/Navigator Reimbursement

CMS CY2024 Physician Fee Schedule

- Landmark Final Rule creates the first of its kind pathway for reimbursement for Community Health Worker labor in the Medicare program.
- **Effective Date: January 1, 2024**
- Part B benefit which applies to persons in **Original Medicare, MA, & Special Needs Plans.**
- Applies to all Medicare Part B providers to include FQHCs & RHCs.
- Not included in the FQHC PPS or RHC AIR Rate.

Community Health Integration Services

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CHI Services List		
Person-Centered Assessment	Facilitating patient-driven goal setting	Providing tailored support
Practitioner, HCBS Coordination	Coordinating receipt of needed services	Communication with practitioners, HCBS providers, hospitals, SNFs
Coordination of care transitions	Facilitating access to community-based social services	Health education
Building patient self-advocacy skills	Health care access / health system navigation	Facilitating behavioral change
Facilitating and providing social and emotional support	Leveraging lived experience when applicable	

New Healthcare Common Procedure Coding System (HCPCS) Billing Codes for Health Equity Services

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	Community Health Integration (CHI)	Principal Illness Navigation (PIN)	Principal Illness Navigation – Peer Support (PIN-PS)
Service			
Purpose	Reimbursement for labor expended to **address Health-Related Social Needs (HRSNs)**	Reimbursement for providing health navigation services for persons with a **serious, high-risk condition that will last at-least 3 months**	Reimbursement for providing Peer Support Services to persons with a **behavioral health need** or **substance use disorder**
Personnel	Community Health Workers, Health Coaches, Social Workers, RDs, Nurses, and other trained staff	*Health navigators and other trained staff*	Peer support workers **(according to SAMSHA National Model Standards)**

CHI HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0019	Community Health Integration Services (CHI) SDOH 60 min	$77.96	$47.55
G0022	Community Health Integration Services (CHI); add ea. 30 min	$48.52	$33.32

PIN HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0023	PIN Service, 60 minutes per month	$77.96	$47.55
G0024	PIN Service, add ea. 30 min	$48.52	$33.32

PIN-PS HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0140	PIN-Peer Support, 60 minute	$77.96	$47.55
G0146	PIN-PS, Peer Support, add ea. 30 min	$48.52	$33.32

***Rates listed are the National Rate, effective <u>January 1, 2025</u>**

Billing and Sustainability

- G0019: Billed for the first hour = $77.96
- G0022: One Unit Billed for every 30 minutes after the first hour, per calendar month = $48.52

Billed with No Cap or Limit per Calendar Month, as long as medically necessary

- Total for 2 labor hours = $175.00
- Total for 3 labor hours = $272.04
- Total for 4 labor hours = $369.08
- Total for 5 labor hours = $466.12

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

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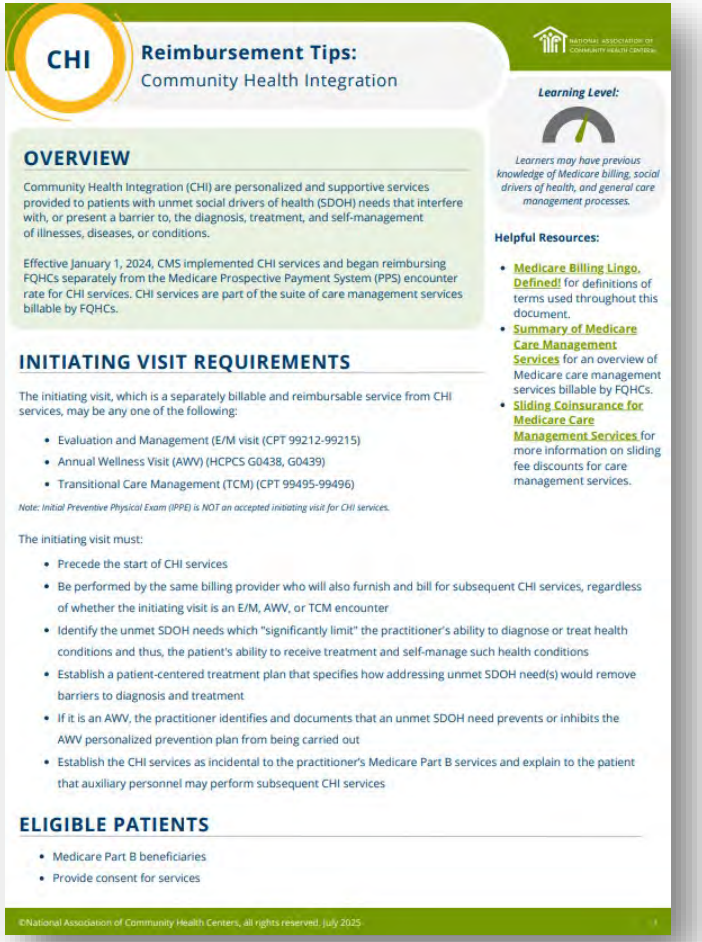
Community Health Integration



CHI

Reimbursement Tips:
Community Health Integration

Learning Level:

Learners may have previous knowledge of Medicare billing, social drivers of health, and general care management processes.

