

# Building a Payment Model for Health Coaching in Primary Care: Lessons From Tennessee

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**CMS HAS RECOGNIZED** the need to increase utilization of preventive services in primary care<sup>1</sup> and has developed payment policies to support delivery of these services by auxiliary personnel such as health coaches working “incident to” qualified billing providers,<sup>2</sup> but few states have adopted aligned Medicaid payment policies. Experts recognize that “psychosocial support, health behavior coaching, [and] health-promoting resources” are essential for realizing the person-centered, family-centered, and community-oriented primary care that people want and deserve.<sup>3</sup> Likewise, evidence-based guidelines recommend increased delivery of preventive cardiovascular services, including regular screening for obesity, hypertension, and diabetes; diabetes prevention program<sup>4</sup> and diabetes self-management education services<sup>5</sup>; intensive behavioral therapy for obesity and cardiovascular disease; intensive multicomponent behavioral weight loss interventions<sup>6</sup>; and tobacco use cessation counseling.<sup>1</sup> These essential population health services are infrequently delivered, and available billing codes are seldom utilized despite CMS authorization for Medicare reimbursement for these services. The need for increased delivery of preventive services is particularly acute in low-income, medically underserved areas.<sup>7,8</sup>

Historically, preventive services have not been delivered at scale to Medicaid beneficiaries because of provider and payer uncertainty about Medicaid coverage, lack of clear guidance regarding proper coding for reimbursement,<sup>9</sup> and substantially lower payment rates for preventive services than for evaluation and management or procedural services. As a result, preventive service codes are rarely billed and seldom paid in most state Medicaid programs, including Tennessee’s, contributing to low utilization by vulnerable populations. Central problems facing Tennessee providers wanting to increase preventive service delivery for Tennessee Medicaid enrollees in early 2020 included a lack of clear guidance from the state Medicaid organization (TennCare) on whether they could bill for incident to provider preventive services and from state Medicaid managed care organizations (MCOs) on how to ensure payment. Providers identified the following as major contributors to provider inertia: opaque and unclear rules regarding Medicaid payment for preventive

## ABSTRACT

**Objectives:** To describe Tennessee’s process for convening key stakeholders to develop uniform payment guidelines that encourage increased preventive service delivery and provide lessons learned that can inform similar work in other states.

**Study Design:** Descriptive case study.

**Methods:** Observational.

**Results:** Tennessee’s statewide multistakeholder health care extension cooperative, the Tennessee Heart Health Network, was instrumental in convening major stakeholders, including Medicaid, health plan, and safety-net provider representatives. Stakeholders reached consensus and developed and implemented common guidelines for reimbursement of health coaching services focused on cardiovascular health in the context of team-based primary care.

**Conclusions:** Tennessee’s experience suggests that statewide multistakeholder health care extension cooperatives can facilitate Medicaid and Medicare payment policy alignment and delivery system improvement. They have potential to yield important benefits in state-based efforts to improve access and quality of care.

services, a focus on sickness rather than preventive care, and lack of interest in taking the risk of developing the infrastructure necessary to reliably deliver preventive services.

**Working with state Medicaid agencies and MCOs to establish new payment policies requires multistakeholder organization, patience, and persistence. Tennessee's process began with a clear shared vision of the end goal and then required an iterative process organized and facilitated by the TN-HHN, driven by the TennCare MCOs, and overseen and approved by TennCare administration. This process required goodwill and shared vision among providers, payers, and government representatives, with iterative work to achieve consensus on details. Medicare and TennCare alignment on a new payment model for HC in team-based primary care was ultimately a 3-year endeavor. Thus, for other state health care extension cooperatives seeking to facilitate delivery system improvement, it is important to recognize that Medicaid/Medicare payment policy alignment requires high-level leadership and substantial commitment.**

This article describes lessons learned from Tennessee's process for convening key stakeholders to develop uniform payment guidelines and encourage increased preventive service delivery that can inform similar work in other states. Specifically, this article seeks

to demonstrate how a state-based multistakeholder health care extension cooperative can help states build consensus and achieve Medicaid/Medicare payment policy alignment in support of evidence-based integration of health coaches into the primary care team.

### **EVIDENCE FOR HEALTH COACHES EXTENDING PRIMARY CARE**

Strong evidence attests to the benefits of employing health coaches (HCs) and other types of community health workers (CHWs) to improve delivery of essential services in primary care settings. HCs support team-based, person-centered care for chronic disease and lifestyle-related conditions<sup>10</sup> by engaging patients in self-management and treatment adherence, assisting patient navigation to improve access to essential care,<sup>11</sup> and providing referrals or resources to address social determinants of health.

Employing HCs and CHWs in primary care has been shown to improve adherence to medical recommendations, increase trust in the health care system, and reduce the need for emergency and specialty services.<sup>12</sup> For example, findings of the PROPEL study (NCT02561221) demonstrated the effectiveness of HCs in supporting weight loss among low-income people with obesity.<sup>13</sup> Similarly, our team's MODEL study (NCT02957513) findings demonstrated improvements in self-efficacy, diet, exercise, body mass index, and hemoglobin A<sub>1c</sub> levels among African American participants with uncontrolled diabetes receiving personal health coaching.<sup>14</sup> Likewise, a New Mexico CHW program targeting high-need individuals reduced emergency department and inpatient utilization.<sup>15</sup> Recent systematic reviews have found that HCs can help patients with hypertension reduce blood pressure, improve dietary and exercise behaviors,<sup>15</sup> and increase self-efficacy.<sup>16</sup>

In light of this evidence, some states have begun to adopt approaches for Medicaid coverage of some CHW services.<sup>17</sup> Yet despite this extensive evidence base and Medicare payment policies supporting payment for HCs in the context of team-based care,<sup>18</sup> most state Medicaid programs do not explicitly support payment for HC services.

