

Review of New Medicare Payment Policies Addressing Health-Related Social Needs Under the Calendar Year 2024 Physician Fee Schedule

I. Background

The Centers for Medicare & Medicaid Services (CMS) reimburses physicians for care furnished under Medicare Part B based on the Medicare Physician Fee Schedule (PFS). In other words, Medicare uses the PFS to determine reimbursement for services including the professional services of physicians and other enrolled health care providers, services covered “incident to” physicians’ services, and certain diagnostic tests (i.e., diagnostic tests other than clinical laboratory tests). The PFS lists [more than 10,000](#) unique covered service codes and their payment rates.

CMS updates the PFS on a regular basis. Payment policy changes are published annually, which process kicks off with a proposed rule to allow for public comment. For Calendar Year (CY) 2024, the [final rule](#) was released on November 2nd.

II. Overview of the Final Rule’s New Payment Policies for Services Addressing Health-Related Social Needs (HRSN)

This analysis focuses on one specific aspect of the final rule: new payment policies for services addressing HRSN. More specifically, CMS has created new codes for (1) Social Determinants of Health (SDOH) Risk Assessment, (2) Community Health Integration (CHI) Services to address unmet HRSN that affect the diagnosis and treatment of a patient’s medical problems, and (3) Principal Illness Navigation (PIN) Services to help people with Medicare who are diagnosed with high-risk conditions identify and connect with appropriate clinical and support resources.

While the individual policies are summarized in greater detail in sections III, IV, and V of this document, there are several cross-cutting themes worth noting. **First**, CMS commentary and the reimbursement rules that attach to these newly recognized services emphasize a close connection between a patient’s clinical care and the delivery of HRSN services and supports. For example, control over the initiation of SDOH risk assessment, CHI services, and/or PIN services rests firmly with Medicare Part B practitioners. There is an expectation that HRSN interventions will be responsive to and integrated into a patient’s care plan. **Second**, the final rule shows that CMS is trying to meet patients and communities where they are. Subject to some firm constraints, discretion is afforded on key aspects such as who can provide these services, how these services are provided, and how often these services can occur. **Finally**, CMS recognizes that these new services intersect with one another, and that these services intersect with other existing covered services, such as care management; the Agency has proactively tried to create sufficient flexibility for overlap. For example, even if an SDOH risk assessment occurs, SDOH needs can be further assessed as part of CHI or PIN services.

III. Social Determinants of Health Risk Assessment

- **New code created:** HCPS Code G0136, Administration of a standardized, evidence-based SDOH risk assessment, 5-15 minutes, not more than every 6 months (per practitioner, per beneficiary)
 - The final rule also adds the code to the Medicare Telehealth List as a permanent code.
- **CMS distinguishes between risk assessment and screening.** SDOH risk assessment refers to a review of an individual’s SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions. It “is 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.” The code is not intended for “routine screening for SDOH at standard intervals or every visit.”

- **The SDOH risk assessment is reimbursable when performed in conjunction with an allowable associated visit.** The types of associated visits that can be performed with HCPCS code G0136 expanded somewhat between the proposed rule and the final rule. In addition to outpatient E/M as proposed, SDOH risk assessment can also be furnished with certain behavioral health visit codes, annual wellness visit, hospital discharge visits, and transitional care management E/M visits. CMS explains the rationale for the limit as follows: “[W]e are generally wary of paying for SDOH risk assessment upon every interaction with the health care system since this could be burdensome for the patient and have less utility if the unmet SDOH needs are never addressed or followed up with in a longitudinal way.”
- **CMS generally expects same day administration of the risk assessment and an associated visit.** According to CMS, “there are limited scenarios in which we envision a practitioner would know ahead of visit that an SDOH risk assessment would be appropriate, such as a patient who has a history of unmet social needs or the patient disclosed such information before the visit.”
- **The final rule is flexible in terms of which evidence-based risk assessment tool is used and approaches to documentation.** The tool must include domains of food insecurity, housing insecurity, transportation needs, and utility difficulties. The final rule requires documentation but only encourages use of “Z codes” in documentation. (“Z codes” are a subcategory of the International Classification of Diseases, Clinical Modification (ICD-CM) which can be used to capture standardized information on social determinants of health.)
- **CMS expects that information derived from a risk assessment is acted upon**—that a practitioner furnishing an SDOH risk assessment would, at a minimum, refer the patient to relevant resources and take into account the results of the assessment in their medical decision making, or diagnosis and treatment plan for the visit.” CMS leaves open the opportunity to reevaluate whether to pair SDOH risk assessment with (i.e., condition payment on) capacity to furnish CHI services, PIN services, or other care management services, or have partnerships with CBOs to address identified SDOH needs.

