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IMPLEMENTATION BRIEFING

Medicare Health Coaching Codes: A Community Care Hub Roadmap

Positioning ACL Title III-D Evidence-Based Program Grantees to Participate in Medicare Part B Reimbursement Under the Proposed CY 2027 Physician Fee Schedule

Prepared for: Community-Based Organizations (CBOs) and Community Care Hubs (CCHs)
Subject: Proposed CY 2027 Medicare Physician Fee Schedule — Health and Well-Being Coaching (CPT 0591T, 0592T, 0593T)
Preparer: Tim McNeill, RN, MPH (tmcneill@freedmensconsulting.com)
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Executive Summary

For the first time, CMS is proposing a standing 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 Administration for Community Living's (ACL) Older Americans Act evidence-based programs as a qualifying coach credential.** For Title III-D grantees, this converts programs that have historically depended on finite grant dollars into services that can generate recurring clinical revenue.

One structural fact governs everything that follows: **the benefit is designed as an *"incident-to"* service**. The Medicare payment does not flow to the CBO or CCH. It flows to an enrolled billing practitioner, and your organization participates as the coaching workforce and infrastructure layer behind that practitioner. Economic participation therefore depends on how deliberately your network positions itself as that layer — which is precisely the community care hub value proposition. **Whoever controls the credentialed coach workforce, the documentation, and the practitioner contract captures the margin**.

THE BOTTOM LINE

This is a community care hub intermediary opportunity. The provisions your network needs are favorable but **proposed, not final**. The window to shape the final rule closes **September 14, 2026**. Readiness and advocacy should proceed in parallel, now.

1. What the Proposed Rule Establishes

The proposed rule establishes national valuation and conditions of payment for three temporary (Category III) CPT codes describing health and well-being coaching. It also, for the first time, articulates a workforce and supervision pathway that fits community-based delivery.

1.1 The three coaching codes

Code	Service described	Delivery format
0591T	Health & well-being coaching, individual — initial assessment, 60–90 minutes	Face-to-face or telehealth; per session
0592T	Health & well-being coaching, individual — follow-up session, at least 30 minutes	Face-to-face or telehealth; per session
0593T	Health & well-being coaching, group (2 or more individuals), at least 30 minutes	Group; billed once per beneficiary in the group

1.2 How the services are valued

CMS proposes to **crosswalk the individual codes to the Chronic Care Management (CCM) family** — 0591T to CPT 99490 and 0592T to CPT 99439 — and the **group code to Group Diabetes Self-Management Training** (G0109). Proposed work RVUs are 1.00 (0591T), 0.70 (0592T), and 0.23 (0593T). **Importantly, CMS is not proposing frequency limitations, so multiple sessions in a calendar month are billable when reasonable and necessary, and all three codes are already on the Medicare Telehealth Services List.**

1.3 Who may deliver the service — the ACL training credential

Coaches (auxiliary personnel) must hold appropriate certification. CMS lists the National Board for Health & Wellness Coaching, the National Commission for Health Education Credentialing (CHES), and the American Holistic Nurses Credentialing Corporation Nurse Coach standards — and then adds the provision most relevant to your network: **certification may also be satisfied by training received through the ACL-overseen evidence-based health promotion and disease prevention programs funded under the Older Americans Act.** CMS reasons that these programs already carry evidence thresholds and embedded training requirements. Your existing CDSMP, DSMP, Matter of Balance, EnhanceFitness, etc. effectively becomes a coach-credentialing engine.

1.4 Supervision — the community-based delivery provision

The default proposal is *direct* supervision, but CMS states that individuals employed by CBOs may operate **under *general* supervision of the billing practitioner**, provided the training and certification standards are met. This is the difference between coaches tethered to a physician's office suite and coaches working in homes, senior centers, and over telehealth — the only model that is operationally viable for aging-services delivery. Note that the rule is internally inconsistent on supervision (it invokes direct supervision for the

codes generally, compares them to CCM's general supervision in the valuation discussion, and grants general supervision to CBO staff specifically). **Resolving that inconsistency in the final rule is a priority advocacy point.**

1.5 Explicit recognition of CBOs and CCHs

CMS carries forward its CY 2023 definition of CBOs and names your constituency directly — **community care hubs, area agencies on aging, centers for independent living, aging and disability resource centers, and other non-profits that receive ACL grants.** It acknowledges that CBOs are often the entities that employ health coaches and that they typically hold the community relationships and infrastructure needed to support these services.