### **MULTISTAKEHOLDER ENGAGEMENT IN TENNESSEE**

Population health leadership at the University of Tennessee Health Science Center (UTHSC) established the Tennessee Heart Health Network (TN-HHN) as Tennessee's statewide health care extension collaborative in early 2020 ([Table](#)).<sup>19,20</sup> Promoting reimbursement

**TABLE.** Timeline

Date	Action
3/30/2020	Statewide primary care extension program focused on supporting cardiovascular care quality improvement in primary care first proposed to TennCare Bureau
4/24/2020	TN-HHN established at its first meeting of key partners across Tennessee
3/1/2021	TN-HHN launched with AHRQ support
6/30/2021	First formal TN-HHN Executive Council meeting: Reimbursement Subcommittee was proposed to address reimbursement questions regarding health coaching and population health services, encourage delivery of health coach services, advocate at the state level for health coach reimbursement, and report back to the TN-HHN Executive Council. Reimbursement Subcommittee was established by the Executive Council, and members volunteered, representing TennCare, TennCare MCOs, commercial insurance, federally qualified health centers, and a primary care advocacy organization.
8/24/2021	<p>First TN-HHN Executive Council Reimbursement Subcommittee meeting held to discuss potential reimbursement of population health billing codes by Tennessee's Medicaid MCOs and commercial health plans, with these desired outcomes:</p> <ul style="list-style-type: none"> <li>• Promote team-based care for patients with chronic disease</li> <li>• Determine whether and how population health service billing codes could be employed for services delivered by health coaches in the context of team-based primary care</li> <li>• Educate primary care providers on appropriate billing practices for health coach interventions</li> </ul> <p>Initial activities:</p> <ul style="list-style-type: none"> <li>• Review of a preliminary list provided by UTHSC of billing codes currently reimbursed by Medicare that could be billed by practices (and paid by each TennCare MCO) to support team-based care</li> <li>• Subcommittee renamed the Population Health Subcommittee</li> </ul> <p>Identified necessary guard rails for subcommittee:</p> <ul style="list-style-type: none"> <li>• Avoidance of discussion or sharing of health plan rates by health plan representatives to avoid antitrust concerns, with members agreeing not to discuss plan rates</li> </ul> <p>Identified reasonable next steps:</p> <ul style="list-style-type: none"> <li>• UTHSC team to gather further information regarding recommended population health codes, appropriate billing specifications, and use case scenarios</li> <li>• MCO representatives to seek clarification from TennCare leadership on how proposed fee-for-service billing and payment would be reconciled with TennCare Patient-Centered Medical Home program payments and incentives</li> <li>• Subcommittee to provide requested regular updates to TennCare leadership</li> </ul>
8/26/2021	TennCare MCO CMOs gave update on subcommittee's early work to TennCare medical director and his team.
9/24/2021	Subcommittee chair (Huffman, MCO CMO) invited the third TennCare MCO CMO to serve on the subcommittee.
1/25/2022	<p>Revised list of Highest Priority Medicaid Service Codes for Heart Health population health services presented to Population Health Subcommittee, with focus placed on Medicaid-specific application of a health coach delivery model and the following next steps agreed upon:</p> <ul style="list-style-type: none"> <li>• Each TennCare MCO to conduct internal review to assess: <ol style="list-style-type: none"> <li>1. Current utilization levels for the recommended codes</li> <li>2. Desire of each MCO to reimburse the codes moving forward</li> <li>3. Current billing requirements/specifications</li> <li>4. Suggested requirements/specifications for using the codes to reimburse providers for health coach delivery of services</li> </ol> </li> <li>• UTHSC to assess and summarize evidence in support of telehealth delivery of health coaching service</li> <li>• MCO to provide preliminary report to TN-HHN Subcommittee</li> <li>• MCO CMO to review preliminary findings with TennCare leadership</li> </ul>
January-July 2022	Subcommittee continued to meet monthly, and representative organizations and UTHSC staff worked to finalize proposed code set and detailed specifications for their use to support health coaching and to ensure that each MCO will be capable of reliably paying claims that are billed correctly for appropriate services.

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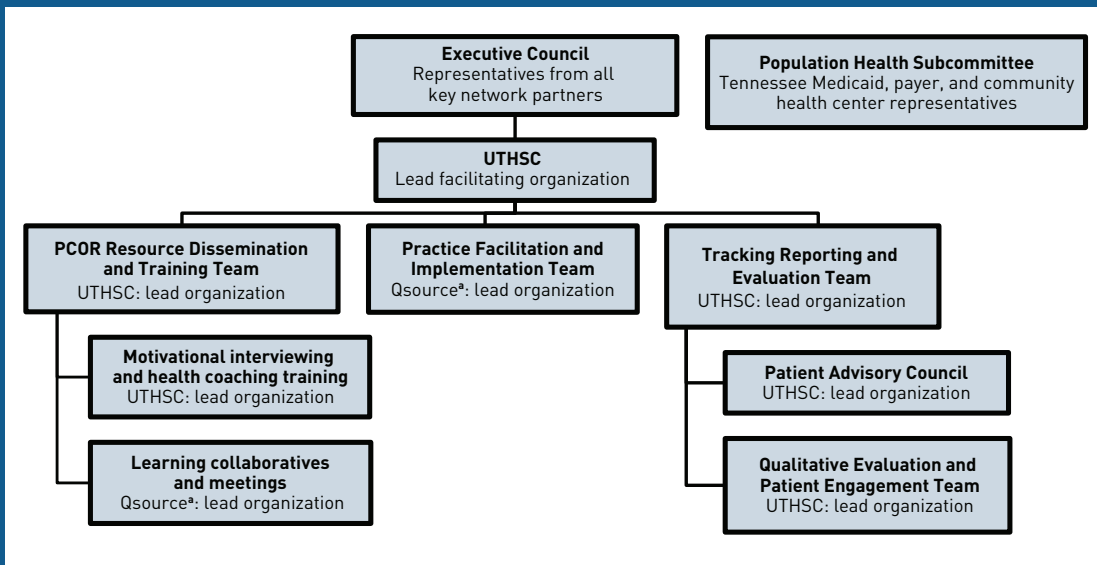
**TABLE.** (Continued) Timeline