IV. Community Health Integration (CHI) Services

- **New codes created:** (1) HCPCS code G0019, Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in activities to address SDOH need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating visit; and (2) HCPCS code G0022, Community health integration services, each additional 30 minutes per calendar month.
- **CHI services are described broadly.** CMS lists the following 8 categories: 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; and leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.
- **Before CHI services can start, there must be an initiating visit.** During the visit, the billing practitioner assesses and identifies SDOH needs that significantly limit the practitioner’s ability to diagnose or treat the patient’s medical condition and establish an appropriate treatment plan. A CHI initiating visit can be an E/M visit (other than a low-level E/M visit that can be performed by clinical staff), including an E/M visit furnished as part of transitional care management, or an annual wellness visit.

- **CHI services must be furnished by the billing practitioner of the initiating visit or under the general supervision of the billing practitioner.** The practitioner may arrange to have services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs or other auxiliary personnel. CMS describes itself as aiming for balance between clinical and community engagement. “We are allowing for the broadest level of supervision possible (general supervision) and contracting with third parties (such as CBOs) in accomplishing the furnishing of CHI services but this must be part of clinical care and treatment by the billing practitioner.”
- **CHI service providers must be certified or trained to perform all included service elements, and authorized to perform them under applicable State laws and regulations.**
 - In states with applicable rules, training/certification must meet any applicable requirements to provide the services that are imposed by the State.
 - In states that do not have applicable rules, training required to provide CHI services must include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity-building, service coordination and system navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including of local community-based resources.
 - CMS does not specify a required number of training hours that need to be obtained in states that do not have an applicable rule to specify the number of required hours.
- **Patient consent is required in advance of providing CHI services.** Consent may be obtained either in writing or verbally, as long as the consent is documented in the patient’s medical record. The consent process must include explaining to the patient that cost sharing applies and that only one practitioner may furnish and bill the services in a given month. Consent for CHI services may be obtained by auxiliary personnel and must be obtained if there is a change in the billing practitioner.
- **CMS acknowledges that CHI services may be available in person, virtually, or through a mix of interactions.** However, the Agency also expects that most elements of CHI services will involve direct contact between providers and patients. (Note: CMS does not add CHI services to the Medicare Telehealth List. This is because elements of CHI services may not require face-to-face interaction with patients.)
- **The final rule does not impose a frequency limit for HCPCS code G0022.** However, only one practitioner may furnish and bill the services in a given month.

V. Principal Illness Navigation (PIN) Services

- **New codes created:** (1) HCPCS code G0023, Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month; (2) HCPCS code G0024, Principal Illness Navigation services, additional 30 minutes per calendar month; (3) HCPCS code G0140, Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month; and (4) HCPCS code G0146, Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month.

- **PIN services will be reimbursable where a patient has a “serious, high-risk condition” with certain additional characteristics.** The condition must be expected to last at least 3 months, place the patient at “significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death,” and require development, monitoring, or revision of a disease-specific care plan.
 - **Peer support codes are limited to the treatment of behavioral health conditions.**
- **PIN services are described broadly.** CMS lists the following 8 categories: 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; and leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.
- **Before PIN services can start, there must be an initiating visit.** A PIN initiating visit can be an E/M visit, an annual wellness visit, a psychiatric diagnostic evaluation, or a visit involving Health Behavior Assessment and Intervention services.
- **PIN services must be furnished by the billing practitioner of the initiating visit or under the general supervision of the billing practitioner.** The practitioner may arrange to have PIN services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as a CBO.
- **PIN service providers must be certified or trained to perform all included service elements, and authorized to perform them under applicable State laws and regulations.**
 - In states with applicable rules, training/certification must meet any applicable requirements to provide the services that are imposed by the State.
 - In states that do not have applicable rules, training required to provide PIN services must include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity-building, service coordination and system navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit.
 - The exception is for PIN peer support services. Training must be consistent with the [National Model Standards for Peer Support Certification](#) published by SAMHSA.
 - CMS does not specify a required number of training hours that need to be obtained in states that do not have an applicable rule to specify the number of required hours.
- **Patient consent is required in advance of providing PIN services.** Consent may be obtained either in writing or verbally, as long as the consent is documented in the patient’s medical record. The consent process must include explaining to the patient that cost sharing applies. Consent for PIN services may be obtained by auxiliary personnel and must be obtained annually.
- **CMS acknowledges that PIN services may be available in person, virtually, or through a mix of interactions.** (Note: CMS does not add PIN services to the Medicare Telehealth List. This is because elements of PIN services may not require face-to-face interaction with patients.)