2. The Reimbursement Economics

Under the proposed CY 2027 conversion factor (approximately $33.17 for qualifying APM participants and $32.84 for others) and the CCM crosswalks, the illustrative per-session economics are as follows. The individual codes are **per session and unlimited in frequency** — a meaningful departure from CCM's single monthly clock.

Code	Illustrative Medicare payment	Revenue characteristic
0591T	~$65 per initial session	One 60–90 min assessment per episode of care
0592T	~$50 per follow-up session	Repeatable within the month; no frequency cap
0593T	Lower per participant; billed per participant	A workshop of 10–12 participants converts each session into a stack of reimbursable encounters

The group code is where the evidence-based program model scales. Although 0593T is valued far lower per participant, it bills **once per beneficiary per session**. A multi-session workshop delivered to a group of ten to twelve converts a single grant-funded class into a series of individually reimbursable encounters — the revenue geometry that can make Title III-D workshop delivery self-sustaining rather than perpetually grant-dependent. A program-specific pro forma (individual vs. group mix, session cadence, panel size, and coinsurance treatment) should be modeled before committing to a delivery design.

> **FIGURES ARE ILLUSTRATIVE**
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> *Dollar estimates are directional, based on the proposed crosswalks and conversion factor and stated in current-year terms. Final rates depend on the CY 2027 final rule, relative value inputs, and geographic adjustment (GPCI). Confirm against the published fee schedule before financial planning.*

3. Implementation Opportunities for Title III-D Grantees

- **Workforce credential without new certification cost.** Coaches can qualify through ACL programs your organization already operates, removing the largest barrier to standing up a lay-coach workforce.
- **Community and home-based delivery becomes billable.** General supervision for CBO-employed coaches permits the field-based model that direct supervision would prohibit.
- **The group code maps onto the workshop format.** Structured, multi-session EBP curricula align with per-participant group billing and the absence of frequency caps.

- **Telehealth reach.** All three codes are telehealth-eligible, matching how much of the rural and homebound aging population is already served; CMS has also raised the audio-only question.
- **A defined role for the community care hub.** The hub can employ and credential the coach workforce, hold the practitioner contract, and supply the documentation and billing infrastructure that individual CBOs cannot build alone.

4. Structural Barriers and Compliance Considerations

4.1 No direct CBO or CCH billing (the incident-to constraint)

Because the service is incident-to, a Medicare-enrolled billing practitioner must submit the claim and receive payment. Your organization reaches the revenue only through a contractual arrangement with that practitioner. That flow of funds must be structured as fair-market-value payment for bona fide services — not a share of Medicare receipts — with anti-kickback, Stark, and fee-splitting exposure addressed deliberately and with counsel. Key: Establish what is fair market value and the payment structure will align with the fair market rate.

4.2 Incident-to clinical prerequisites

The beneficiary must be an established patient of the billing practitioner, operating under a physician-established plan of care into which the coaching is integrated. You cannot bill for a participant recruited at a congregate meal site absent that clinical linkage. This requires a bidirectional referral-and-attribution workflow between the CBO/CCH and its clinical partner. Initiating visits are required.

4.3 Braided funding and non-duplication

Older Americans Act Title III-D dollars cannot pay for a service that is simultaneously billed to Medicare, and supplantation rules apply. A clean cost-allocation methodology must segregate grant-funded encounters (uninsured participants, non-covered activities) from Medicare-billable ones. Done well, Medicare reimbursement lets you reserve finite Title III-D funds for gap-fill and demonstrate leveraged sustainability to ACL; done carelessly, it becomes an audit finding.

4.4 The favorable provisions are not yet final

The general-supervision carve-out and the ACL-training credential are proposed. If CMS resolves the supervision inconsistency toward direct supervision, or narrows the credential pathway, the community-delivery model is materially weakened. **These provisions must be defended during the comment period.**

4.5 Documentation, compliance, and audit exposure

These are time-based codes requiring contemporaneous time logs, documented beneficiary consent, and an established care plan — within an incident-to context that carries elevated audit scrutiny. Health IT systems, EHRs, and Revenue Cycle Management processes are essential to implementation.