Date	Action
August 2022	TennCare MCO CMOs presented their preliminary findings and recommendations to TennCare leadership team to: <ul style="list-style-type: none"> <li>• Ensure that they have no concerns</li> <li>• Allow TennCare to take this work into consideration while the Workforce Development Strategy for the Health Starts SDOH program is being rolled out to fund community health workers, lactation consultant specialists, and doulas</li> </ul>
10/5/2022	Recommendations for State of Tennessee Community Health Worker and Health Coach Certification drafted, circulated, and discussed by subcommittee
11/1/2022	TN-HHN Executive Council adopted formal bylaws.
1/3/2023	Subcommittee reviewed and tentatively approved revised Training and Certification Standards for Health Coaches. FAQs document on recommended codes for CHW/health coach services in Tennessee was proposed.
January-December 2023	Subcommittee reviewed 3 documents summarizing their final recommendations, obtaining extensive input from stakeholders and conducting multiple rounds of revisions, including (1) Health Coach Training and Certification Standards, (2) Service Codes for Use by Health Coaches in Team-based Care, and (3) FAQs Regarding Service Codes for Use by Health Coaches in Team-based Care. A proposal was brought to the subcommittee to add additional behavioral health service codes, but after input from TennCare leadership, the subcommittee recommended limiting the initial list of approved service codes to those directly focused on cardiometabolic health originally proposed, consistent with the original purposes of the subcommittee.
12/6/2023	Population Health Subcommittee approved 3 final guideline documents and recommended their approval by the TN-HHN Executive Council and dissemination through the TN-HHN, employing <a href="http://www.TNHeartHealth.org">www.TNHeartHealth.org</a> .
January 2024	TN-HHN Executive Council unanimously approved the 3 guideline documents with minor modifications.
2/29/2024	“Coding and Billing Updates for Health Coach Sustainability” was presented as a live learning collaborative and posted as enduring material webinar on <a href="http://www.TNHeartHealth.org">www.TNHeartHealth.org</a> to provide education to TN-HHN members about the utilization and payment structures available for health coaches at the conclusion of this work. The 3 final guideline documents were also posted at <a href="https://tnhearthealth.org/resources/reimbursement/">https://tnhearthealth.org/resources/reimbursement/</a> and shared with members through the TN-HHN newsletter.

AHRQ, Agency for Healthcare Research and Quality; CHW, community health worker; CMO, chief medical officer; FAQs, frequently asked questions; MCO, managed care organization; SDOH, social determinants of health; TennCare, Tennessee Medicaid; TN-HHN, Tennessee Heart Health Network; UTHSC, University of Tennessee Health Science Center.

of HC services in primary care was an early goal of the TN-HHN. Tennessee’s selection as 1 of 4 states (the others being Alabama, Ohio, and Michigan) to participate in the Agency for Healthcare Research and Quality (AHRQ) EvidenceNOW: Building State Capacity (ENOW BSC) initiative gave UTHSC the opportunity to engage payers, providers, and other stakeholders in statewide efforts to incorporate patient-centered approaches to improve the health of people with cardiovascular disease.<sup>21,22</sup> As part of a large land grant university (University of Tennessee) with 4 health science center campuses and affiliated health systems spanning the state, UTHSC was ideally positioned to organize, host, and support a statewide health care extension collaborative and serve as a trusted mediator to bring together key stakeholders across Tennessee.

From the outset, key partners across the state recognized strong potential benefits to patients, providers, and plans from HC services in the context of team-based care, but they expressed concern over the lack of clear and consistent payment mechanisms to support delivery of these new services. Tennessee safety-net primary care providers expressed support for implementing evidence-based lifestyle interventions for blood pressure control and smoking cessation, but they reported needing to better understand how to implement team-based care using HCs from a business perspective.<sup>23</sup> Providers particularly expressed interest in joining forces in collaborative quality improvement efforts to increase statewide impact on patient outcomes. Providers with high proportions of Medicaid patients also sought to improve their performance in the state Medicaid value-based purchasing program.

**FIGURE.** Tennessee Heart Health Network Governance Structure

PCOR, Patient-Centered Outcomes Research; UTHSC, University of Tennessee Health Science Center.

\*Qsource is a 501(c)(3) nonprofit health care quality improvement and quality assurance organization based in Tennessee.

Likewise, TennCare's MCO leadership reported needing more clarity from the state Medicaid program regarding expectations for MCO reimbursement of preventive services. Even though TennCare MCOs already had the ability to implement payment for preventive services, they reported concern that lack of clarity prior to implementation could jeopardize their relationship with TennCare if new payment policies were implemented without direct TennCare guidance. Furthermore, the TennCare MCOs had not previously come together in a formal way to establish uniform guidance regarding coverage of preventive services delivered by auxiliary personnel working under the supervision of qualified billing providers. All 3 MCOs recognized the need to seek the input of TennCare leadership in this process. Thus, the TN-HHN overcame competition among MCOs by bringing together high-level payer, provider, and TennCare leadership, with the UTHSC serving as a trusted neutral convener.