OVERVIEW

Community Health Integration (CHI) are personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.

Effective January 1, 2024, CMS implemented CHI services and began reimbursing FQHCs separately from the Medicare Prospective Payment System (PPS) encounter rate for CHI services. CHI services are part of the suite of care management services billable by FQHCs.

Helpful Resources:

- Medicare Billing Lingo, Defined! for definitions of terms used throughout this document.
- Summary of Medicare Care Management Services for an overview of Medicare care management services billable by FQHCs.
- Sliding Coinsurance for Medicare Care Management Services for more information on sliding fee discounts for care management services.

INITIATING VISIT REQUIREMENTS

The initiating visit, which is a separately billable and reimbursable service from CHI services, may be any one of the following:

- Evaluation and Management (E/M visit (CPT 99212-99215)
- Annual Wellness Visit (AWV) (HCPCS G0438, G0439)
- Transitional Care Management (TCM) (CPT 99495-99496)

Note: Initial Preventive Physical Exam (IPPE) is NOT an accepted initiating visit for CHI services.

The initiating visit must:

- Precede the start of CHI services
- Be performed by the same billing provider who will also furnish and bill for subsequent CHI services, regardless of whether the initiating visit is an E/M, AWV, or TCM encounter
- Identify the unmet SDOH needs which "significantly limit" the practitioner's ability to diagnose or treat health conditions and thus, the patient's ability to receive treatment and self-manage such health conditions
- Establish a patient-centered treatment plan that specifies how addressing unmet SDOH need(s) would remove barriers to diagnosis and treatment
- If it is an AWV, the practitioner identifies and documents that an unmet SDOH need prevents or inhibits the AWV personalized prevention plan from being carried out
- Establish the CHI services as incidental to the practitioner's Medicare Part B services and explain to the patient that auxiliary personnel may perform subsequent CHI services

ELIGIBLE PATIENTS

- Medicare Part B beneficiaries
- Provide consent for services

Reimbursement Tip Sheet: Community Health Integration

Personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.

Services may be billed once per calendar month after at least **60 minutes** of services, including:

- Patient-centered assessment
- Coordination with home- and community-based resources
- Health education
- Developing self-advocacy skills
- Health care access and navigation
- Patient behavioral change facilitation
- Facilitate and provide social and emotional patient support

Examples of auxiliary personnel who can provide services under the supervision of an authorized billing provider:

Certified or trained:

- Community Health Workers
- Nurses (nurse care manager, CNS, RN, LPN)
- Social Workers

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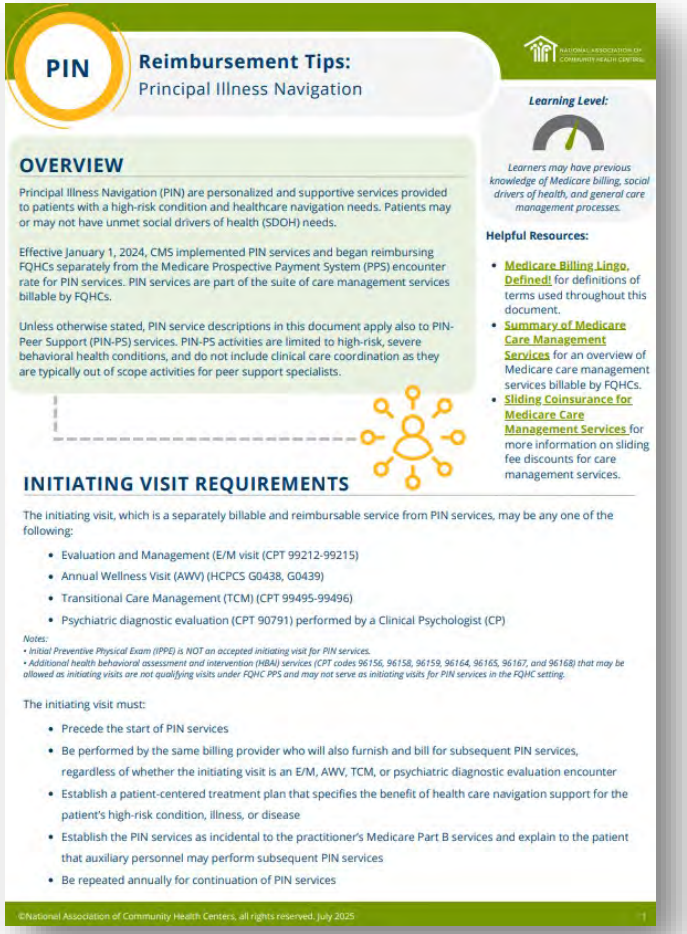
Principle Illness Navigation



PIN

Reimbursement Tips:
Principal Illness Navigation

Learning Level:

Learners may have previous knowledge of Medicare billing, social drivers of health, and general care management processes.