- **The final rule does not impose a practitioner, frequency, or duration limit for PIN services.** Still, CMS notes ongoing concern about care fragmentation when patients receive multiple PIN services for different high-risk conditions: “We believe that PIN is best suited for situations in which the navigator can serve as a point of contact for the patient. Given this, we do not expect a patient to require multiple PIN services for a prolonged period of time, except in circumstances in which a patient is receiving PIN services for highly specialized navigation, such as behavioral health or oncology.”

Appendix
Summary of Proposed Rule

The chart below reviews the **proposed rule** that was released in July 2023. We have appended it to the summary of the **final rule** for comparison purposes only.

Service	Proposed Codes and Valuation	Additional Information on Proposed Parameters
Community Health Integration (CHI) Services	<p>GXXX1 Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address SDOH need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit:</p> <ul style="list-style-type: none"> (a) Person-centered assessment (b) Practitioner, home-, and community-based care coordination (c) Health education (d) Building patient self-advocacy skills (e) Health care access / health system navigation (f) Facilitating behavioral change (g) Facilitating and providing social and emotional support (h) Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals <p>GXXX2 Community health integration services, each additional 30 minutes per calendar month</p> <p>Valuation for GXXX1 = Work RVU of 1.00; work time of 25 minutes</p>	<ul style="list-style-type: none"> • Initiating visit: CHI services could be furnished monthly, as medically necessary, following an initiating Evaluation/Management visit in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner’s ability to diagnose or treat the problem(s) addressed in the visit. CMS would not require an initiating E/M visit every month that CHI services are billed—only before commencing CHI services (to establish the treatment plan, specify how addressing the unmet SDOH need(s) would help accomplish that plan, and establish the CHI services as incident to the billing practitioner’s service). Per CMS, “certain types of E/M visits, such as inpatient/observation visits, ED visits, and SNF visits would not typically serve as CHI initiating visits because the practitioners furnishing the E/M services in those settings would not typically be the ones to provide continuing care to the patient, including furnishing necessary CHI services in the subsequent month(s).” • Billing and documentation: The same practitioner would furnish and bill for both the CHI initiating visit and the CHI services. Time spent furnishing CHI services for purposes of billing HCPCS codes GXXX1 and/or GXXX2 would have to be documented in the patient’s medical record in its relationship to the SDOH need(s) they are intended to address and the clinical problem(s) they are intended to help resolve. Per the proposed rule, “[t]he activities performed by the auxiliary personnel would be described in the medical record, just as all clinical care is documented in the medical record. We are proposing to require the SDOH need(s) to be recorded in the patient’s medical record, and for data standardization, practitioners would be encouraged to record the associated ICD-10 Z-code (Z55-Z65) in the medical record and on the claim.” Only one practitioner per beneficiary per calendar month could bill for CHI services to support coordination and avoid duplication / fragmentation in addressing specific SDOH. • Service delivery: CHI services would have to be performed by “certified or trained auxiliary personnel,” which may be a CHW, incident to the professional services and under the general supervision of the billing practitioner. <ul style="list-style-type: none"> ○ General supervision means the service is furnished under the physician’s (or other practitioner’s) overall direction and control, but the physician’s (or other practitioner’s) presence is not required during the performance of the service.