TN-HHN was envisioned from the outset as a self-governing multistakeholder group supported by high-level representatives of partner organizations who served as the 21 founding members of its Executive Council<sup>22</sup> (Figure). TennCare and TennCare MCOs, community health centers (CHCs), and other safety-net

providers were highly engaged from the outset. The TN-HHN Executive Council adopted formal bylaws in November 2022, at which time the Founding Council nominated and elected its chair and 10 high-level representatives of the Tennessee Department of Health (n = 1), TennCare (n = 1), TennCare MCOs (n = 3), other health insurance plans (n = 1), CHCs (n = 1), other safety-net providers (n = 2), and primary care professional organizations (n = 1) to serve as members. The TN-HHN developed governance and engaged payers through its Executive Council, which formed the Population Health Subcommittee as its only subcommittee (which included representatives of Medicaid MCOs, commercial insurance, and federally qualified health center representatives) to develop and help implement common reimbursement guidelines for HC services and set certification standards.<sup>22</sup> The TN-HHN was fortunate that the MCOs agreed to help champion this work, given their reported challenges committing the time required to develop, adopt, and educate providers in a uniform approach to reimbursement of HC services consistent with state guidelines for billing and payment.

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As shown in the Table, all major stakeholders reached consensus by mid-2021 on the value of expanding TennCare reimbursement of HC services for preventive cardiovascular services. Work to reach full consensus on detailed guidelines took more than 2 years. TN-HHN served as a neutral convener and used this effort as part of a broader approach to improve heart health in Tennessee. In January 2024, the TN-HHN Executive Council approved the following voluntary standards:

1. HC training and certification standards (**eAppendix 1** [eAppendices available at [ajmc.com](http://ajmc.com)])<sup>24</sup>: These standards provided the foundation of the proposed reimbursement approach and detailed the required qualifications for HCs to deliver services in primary care. There was broad agreement for general consistency with Medicare requirements and no requirement for licensure.
2. Service codes for use by HCs in team-based care (**eAppendix 2**)<sup>25</sup>: These service codes represented almost the exact same list of billing codes initially proposed by the UTHSC population health research leadership in January 2022, soon after the formation of the Executive Council and its Population Health Subcommittee. The subcommittee, with guidance from the TennCare Division, rejected a proposal to add coverage of additional behavioral health service codes, limiting the initial list of approved service codes to those focused directly on cardiometabolic health.
3. Frequently asked questions (FAQs) regarding service codes for use by HCs in team-based care (**eAppendix 3**)<sup>26</sup>: The subcommittee agreed to continually update FAQs to address additional provider/payer questions and concerns as they arose. The subcommittee had lengthy discussions regarding preferred dissemination approaches for the information referenced above, and it was unanimously recommended that the TN-HHN serve as the primary dissemination vehicle through its website and learning collaborative sessions.

## LESSONS LEARNED

Working with state Medicaid agencies and MCOs to establish new payment policies requires multistakeholder organization, patience, and persistence. Tennessee's process began with clear shared vision of the end goal and then required an iterative process organized and facilitated by the TN-HHN, driven by the TennCare MCOs,

and overseen and approved by TennCare administration. This process required goodwill and shared vision among providers, payers, and government representatives, with iterative work to achieve consensus on details. Medicare and TennCare alignment on a new payment model for HC services in team-based primary care was ultimately a 3-year endeavor. Thus, for other state health care extension cooperatives seeking to facilitate delivery system improvement, it is important to recognize that Medicaid/Medicare payment policy alignment requires high-level leadership and substantial commitment of time and effort.

State-level payment policy change also requires vocal payer and provider champions. State engagement, representation, and high-level payer and government leadership, including chief medical officers (CMOs) for all 3 TennCare MCOs and key TennCare directors, were essential to align Medicare and Medicaid payment policies. Payer and provider champions who understood and cared about the mission of the ENOW BSC-supported state-based health care extension cooperative were nominated to lead critical TN-HHN committees and then were given strong university management, administrative, and faculty expert support to empower them in their roles. The vice president and CMO for population health services of a major Tennessee health system and a well-respected CMO of a TennCare MCO accepted nominations to chair the TN-HHN Executive Council and its Population Health Subcommittee, respectively. Together, these chairs and university management of the TN-HHN worked together to continually remind collaborative members of common interest related to improving the health care of Tennesseans and effectively resolved tensions among organizations that typically compete with each other. Leadership at all levels modeled a primary focus on service to health plan members that was contagious and helped plan and provider leadership justify their involvement in the cooperative. The TennCare administration's contractual requirements for MCO cooperation on key program aspects and TennCare leadership's presence at TN-HHN meetings also assisted in keeping MCO representatives accountable to common goals.

Keeping key collaborative members engaged in the Population Health Subcommittee of the TN-HHN Executive Council was critical to successful payment policy change. Two factors contributed most to long-term partner engagement in the subcommittee. First, the subcommittee chair was highly respected and collaborated well with other MCO leaders and TennCare leadership. He played a critical role by keeping his fellow CMOs and their staff engaged by encouraging attendance at regular meetings and keeping TennCare

administration leadership informed and engaged at each step. Second, university management and administrative support of the TN-HHN ensured that meetings were scheduled well in advance at times convenient for members, agendas with clear deliverables were circulated prior to meetings, a regular meeting cadence was established, and meetings stayed on task.