OVERVIEW

Principal Illness Navigation (PIN) are personalized and supportive services provided to patients with a high-risk condition and healthcare navigation needs. Patients may or may not have unmet social drivers of health (SDOH) needs.

Effective January 1, 2024, CMS implemented PIN services and began reimbursing FQHCs separately from the Medicare Prospective Payment System (PPS) encounter rate for PIN services. PIN services are part of the suite of care management services billable by FQHCs.

Unless otherwise stated, PIN service descriptions in this document apply also to PIN-Peer Support (PIN-PS) services. PIN-PS activities are limited to high-risk, severe behavioral health conditions, and do not include clinical care coordination as they are typically out of scope activities for peer support specialists.

Helpful Resources:

- Medicare Billing Lingo, Defined! for definitions of terms used throughout this document.
- Summary of Medicare Care Management Services for an overview of Medicare care management services billable by FQHCs.
- Sliding Coinsurance for Medicare Care Management Services for more information on sliding fee discounts for care management services.

INITIATING VISIT REQUIREMENTS

The initiating visit, which is a separately billable and reimbursable service from PIN services, may be any one of the following:

- Evaluation and Management (E/M visit (CPT 99212-99215)
- Annual Wellness Visit (AWV) (HCPCS G0438, G0439)
- Transitional Care Management (TCM) (CPT 99495-99496)
- Psychiatric diagnostic evaluation (CPT 90791) performed by a Clinical Psychologist (CP)

Notes:
• Initial Preventive Physical Exam (IPPE) is NOT an accepted initiating visit for PIN services.
• Additional health behavioral assessment and intervention (HBAI) services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168) that may be allowed as initiating visits are not qualifying visits under FQHC PPS and may not serve as initiating visits for PIN services in the FQHC setting.

The initiating visit must:

- Precede the start of PIN services
- Be performed by the same billing provider who will also furnish and bill for subsequent PIN services, regardless of whether the initiating visit is an E/M, AWV, TCM, or psychiatric diagnostic evaluation encounter
- Establish a patient-centered treatment plan that specifies the benefit of health care navigation support for the patient's high-risk condition, illness, or disease
- Establish the PIN services as incidental to the practitioner's Medicare Part B services and explain to the patient that auxiliary personnel may perform subsequent PIN services
- Be repeated annually for continuation of PIN services

Reimbursement Tip Sheet: Principal Illness Navigation

Personalized and supportive services provided to patients with a high-risk condition and healthcare navigation needs.

Services may be billed once per calendar month after at least **60 minutes** of services, including:

- Patient-centered assessment or interview
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
- Health education
- Developing self-advocacy skills
- Health care access/health system navigation
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
- Facilitating and providing social and emotional support

Examples of auxiliary personnel who can provide services under the supervision of an authorized billing provider:

Certified or trained:

- Community Health Workers
- Nurses (nurse care manager, CNS, RN, LPN)
- Social Workers
- Peer support specialists

Priority Population for Replicating a National Model

Dual Eligible Medicare Beneficiaries in Original Medicare

- Duals represent a priority population to test a regional implementation strategy.
- [4]Who are the Duals?
  - **12.3 Million** people are dually enrolled in Medicare and Medicaid.
  - 49% of Duals are in Fee-For-Service (FFS) Medicare.
  - Disproportionate financial impact on CMMI Alternative Payment Model Participant Shared Savings.
  - Eligibility requirement to be a Dual Eligible:
    - **Aged or Disabled and living at poverty.**

[4]CMS. Medicare Medicaid Coordination Office. Fact Sheet. *People Dually Eligible for Medicare and Medicaid.* 2019. 2025.

Disease Burden and of Duals

- [4]CMS Medicare Medicaid Coordination Office Data (MMCO) Data
  - 49% of Duals receive long-term services and supports (LTSS)
    - CHI/PIN supporting access to Medicaid LTSS
    - Medicaid LTSS: PCA, Homemaker, Home-Delivered Meals, Respite, Adult Day Health, ETC.
  - 60% have 2+ chronic conditions
    - Opportunity for evidence-based disease self-management interventions
  - 27% have 6+ chronic conditions
    - Health Navigation to address greater disease burden
  - 41% have at least one mental health diagnosis
    - Peer Support Services and Collaborative Care to address co-morbid behavioral health and SUD

[4]CMS. Medicare Medicaid Coordination Office. Fact Sheet. *People Dually Eligible for Medicare and Medicaid.* 2019. 2025.

Care Coordination Needs of Duals

- [4]CMS Medicare Medicaid Coordination Office Data on Care Coordination Needs
- Beneficiaries must navigate multiple systems to access care:
  - Medicare Part A for hospital services, home health, and hospice.
  - Medicare Part B for prevention, primary care, and other outpatient services.
  - Medicare Part D for prescription drugs.
  - Medicaid for behavioral health and Medicare cost sharing.
  - Medicaid LTSS for long-term care needs in community settings.
  - Community Access to Support Services
    - Senior Centers, Meals on Wheels, Congregate Meals, AAA Programs, CIL Services

[4]CMS. Medicare Medicaid Coordination Office. Fact Sheet. *People Dually Eligible for Medicare and Medicaid.* 2019. 2025.