4.6 Coach credential verification

"Trained through an ACL evidence-based program" is a category, not a roster. CMS has not yet specified which programs confer eligibility, so each coach's qualifying training must be documented and retained for audit. **Seeking an enumerated list from CMS is an advocacy priority. An alternative is for CMS to default to ACL to provide the list of approved programs that meet the ACL criteria.**

4.7 Beneficiary cost-sharing

Standard 20% Part B coinsurance applies. A service that is free under Title III-D becomes an out-of-pocket charge once billed to Medicare — a real participation deterrent for the low-income older adults these programs serve, mitigated only for dual-eligible/QMB beneficiaries (Medicaid covers it) or those with Medigap. Enrollment targeting should account for this.

4.8 The coaching vs. EBP-delivery definitional gap

The code language describes individualized, patient-directed coaching. A fidelity-bound EBP workshop is not obviously the same service. CMS ties the training to ACL programs but defines the service as coaching, leaving unresolved whether delivering a Matter of Balance or CDSMP session is itself billable coaching, or whether EBP training merely qualifies a coach to deliver separate coaching encounters. **This ambiguity is material to the group-code business case and should be clarified in comment.**

4.9 Category III durability and Medicare Advantage adoption

These remain temporary tracking codes; CMS is openly soliciting comment on whether to convert them to HCPCS G-codes for CY 2027. Medicare Advantage recognition of Category III codes is inconsistent even when Traditional Medicare prices them, so plan-by-plan verification will be necessary. Advocacy for HCPCS G-codes is an advocacy priority.

5. The Community Care Hub Operating Model

Participation is best structured with the community care hub as the integrator that links a credentialed coach workforce to one or more Medicare-enrolled billing partners. In practice, the hub carries the following functions:

- **Employs and credentials coaches** through ACL evidence-based program training, and maintains the audit-ready credential file for each.
- **Holds the billing-practitioner contract(s)** — an FQHC, primary care group, or affiliated medical group — on fair-market-value terms.
- **Operates the shared documentation and claims interface** (EHR, time capture, consent, session notes) that supports incident-to billing at fidelity.
- **Manages braided-funding cost allocation** so Title III-D and Part B are never charged for the same encounter.
- **Runs the referral and attribution pipeline** that connects community participants to the billing practitioner's established-patient panel.

This is the shared-infrastructure thesis expressed through a fee-for-service code set: the individual CBO delivers; the hub makes the delivery billable, compliant, and sustainable.

6. The Comment Period — A Time-Limited Advocacy Window

The proposed rule is open for public comment through **September 14, 2026**, and CMS is actively soliciting comment on the very provisions that determine whether your network can participate. A coordinated comment strategy — ideally submitted through your CCH network — should:

1. **Preserve and clarify general supervision** for CBO/CCH-employed coaches, and resolve the direct-versus-general inconsistency in favor of general supervision. We must push CMS to codify General Supervision guidance to facilitate community-based delivery models.
2. **Support the ACL evidence-based program credential** and request that CMS enumerate the qualifying programs so grantees have an auditable list **or require CMS to defer to ACL to provide the list of approved programs.**
3. **Request explicit braided-funding guidance** on non-duplication and cost allocation between Title III-D and Part B.
4. **Clarify the coaching-versus-EBP-delivery definition** so the group code's application to workshops is unambiguous.
5. **Weigh in on the G-code question** — conversion to HCPCS G-codes would likely improve MAC and Medicare Advantage recognition and long-term durability. **It is essential that CMS establish permanent HCPCS G-codes for this service beginning CY2027. This will ensure Medicare Advantage Plan uptake of the codes.**
6. **Advocate a recognized CBO/CCH participation and contracting pathway** where a broader coalition can be assembled. We want explicit language in the final rule to support CCH contracting as a pathway for scaling.

About Freedmen's Health Consulting

Freedmen's Health Consulting advises networks of community-based organizations and community care hubs on governance, shared infrastructure, Medicare care-management billing, and value-based participation. We can develop the reimbursement pro forma, a model comment letter for network co-signature, and a hub contracting-and-cost-allocation framework as follow-on deliverables.

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This briefing summarizes provisions of a proposed federal rule for planning purposes and reflects the rule as proposed; provisions may change in the final rule. It does not constitute legal, tax, or billing-compliance advice. Organizations should confirm all requirements and payment amounts against the published CY 2027 Physician Fee Schedule final rule and obtain qualified counsel before implementation.