Rising health care costs, a competitive health care marketplace, provider burnout, increased reporting metrics, privacy concerns, and care complexity are among the many powerful payer/provider incentives favoring the status quo in primary care billing and payment. However, the AHRQ ENOW BSC–supported state-based health care extension cooperative agreement, together with the support of TennCare, TennCare MCOs, and safety-net providers, created shared goodwill and opportunity for change. Specifically, ENOW BSC provided the framework for engagement of multistakeholder payers and providers in TN-HHN collaborative governance. Then the TN-HHN Executive Council developed a shared vision for aligning state and federal payment policy to strengthen the primary care sector and expand its capacity to improve patient outcomes.

With the support and framework of the new collaborative governance provided by the ENOW BSC–supported TN-HHN, Tennessee stakeholders were able to achieve consensus by identifying a strategic area for a win-win-win for patients, providers, and payers by focusing on high-burden, high-cost chronic cardiometabolic conditions for which critical preventive services were underutilized. Tennessee's health care collaborative governance approach has laid a strong foundation for future quality improvement efforts and has strong potential for replication nationwide.

## FUTURE DIRECTIONS AND POLICY RECOMMENDATIONS

Although many authors have called for increased Medicare-Medicaid coverage integration for those dually eligible,<sup>27</sup> less attention has been placed on the need for Medicare-Medicaid payment policy alignment for all recipients. Although national consensus on Medicare-Medicaid alignment is unlikely without legislation, Tennessee's experience demonstrates that state efforts supported by strong multistakeholder health care extension cooperatives can be successful in achieving statewide consensus among payers, providers, and government leadership for reimbursement of HCs in the context of team-based care. The TN-HHN governance model for high-level engagement

of payer, provider, and government leadership has the potential to be deployed in states across the US to expand access to essential population health services among Medicaid enrollees nationwide.

Expanding fee-for-service (FFS) payment for preventive health services delivered by HCs and other CHWs in the context of team-based care is a critical first step to expanding access to essential services. But FFS payment must be supplemented by value- and outcomes-based payment to support the low-cost personnel needed to deliver these services long-term. Evidence suggests that incorporating value-based payment into state-directed payment arrangements can improve outcomes for dually eligible individuals.<sup>28</sup> Value-based payments have potential to bring similar benefits to nondual Medicaid enrollees as well.<sup>29</sup> In Tennessee, it remains to be seen whether increased availability of FFS billing opportunities for HCs in the context of team-based care will translate into increased delivery of essential preventive services. Further efforts are needed to assess the effectiveness of Tennessee's payment policy change in improving clinical outcomes.

Tennessee's experience suggests that building state capacity to support delivery system and payment policy improvements through statewide multistakeholder health care extension services, such as the TN-HHN, can yield important benefits in state efforts to align Medicaid and Medicare payment policy and improve access and quality of care.

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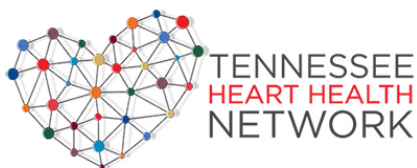
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# Health Coach Training and Certification Standards

## Introduction

Increased healthcare costs, emphasis on chronic care management, and overwhelmed clinical staff have accelerated the need for resource-saving and alternative approaches to improve the delivery of primary care services, especially in rural and underserved areas. Non-clinical or lay staff, such as health coaches (HC) and community health workers (CHW) can support team-based care by providing person-centered care for chronic disease and lifestyle-related conditions to better engage patients in their self-management and treatment adherence. In addition, they can provide patient advocacy, assist with patient navigation, and provide referrals and resources that address negative Social Determinants of Health (SDOH) that impact health and access to care. This document focuses on training and certification standards for HC.

## Barriers to Incorporation of Health Coaches in Primary Care

Past barriers to the incorporation of these lay workers include: (1) lack of appreciation for the efficacy of health coaching using best practices; (2) lack of approved CPT codes or adoption of existing ones to engender sustainability; (3) lack of full integration of lay staff into the primary care team; and (4) lack of standardization of training and quality assurance for lay staff.

## Health Coach Standards

Our Tennessee Heart Health Network (TN-HHN) Population Health Subcommittee has worked over the last year to come to consensus on billing and reimbursement standards for HC services. The purpose of this report is to establish training and certification standards for lay health workers in Tennessee to ensure quality and standardization for patient care. Currently, the state of Tennessee lacks training and certification standards for this workforce.

## Health Coaches

HC typically have an undergraduate degree in a health promotion or health science field, with many holding a graduate degree as well. HC, like other types of CHW, are typically recruited from the community they serve and demonstrate cultural competence and humility. HC in primary care clinics provide patient coaching and outreach services and extend primary care into community through brief encounters at community events, community health centers, and public health screenings. Many HC specialize in chronic condition and lifestyle management and tend to have long-term (six months or more) coaching relationships with their clients.

Currently, the healthcare industry does not formally recognize a national standard for health coaches; however, the most recognized national standards have been developed by the National Board for Health and Wellness Coaching (NBHWC) (see <https://nbhwc.org>). The downside of requiring the full NBHWC certification as a state standard is that this program has burdensome requirements. Candidates must demonstrate previous health coaching experience and complete an extensive proprietary training program to take the examination. This greatly limits the practicality of increasing capacity of a scarce resource. Additionally, the NBHWC program does not require a validated, standardized competency demonstration for certification. Coaching is a complex skill set that cannot be demonstrated via multiple-choice questions.

### NBHWC Competencies for Health Coaches

1. Coaching Structure
2. Coaching Process - coaching relationship/communication techniques
3. Health and Wellness Topics including Chronic Disease
4. Ethics/Legal Issues

Therefore, the Tennessee Heart Health Network (TN-HHN) and its member organizations adhere to the NBHWC identified competencies and suggested curriculum. In addition, we require the satisfactory completion of a practical competency demonstration using a standardized, validated assessment tool for health coaching.