Medicare Care Management Services

- Chronic Care Management (CCM)
  - Priority Population: Persons with 2+ chronic conditions
- Collaborative Care Management (CoCM)
  - Priority Population: Persons with a behavioral health comorbidity
- Community Health Integration (CHI)
  - Priority Population: Persons with an Upstream Driver of Health or Health-Related Social Need
- Principal Illness Navigation (PIN)
  - Priority Population: Persons with a serious, high-risk condition that needs navigation services
- Principal Illness Navigation - Peer Support (PIN-PS)
  - Priority Population: Persons with a behavioral health condition or substance use disorder

- *The Care Management codes allow for concurrent billing.

Medicare Payment Pathways for Disease Prevention Services

- Evidence-Based Program Reimbursement Opportunities
  - DSMT (Diabetes Self-Management Training)
    - Priority Population: Diabetes
  - MNT (Medical Nutrition Therapy)
    - Priority Population: Diabetes and Chronic Kidney Disease
  - MDPP (Medicare Diabetes Prevention Program)
    - Priority Population: Prediabetes
  - HBAI (Health Behavior Assessment and Intervention)
    - Chronic Conditions

Impact of the One Big Beautiful Bill (OBBB) Act

- Medicaid Recertification
  - Mandates States to conduct Medicaid recertification for adults every six months starting CY2027
  - For individuals with work requirements, verification will be needed at application and then every six (6) months
- SNAP Work Recertification
  - Older Adults aged 55 to 64 (Disabled Medicare Beneficiaries) are subject to new time-limited work requirements
  - Increased administrative burden to file for exemptions

Impact on Medicare Advantage and D-SNPs

- Identify Priority Population
  - Dual Eligible Members
  - Low-Income Subsidy (LIS) Members
- Develop targeted strategies that include the following elements:
  - Providers: Redesign care delivery to focus on care coordination for priority populations.
  - CCHs/CBOs: Increased support with Medicaid recertification, SNAP benefit management and blending and braiding resources to address identified needs of the population.

CHI Case Study

CHI Services: Introducing Beneficiary

Monica is a 61-year-old disabled woman experiencing food insecurity & enrolled in a D-SNP. She resides in a HUD-supported apartment w/ mild dementia. Admitted for complications related to diabetes and requires in-home supports to transition home.

*Must recertify for Medicaid to maintain enrollment in D-SNP and transition supports.

Community Care Hub CHW

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- Monica must recertify for Medicaid to enroll in LTSS for home-delivered meals and in-home aide services.
- Recertification: Proof of Social Security Income
  - Lost Real ID
  - Without Real ID cannot obtain social security statement or replacement social security card.
  - Without Social Security card, cannot obtain replacement Real ID.
  - Limited Mobility to address identity requirements.
- **Solution:** Certified Medical Records can be used to obtain birth certificate. Birth certificate and medical records can be used for ID at SSA to obtain SS Card and SS benefit statement.

Implementation Free Resources

- www.communityhealthintegration.info
- Several New Implementation Resources Posting this week!
- Free Implementation Resources including:
  - Sample Contract Agreement (Clinic – CBO)
    - https://communityhealthintegration.info/sample-cbo-contract/
  - Sample Process Flows
    - https://communityhealthintegration.info/process-flow/
  - Many more implementation support resources
    - www.communityhealthintegration.net

FREEDMEN'S MEDICINE
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Community Care SOLUTIONS

Intro To SARCOA & Community Care Solutions

SARCOA
healthy · active · home

Community Care SOLUTIONS

Community Care Solutions
Community Care Hub

- **Improving Care Management and Coordination thru healthcare integration**
- **Facilitating Contracting with Healthcare Community**

