Summary of Medicare Services to Address Health Related Social Needs

Background

The Centers for Medicare and Medicaid Services (CMS) established new coding and payment for a set of services designed to address beneficiaries' health related social needs (HRSNs). These nonmedical drivers of health, or HRSNs, include individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation. Addressing patients' nonmedical drivers of health helps to better manage chronic conditions, prevent avoidable emergency department visits and hospitalizations, and achieve population health goals.

Many of these services were effective January 1, 2024, with additional modifications going into effect January 1, 2025. These services were created to better account for the resources required to furnish person-centered, team-based care. The new services include community health integration (CHI), principal illness navigation (PIN), principal illness navigation peer support (PIN-PS), and social determinants of health (SDOH) risk assessment. Importantly, these codes allow reimbursement for work done by auxiliary personnel, including community health workers (CHWs), incident to the professional services of the billing Medicare provider. Medicare providers can also contract with community-based organizations (CBOs) that employ CHWs, peer support specialists, and other auxiliary personnel to address identified HRSNs and connect patients with appropriate services, so long as they meet all "incident to" requirements.

Community Health Integration Services

- Performed by a CHW or other auxiliary personnel incident to the professional services of the practitioner who bills the CHI initiating visit.
- Designated as care management services that may be furnished under the general supervision of the billing practitioner.
- Intended to help resolve a patient's HRSNs that are impacting their care and the practitioner's ability to properly diagnose and treat the patient.

G0019—CHI services, 60 minutes per calendar month [RVU 1.00] and G0022—CHI services, each additional 30 minutes [RVU 0.70]

Services performed by certified or trained auxiliary personnel under the direction of a physician or other practitioner; in the following activities to address SDOH need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating visit: Person-centered assessment; practitioner, home-, and community-based care coordination; 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 to provide support, mentorship, or inspiration to meet treatment goals.

Principal Illness Navigation and Principal Illness Navigation-Peer Support Services

- PIN service activities are parallel to CHI services, but focused on patients with a serious, high-risk illness who may not necessarily have SDOH needs.

- PIN-PS services are limited to the treatment of behavioral health conditions that otherwise satisfy the definition of a high-risk condition(s), with service activities tailored to the work of certified peer support specialists.
- Intended to account for when auxiliary personnel under the direction of a billing practitioner, support patient navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/ decompensation, functional decline, or death.
- Designated as care management services that may be furnished under the general supervision of the billing practitioner.

G0023—PIN services, 60 minutes per calendar month, [RVU 1.00] and G0024—PIN services, each additional 30 minutes [RVU 0.70]
Services performed by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist, following an initiating visit.

G0140—PIN-PS services, 60 minutes per calendar month, [RVU 1.00] and G0146—PIN-PS services, additional 30 minutes per calendar month, [RVU 0.70]
Services performed by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist. PIN and PIN-PS services cannot be billed concurrently.

Social Determinants of Health Risk Assessment

- Intended to value work of administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to a qualifying Annual Wellness Visit (AWV), behavioral health, or evaluation and management (E/M) visit.
- The SDOH risk assessment is not designed to be a screening, but intended to be used when a practitioner has reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment of a condition or illness.
- SDOH needs identified through the risk assessment must be documented in the medical record and may be documented using Z codes.

G0136—SDOH Risk Assessment, 5-15 minutes, [RVU 0.18], limited to once every 6 months per practitioner per beneficiary
Administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties. Acceptable tools include CMS Accountable Health Communities (AHC) tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

Considerations for Implementation by Value-Based Care Providers
Value-based care (VBC) models such as accountable care organizations (ACOs) are incentivized to improve quality while controlling costs. Given the strong influence that unmet social needs have on health outcomes, addressing these factors is critical to the success of VBC. Studies have shown that VBC providers are increasingly working to address patients' nonmedical needs to improve their health. Many VBC strategies focus on patient-centered care and improved care coordination, including increased integration of home and community-based services.

Many VBC providers and entities provide the services described in the CHI, PIN, and SDOH risk assessment codes as they support population health strategies and patient-centered care coordination.

While introduction of these new codes now offers a pathway to reimbursement for this work, certain challenges may prevent VBC providers from actually billing these codes.

Challenges

- Required cost sharing is a significant barrier to obtaining patient consent for billing.
- Significant administrative burden associated with counting time and other documentation required for billing purposes.
- Impact on total cost of care. Many ACOs pay for care management and patient navigation services as an expense, such as through shared savings, because seeking reimbursement would increase ACO expenditures as measured against the benchmark and negatively impact the ACO's ability to earn shared savings.

Potential Solutions

- Use grant funding to embed CHWs, starting with a targeted population before expanding.
- Leverage outside vendors that support care management services; this typically requires larger scale.
- Reduce administrative burden on health care providers by using an electronic health record (EHR) platform to set up an order for providers to establish CHI and PIN services. This allows for two pathways for patients: (1) provider identifies need(s) during a visit and uses order to refer patient to care management team, or (2) social worker identifies a patient with a need, gets patient consent, and pushes order to the patient's provider to see the patient and authorize CHI/PIN services.

Resources

- NAACOS Discovery Call on Community Health Integration and Part B Payment Codes
- Partnership to Align Social Care HRSN Codes Implementation Resources
    - Understanding Medicare PFS Codes for CHI, PIN, PIN-PC: A Primer
- Freedmen's Health Consulting Community Health Integration & Principal Illness Navigation Implementation Resources
- Medicare Learning Network: Health Equity Services in the 2024 Physician Fee Schedule Final Rule
- CMS Fact Sheet on 2024 Medicare PFS Final Rule
- CMS Innovation Center Key Concepts: SDOH and HRSN

Coming soon: NAACOS recently began working with the Partnership to Align Social Care to identify opportunities and develop joint resources that support VBC providers and entities in contracting with CBOs and community care hubs to deliver these services and address patients' needs. If you are interested in learning more about NAACOS' work in this space, or if you would like to share your experiences implementing these services for your organization's Medicare beneficiaries, please contact us at advocacy@naacos.com.