## TN-HHN Recognition and Approval of Existing Training Programs

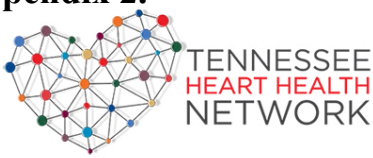
The TN-HHN and its member organizations recognize existing HC training and certification programs whose curricula meet these national standards and who utilize a competency-based assessment with which to grant certification. To the best of our knowledge, the following training and certification programs in Tennessee currently meet these standards:

- [UTHSC Health Coach Certification Program](#)
- [Vanderbilt Health Coaching Program](#)
- [Coalition for Better Health Training for Preventive Health Specialists](#)

Contact Susan Butterworth, PhD at [sbutter1@uthsc.edu](mailto:sbutter1@uthsc.edu) for questions or suggestions regarding HC training and certification programs meriting TN-HHN recognition.

## Reference

The National Board For Health & Wellness Coaching. (2022) NBHWC Content Outline. NBHWC HWC Certifying Examination Content Outline. Accessed August 15, 2022. Available [here](#).



# Service Codes for Use by Health Coaches in Team-based Care

Service	Code	Notes	Will code pay when billed alone (Yes/No)	If code will not pay when billed alone provide explanation on why	Will code pay when billed with office visit code (Yes/No)	If code will not pay when billed with office visit provide explanation on why	Will code pay when billed with all the other codes listed on the spreadsheet (Yes/No)	If code will not pay when billed with all the other codes provide explanation on why	Comments
Intensive Behavioral Therapy for Cardiovascular Disease	<b>G0446</b> - Face to face 15 min	Encourage aspirin use for the primary prevention of CVD when benefits outweigh the risk, screening for HTN, counseling for healthy diet	Yes		No	Receives a bundling edit (procedure has unbundle relationship)	Yes	G0446 receives a coding edit if it exceeds the maximum number of units that it can be performed each calendar year.	G0446 will allow if office visit is filed with modifier25 Billing as telehealth would require a 95 modifier and POS 02 or 10**** This code is for 15 minutes increments (i.e. 30 minutes would be 2 units) Services rendered in the home should be billed with POS 12
Intensive Behavioral Therapy for Obesity	<b>G0447</b> - Face-to-face behavioral counseling for obesity, 15 minutes	22 sessions allowed in a 12-month period, 1 face-to-face visit every week for the first month, one face to face visit every other week for months 2-6, and one face to face visit every month for months 7-12 if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months	Yes		No	Receives a bundling edit (procedure has unbundle relationship)	Yes		G0446 will allow if office visit is filed with modifier25 Billing as telehealth would require a 95 modifier and POS 02 or 10**** This code is for 15 minutes increments (i.e. 30 minutes would be 2 units) This code is not limited to annually
Smoking and tobacco use cessation counseling	<b>99406</b> - intermediate: 3 - 10 minutes	Patients must be a tobacco user at the time of billing.	Yes		Yes		No	Receives a bundling edit (procedure has unbundle relationship)when filed with 99407	
	<b>99407</b> -> 10 minutes	TennCare now covers smoking cessation products for all	Yes		Yes		Yes		
Counseling/risk factor reduction intervention	<b>99401</b> - 15 min individual	Need local CPT to provide in-house smoking cessation, weight management, bp counseling	Yes		Yes		No	Receives a bundling edit (procedure has unbundle relationship)when filed with 99403	Billing as telehealth would require a 95 modifier and POS 02 or 10****
	<b>99402</b> - 30 min individual		Yes		Yes		No	Receives a bundling edit (procedure has unbundle relationship)when filed with 99404	Billing as telehealth would require a 95 modifier and POS 02 or 10****
	<b>99403</b> - 45 min individual		Yes		Yes		No		Billing as telehealth would require a 95 modifier and POS 02 or 10****
	<b>99404</b> - 60 min individual		Yes		Yes		Yes		Billing as telehealth would require a 95 modifier and POS 02 or 10****
Diabetes Self-Management Education	<b>G0108</b> - Diabetes outpatient selfmanagement training services, individual, 30 minutes	Medicare requires ADA or AADE accreditation.	Yes		Yes		Yes		
	<b>G0109</b> - Diabetes outpatient selfmanagement training services, group session (2 or more), per 30 minutes		Yes		Yes		Yes		

Diabetes Prevention Program (DPP)	Core Sessions Months 1-6:	Requires CDC accreditation						
	G9873 - 1st session attended		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	G9874 - 4 sessions attended							
	G9875 - 9 sessions attended		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	Core Maintenance with 5% weight loss:							
	G9876 - 2 sessions attended in months 7-9		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	G9877 - 2 sessions attended in months 10-12		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	Ongoing Maintenance Months 13-24 (Maintained 5% weight loss and attended 2 sessions every 3 months):							
	G9882 - Months 13-15		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	G9883 - Months 16-18		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	G9884 - Months 19-21		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	G9885 - Months 22-24		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	Weight Loss Performance:							
	G9880 - Achieved 5% weight loss OR had absolute reduction of waist circumference by 3.2 cm during months 1-12		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
	G9881 - Achieved 9% weight loss during months 1-24		No	(Measurement/Reporting codes no fee)	No	(Measurement/Reporting codes no fee)	No	Measurement/Reporting codes no fee)
Subtotal Maximum Payment Attendance Only:								
Total Maximum Payment								