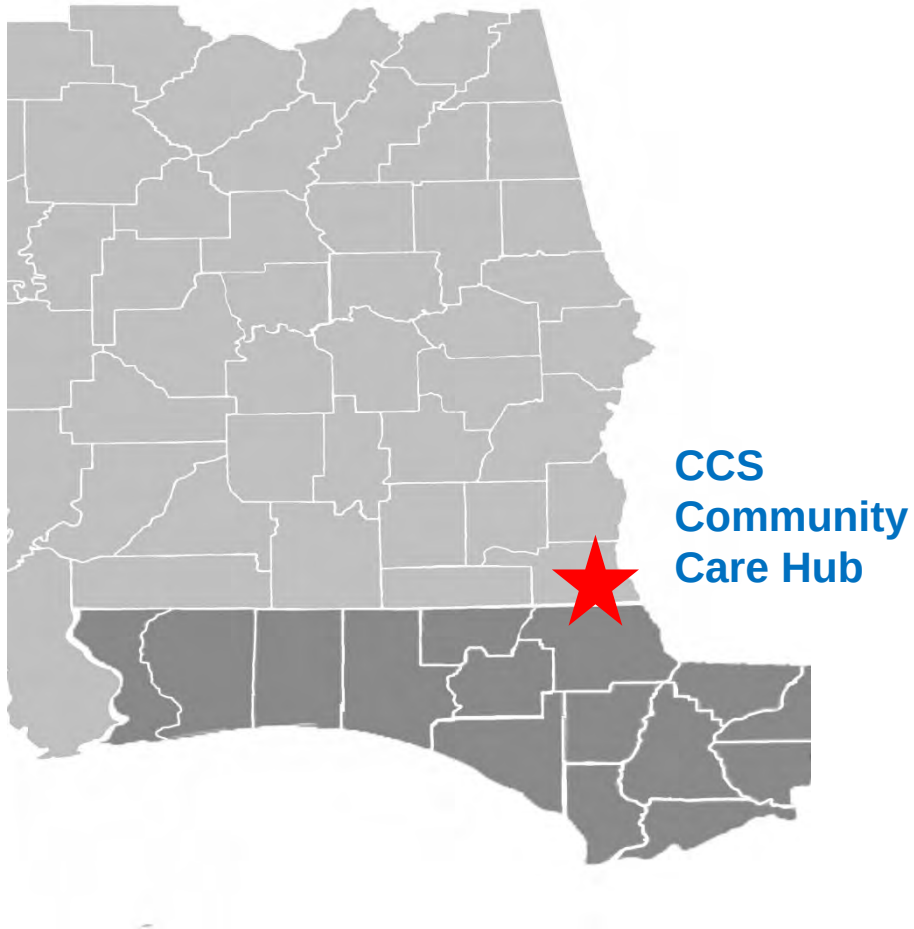
Part C Health Plan w PMPM w performance metrics

Veteran Directed Care Case Management Contract - FL & AL

TCM CCM Provider Contract

Previous Contracts:

- EMS Post Call Assessment
- CHF Pt Tracking



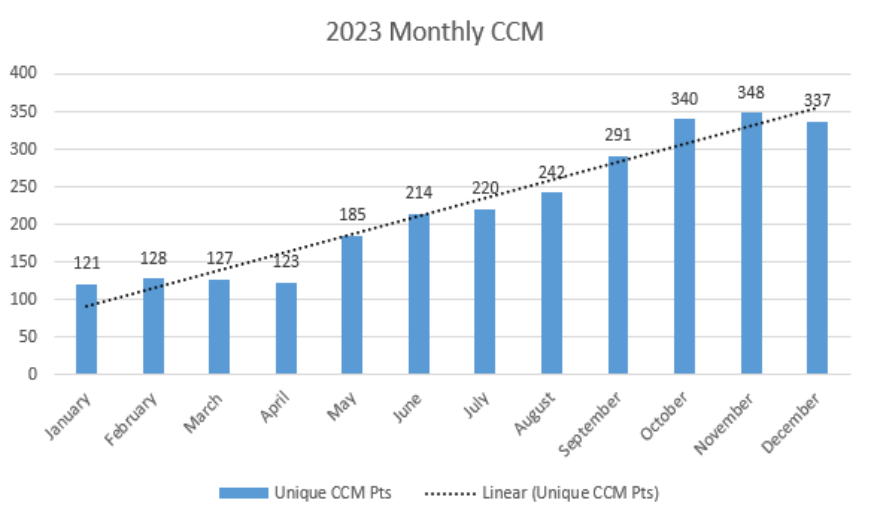
Southeast Health System & Statera

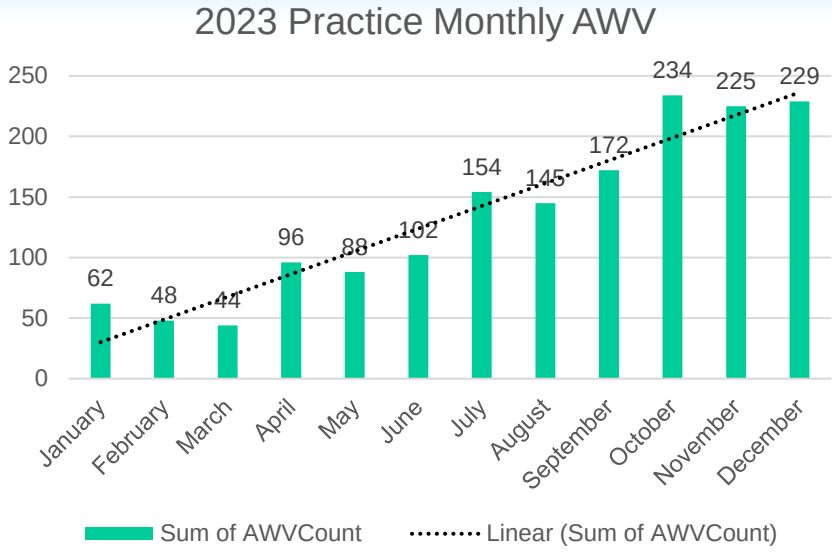
A Physician Hospital Organization established in 2015 in Dothan, AL by a group of physicians, Southeast Health, and the Houston County Health Care Authority. As a Clinically Integrated Network and Accountable Care Organization our collaborative works to balance quality and cost to create healthcare value.

- 13 Independent Physician Practices
- Southeast Health – 420 Bed Hospital, 6 Primary Care clinics, multiple specialty groups
- 280+ Physicians members
- 23,000+ Covered Lives across all contracts

Key Performance Metrics

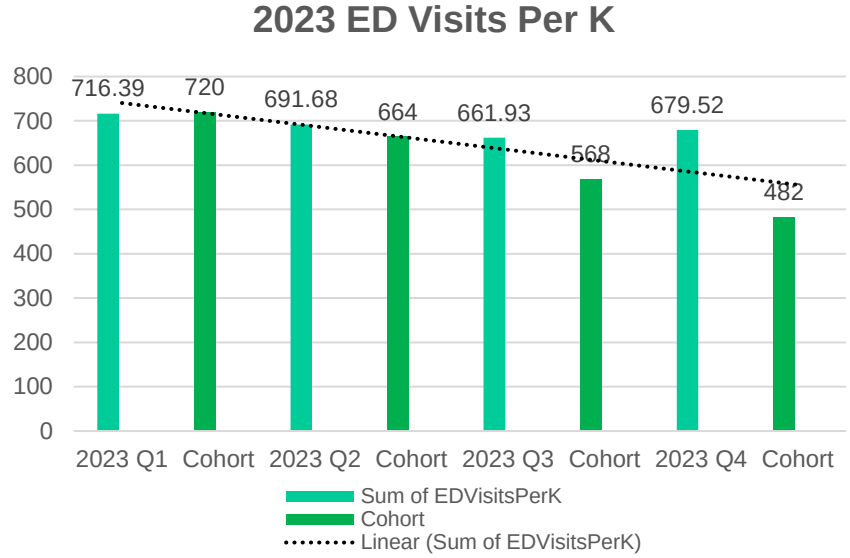
Contract Expansion in April 2023





Annual Wellness Visit rates increased 447%

ED utilization decreased 32.7%



Readmission rates decreased 25.3%

Community Care SOLUTIONS

ACO Data for CY2024

- Southern Clinic had a total of 2,643 attributed patients in the ACO, 21.1% (558) of those were considered medium-high risk individuals that were “impactable”
- 67.4% of patient panel is considered to be living in a high poverty census block
- 59.6% were female and 40.4% were male
- 346 unique patients received CCM, 61% of patients of risk list for over 1,800 billed episodes

Emergency Department Utilization

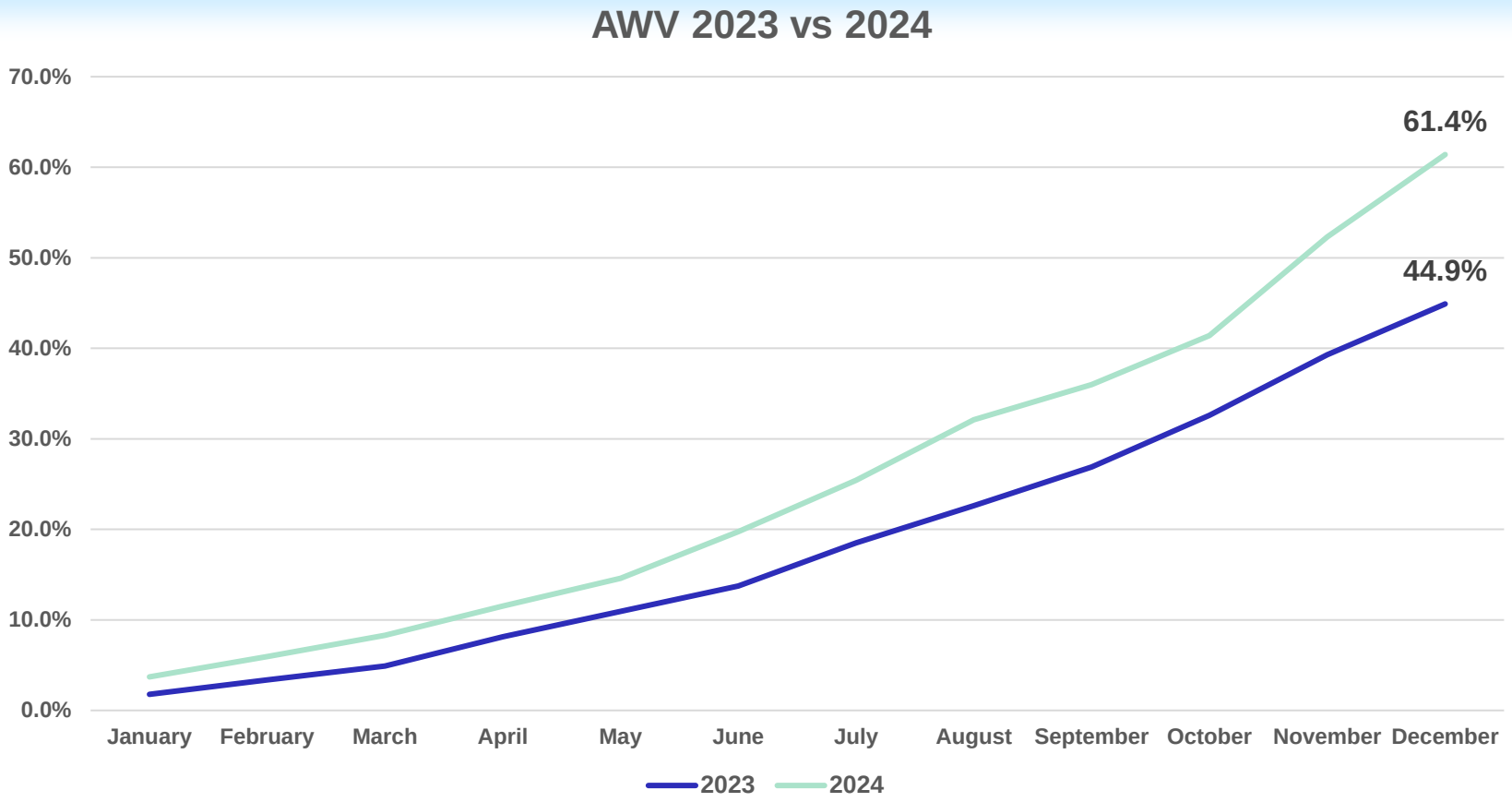
CCM patients had a 15.8% lower rate than clinic as a whole