Chronic Care Management	99490 - Non-complex CCM	May be administered under general supervision (not personally performed by the billing practitioner but under overall direction not under same roof). Patients must be seen by billing provider within 12 months. In Rural Health Clinics or FQHCs must be initiated by provider but may be provided by clinical staff.	Yes	99490 receives a coding edit (subset/Redundant Procedure Disallow) - denied if care management service 99490 has already been reported for the same calendar month	Yes	No	G0446 receives a coding edit if it exceeds the maximum number of units that it can be performed each calendar year.	G0446 will allow if office visit is filed with modifier 25 Billing as telehealth would require a 95 modifier and POS 02 or 10**** This code is for 15 minutes increments (i.e. 30 minutes would be 2 units) Services rendered in the home should be billed with POS 12	
	99439 - CCM each additional 20 min		No	Receives a coding edit (per Medicaid guidelines, add-on procedure code 99439 has been submitted without an appropriate primary procedure	No	Receives a bundling edit (procedure has unbundle relationship)	No		
	99487 - Complex CCM first 60 min		Yes	99487 receives a coding edit (subset/Redundant Procedure Disallow) if care management service 99487 has already been reported for the same calendar month	Yes		Yes		
	99489 - Complex CCM each additional 30 min		No	Receives a coding edit (per Medicaid guidelines, add-on procedure code 99489 has been submitted without an appropriate primary procedure	No	Receives a coding edit (per Medicaid guidelines, add-on procedure code 99489 has been submitted without an appropriate primary procedure	Yes		
Remote Patient Management	99453 - Remote monitoring of physiologic parameter, initial set up included, monitoring of not less than 16 days	May be administered under general supervision (not personally performed by the billing practitioner but under overall direction not under same roof). Patients must be seen by billing provider within 12 months.	Yes		Yes	Yes			
	99454 - Device supply with daily recording or programmed alerts transmission, each 30 days (initial collection, transmission, report/summary with clinician)		Yes		Yes	Yes			
	99457 - Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month, requiring interactive communication with the patient/caregiver during the month; first 20 minutes		Yes		Yes	Yes	Yes		
	99458 - Each additional 20 minutes		No	Receives a coding edit (per Medicaid guidelines, add-on procedure code 99458 has been submitted without an appropriate primary procedure	No	Receives a coding edit (per Medicaid guidelines, add-on procedure code 99458 has been submitted without an appropriate primary procedure	Yes		
	99091 - Collection and interpretation of physiologic data, digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation requiring a minimum of 30 min of time		Yes		No	Receives a bundling edit (procedure has unbundle relationship) when filed with 99215 office visit code	No	Receives a bundling edit (procedure has unbundle relationship) when filed with 99407	

**See the following for more information on use of self-management and education codes by health coaches:**

[https://docs.ucare.org/filer\\_public/files/pp\\_chw.pdf](https://docs.ucare.org/filer_public/files/pp_chw.pdf)

<https://www.bluecrossmn.com/sites/default/files/DAM/2021-12/General-Coding-078-Community-Health-Worker.pdf>

[https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16\\_140357](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_140357)

<https://www.oregon.gov/oha/OEI/Documents/EOCCO-CHW-Policy.pdf>

**See the following for more information on use of preventive screening codes by health coaches:**

<https://www.aafp.org/pubs/fpm/issues/2017/1100/p25.html>

**See the following for more information on use of other counseling codes by health coaches:**

[https://www.aafp.org/dam/AAFP/documents/patient\\_care/lifestyle-medicine/lifestyle-reimbursement-coding.pdf](https://www.aafp.org/dam/AAFP/documents/patient_care/lifestyle-medicine/lifestyle-reimbursement-coding.pdf)

**See the following for more information on use of telehealth modifiers for above codes:**

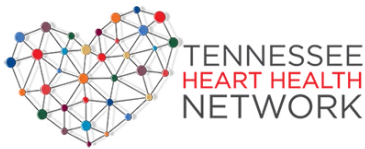
<https://medconverge.com/cpt-codes-for-telemedicine/>

<https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes>

<https://arkenea.com/blog/telemedicine-cpt-codes-and-billing/>

<https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

<https://doxy.me/en/telehealth-cpt-codes/>



# FAQs: Service Codes for Use by Health Coaches in Team-based Care

## Who's eligible to bill for and receive these services?

These reimbursement guidelines apply to all Tennessee Medicaid (TennCare) managed care organizations (MCOs) and the patients enrolled in these plans. These guidelines have been voluntarily adopted and were approved by all three TennCare MCOs in November 2023. In general, these guidelines are consistent with Medicare reimbursement guidelines, and other health plans in Tennessee may voluntarily adopt them. This guidance is particularly directed toward practices participating in the Tennessee Heart Health Network (TN-HHN).

## What services can lay health coaches (HC) provide for patients? And what billing codes can HC use in team-based care to get reimbursement for these services?

HC can deliver these services using the indicated billing codes for team-based care:

- G0446 – Intensive Behavioral Therapy for Cardiovascular Disease
- G0447 – Intensive Behavioral Therapy for Obesity
- 99406-99407 – Smoking and Tobacco Use Cessation Counseling
- 99401-99404 – Counseling/Risk Factor Reduction Intervention
- G0108-G0109 – Diabetes Self-Management Education (DSME)
- G9873-G9885 – Diabetes Prevention Program (DPP)

Please review the [TN-HHN Coding Review document](#), which was approved by the TennCare MCOs in November 2023, for more information about these codes and how they can be used in team-based care.

## Will the insurance companies accept these reimbursement codes?

The TennCare MCOs will accept these reimbursement codes when used by lay HC in primary care settings. In general, these guidelines are consistent with Medicare reimbursement, and other health plans in Tennessee may voluntarily adopt them.