Readmission Rate

CCM patients had a 19.2% lower readmission rate compared to total clinic

Community Care SOLUTIONS

Continued Direct Impact on Annual Wellness Visits



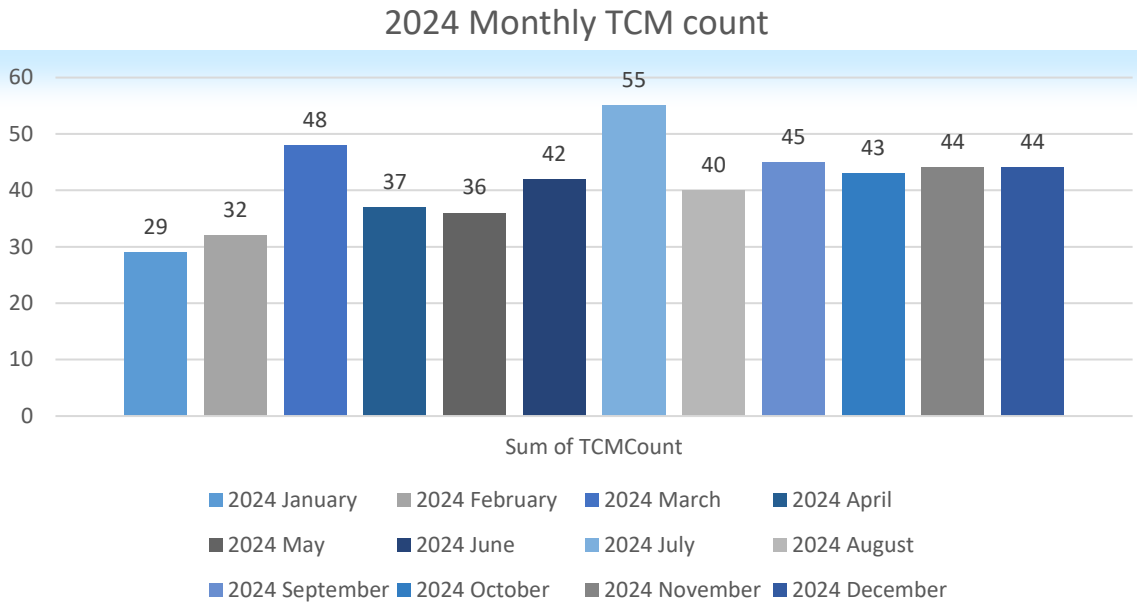
2022 – 36%

2023 – 45%

2024 – 61%

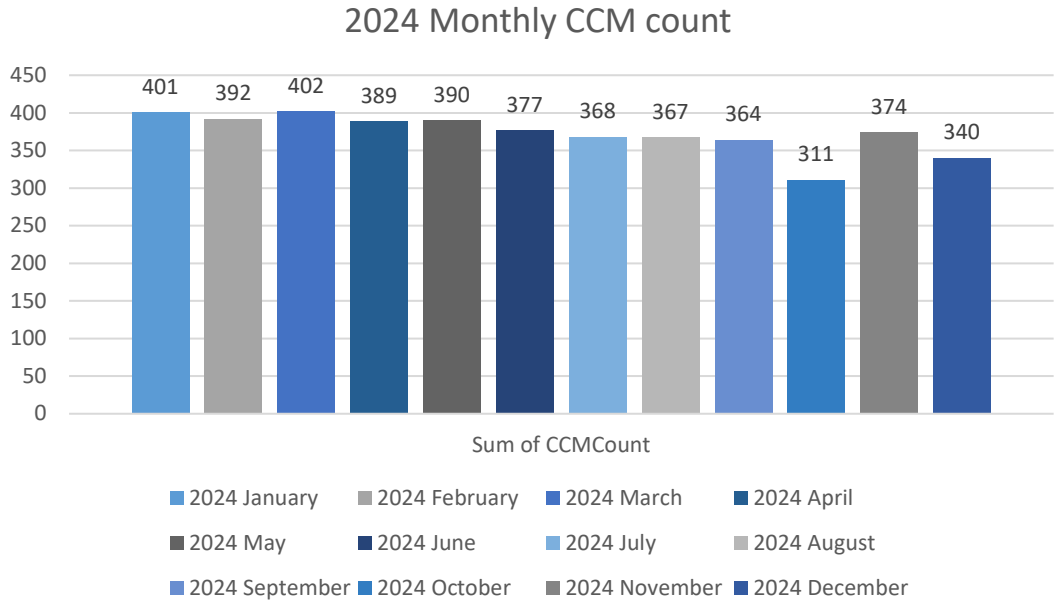
Annual Wellness Visit Rate – 61% of the CCM patients had a AWV (compared to 2022 rate prior to our work of 36%)

Extended Care Management (XCM) Metric



Transition of Care Management Visits – 495 TCM visits for 2024 among the ACO patients, resulting in a 38% TCM rate (ranks the highest among Southeast Health Clinics)

Chronic Care Management Episodes – 4,475 CCMs for 2024 among ACO patients resulting in a 72% XCM (extended care management) rate for the 2024 Shared Savings Metric (ranks the highest among Southeast Health Clinics and top 10% of the consolidated ACO parent organization)



Community Care SOLUTIONS

Recent Success Stories from the field

House was badly in need of repair, and it was becoming unsafe for the patient to continue residing there. Vinyl siding and repairs were made at no cost to the patient thru OCAP grant.

2 diabetic patients were assisted with Patient Assistance Program (PAP) applications for Ozempic. Both patients were approved. Patients indicated that they would have been unable to purchase the medications without PAP.

CCM Patient was unable to get her Dexcom Sensor, had been crucial to stabilizing her Glucose Levels. Coach cleared communication issue between pharmacy and provider!

Linkage To Quality Outcomes

Community Care
SOLUTIONS

Results show the direct impact that increased communication and engagement provided by the Health Coaches between the patient population and the health care providers can have on quality metrics and patient outcomes.

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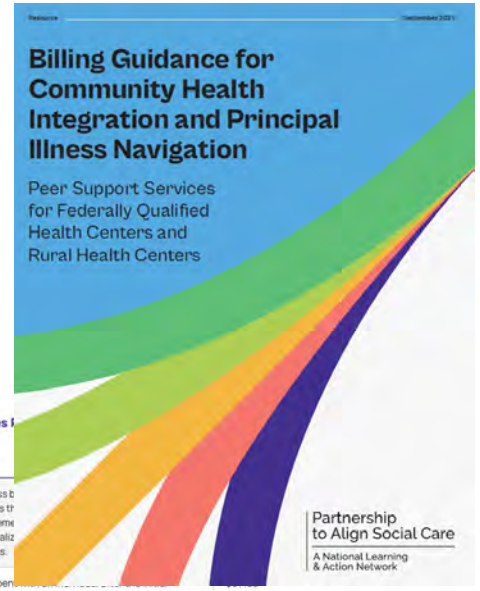
Additional Resources

- **Billing Guidance for Community Health Integration and Principal Illness Navigation** (https://www.partnership2asc.org/wp-content/uploads/2025/10/FINAL-FQHC-RHC-Billing-Guidance-for-CHI-PIN_.pdf)
- **Implementation Key for the Delivery of Evidence-Based Programs and CHI / PIN Services as Part of a Whole-Person Health Strategy** (https://www.partnership2asc.org/wp-content/uploads/2025/10/FINAL-Implementation-Key-for-Whole-Person-Health-Strategy.pdf)
- **HBAI Services Implementation Resource** (https://www.partnership2asc.org/wp-content/uploads/2025/10/FINAL-HBAI-Services-Implementation-Resource.pdf)
- **The Role of CSWs in Providing CHI and PIN** (https://www.partnership2asc.org/wp-content/uploads/2025/10/FINAL-CSW-CHI-PIN-Implementation-Resource.pdf)




Q
A

Thank You!

Autumn Campbell
acampbell@partnership2asc.org

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