## How will the provider bill this service?

The HC can provide direct services under the supervision of a physician, physician assistant or nurse practitioner. The supervising physician must be credentialed and contracted with the member's assigned MCO, be registered with the Division of TennCare and have a valid Medicaid ID for all dates of services on the claim. The supervising physician will be listed as the billing and rendering provider on the claim. The HC won't be listed on the claim form. Providers should follow all billing guidelines listed in the MCOs' provider administration manuals.

## Can a provider bill more than one service on one claim?

Yes. The provider can bill more than one service on one claim for these codes. When service codes are billed with a combination of other services on the same day, please append the appropriate modifier (basic guidelines for coding – for example, 25 modifiers if an evaluation and management (E&M) code is being billed). Please refer to coding sources to determine the appropriate modifier.

## Can providers use modifiers for telehealth services when these services are provided by phone or videoconference?

For these service codes, providers must append a modifier to indicate the service is telehealth. The use of a telehealth modifier code won't impact payment but is informational only for the health plan. Providers should use place of service (POS) 02 (telehealth) or POS 10 (telehealth in the member's home) modifiers for this purpose.

## What are the education, training and certification requirements for office-based HC in Tennessee?

Training will be provided through approved training and certification organizations. To ensure consistency and content, TN-HHN member organizations, in consultation with qualified TennCare provider organizations, have adopted common voluntary training and certification standards for HC in Tennessee to ensure quality and standardization for patient care (see the [TN-HHN Health Coach Training and Certification Standards document](#) for more information). These common standards will give clear guidance on how the TN-HHN will ensure consistency and high-quality training content. The three TennCare MCOs have agreed on these common standards, they are generally consistent with Medicare requirements, and other health plans can voluntarily adopt these standards.

## What training or certification will the HC need to have?

The HC will need to satisfactorily complete an existing HC training and certification program recognized and approved by the TN-HHN. Recognized programs' curricula and competencies adhere to those of the National Board for Health and Wellness Coaching (NBHWC) AND they use a competency-based assessment to grant certification. See the [TN-HHN Health Coach Training and Certification Standards document](#) for more detailed information about TN-HHN-recognized HC training and certification programs.

The following training and certification programs in Tennessee currently meet these standards:

- [UTHSC Health Coach Certification Program](#)
- [Vanderbilt Health Coaching Program](#)
- [Coalition for Better Health Training for Preventive Health Specialists](#)

## Will health coaches require credentialing and contracting?

No. HC won't require credentialing or contracting since the medical doctor or other qualified provider will bill the service.

## Will the HC need a Medicaid ID number?

No. HC won't need a Medicaid ID number since the medical doctor or other qualified provider will bill the service.

## How do the MCOs verify that HC have the correct training?

MCOs can verify that HC have the correct training by getting a copy of each HC's certification and contact information for the accrediting organization. Please provide this information to the MCO or health plan on request.

## Can a practice subcontract with a vendor for remote patient management/monitoring (RPM) services?

Yes, a practice is allowed to do so if all subcontracting requirements are followed. Several of the codes reflect services that appear somewhat inclusive under other codes (e.g., if providing diabetes prevention program (DPP) education, can the tobacco and obesity codes also be billed?).

## Can HC provide more than one of these services on the same day or is this considered a duplication of services?

There is some overlap, but on some occasions, billing providers can bill for more than one service delivered by HC on the same day. If the provider's intent is to bill for more than one of these services on the same day, they should append the appropriate 59 modifier on claims. Providers should use the 25 modifier if the service(s) are provided in combination with an E&M service. Please refer to standard coding sources to determine the appropriate modifier and procedure code standards.

## What combinations of codes can providers submit during visits?

Providers could possibly submit many different combinations during a visit, but only if all services provided meet billing guidelines. For example: 99401-99404 (Counseling/Risk Factor Reduction Intervention) generally shouldn't be billed with G0446-G0447 (Intensive Behavioral Therapy for Cardiovascular Disease and Intensive Behavioral Therapy for Obesity) and/or 99406-99407 (Smoking and Tobacco Use Cessation Counseling). If combinations of these codes are submitted, the appropriate modifier (e.g., 59 or 25) should be billed based on standard billing guidelines.

### **How will TennCare MCOs and other health plans audit to ensure services are accurately and consistently provided to the members?**

All HC visits and essential visit elements, including the visit length, goals of the visit and patient plans for behavioral change, should be documented in the electronic health record (EHR). Health outcomes may also be assessed. We'll create and share visit note EHR templates for each service with practices through the TN-HHN and TN-HHN member organizations.

### **Should the National Correct Coding Initiative (NCCI) coding edits apply to this initiative?**

Yes. The NCCI promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments of Medicare Part B and Medicaid claims. Standing NCCI coding edits apply to this initiative. Reporting codes (e.g., codes in categories Z55-Z65 describing social determinants of health) are ICD-10 diagnosis codes that don't have fee schedules associated with them.

### **Are these codes submitted for informational purposes only?**

Yes. Reporting codes are submitted for informational purposes only.

### **Can pharmacists and other billing providers use these codes?**

All three TennCare MCOs will be doing more collaborative research in 2024 to answer this question. At this time, the statement above, "The HC can provide direct services under the supervision of a physician, physician assistant or nurse practitioner," holds true.

### **Do HC have to be part of an ADA- or AADE-accredited program to bill for Diabetes Self-Management Education (DSME) services?**

Yes and no, depending on the patient's coverage. TennCare MCOs and other health plans following these guidelines don't require HC to be part of an ADA- or AADE-accredited program to bill for DSME services. However, Medicare does require ADA or AADE accreditation for providers to bill for DSME services.

### **Where can providers get more information if they have questions not covered in this document?**

For questions not covered in the above responses, providers should contact their MCO or health plan network managers for assistance.