Service	Proposed Codes and Valuation	Additional Information on Proposed Parameters
	Valuation for GXXX2 = Work RVU of .70; work time of 20 minutes	<ul style="list-style-type: none"> ○ In States where there are no applicable licensure or other laws or regulations relating to individuals performing CHI services, we are proposing to require auxiliary personnel providing CHI services to be trained to provide them. Training must include the competencies of patient and family communication, interpersonal and relationship building, patient and family capacity-building, service coordination and system navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including of local community-based resources. ○ Regarding scope, CMS explains that “[s]ince Medicare payment generally is limited to items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury, the focus of CHI services would need to be on addressing the particular SDOH need(s) that are interfering with, or presenting a barrier to, diagnosis or treatment of the patient’s problem(s) addressed in the CHI initiating visit.” ○ Performance of services by a third party: CMS proposes that a billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the requirements and conditions for payment of CHI services are met. There must be “sufficient clinical integration between the third party and the billing practitioner.”
SDOH Risk Assessment	<p>GXXX5 Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.</p> <p>Valuation = Work RVU of .18; work time of 15 minutes</p>	<ul style="list-style-type: none"> ● Initiating visit: The SDOH risk assessment must be furnished by a practitioner on the same date they furnish an E/M visit, as the SDOH assessment would be reasonable and necessary when used to inform the patient’s diagnosis, and treatment plan established during the visit. ● Billing and documentation: The SDOH needs identified through the risk assessment must be documented in the medical record, and may be documented using Z codes Z55-Z65. ● Service delivery: Required elements would include 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. <ul style="list-style-type: none"> ○ Possible evidence-based tools include the CMS Accountable Health Communities 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. ○ CMS is also proposing to add this code to the Medicare Telehealth Services List to accommodate a scenario in which the practitioner (or auxiliary personnel incident to the practitioner’s services) completes the risk assessment via telehealth.
Principal Illness	GXXX3 Principal Illness Navigation services by certified or trained auxiliary personnel under the	<ul style="list-style-type: none"> ● Initiating visit: E/M visit performed by the billing practitioner who will also be furnishing the PIN services during the subsequent calendar month(s). During the visit, the billing practitioner

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Navigation (PIN) Services	<p>direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities:</p> <ul style="list-style-type: none"> (a) Person-centered assessment (b) Identifying or referring patient (caregiver, family) to appropriate supportive services (c) Practitioner, home-, and community-based care coordination (d) Health education (e) Building patient self-advocacy skills (f) Health care access / health system navigation (g) Facilitating behavioral change (h) Facilitating and providing social and emotion support (i) Leverage knowledge of the series, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals <p>GXXX4 Principal Illness Navigation services, additional 30 minutes per calendar month</p> <p>Valuation for GXXX3 = Work RVU of 1.00; work time of 25 minutes</p> <p>Valuation for GXXX4 = Work RVU of .70; work time of 20 minutes</p>	<p>would identify the medical necessity of PIN services and establish an appropriate treatment plan. CMS would not require an initiating E/M visit every month that PIN services are billed—only before commencing PIN services. Per CMS, “certain types of E/M visits, such as inpatient/observation visits, ED visits, and SNF visits would not typically serve as PIN initiating visits because the practitioners furnishing the E/M services in those settings would not typically be the ones to provide continuing care to the patient, including furnishing necessary PIN services in the subsequent month(s).”</p> <ul style="list-style-type: none"> • Eligible beneficiaries: The following characteristics would have to be present: (a) one serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death; <u>and</u> (b) The condition requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver. <ul style="list-style-type: none"> ○ According to CMS, “[e]xamples of a serious, high-risk condition/illness/disease include, but are not limited to, cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.” • Billing and documentation: The PIN initiating visit would be billed separately, and would be a pre-requisite to billing for PIN services. The same practitioner would furnish and bill for both the PIN initiating visit and the PIN services. Time spent furnishing PIN services for purposes of billing HCPCS codes GXXX3-4 must be documented in the medical record in its relationship to the serious, high-risk illness. The activities performed by the auxiliary personnel, and how they are related to the treatment plan for the serious, high-risk condition, would be described in the medical record, just as all clinical care is documented in the medical record. CMS would require identified SDOH need(s), if present, to be recorded in the medical record, and for data standardization, practitioners would be encouraged to record the associated ICD-10 Z-code in the medical record and on the claim. Only one practitioner per beneficiary per calendar month could bill for PIN services for a given serious, high-risk condition. • Service delivery: PIN services would be performed by “certified or trained auxiliary personnel” incident to the professional services and under the general supervision of the billing practitioner. <ul style="list-style-type: none"> ○ General supervision means the service is furnished under the physician’s (or other practitioner’s) overall direction and control, but the physician’s (or other practitioner’s) presence is not required during the performance of the service. ○ In States that do not have applicable licensure, certification, or other laws or regulations, CMS proposes to require auxiliary personnel providing PIN services to be trained to provide them. Training must include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity

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		<p>building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit.</p> <ul style="list-style-type: none"> ○ Regarding scope, “[s]ince Medicare payment is limited to items and services that are reasonable and necessary for the diagnosis or treatment of illness or injury, with respect to addressing SDOH need(s), the focus of PIN services would need to be on addressing particular SDOH need(s) that are interfering with, or presenting a barrier to, diagnosis or treatment of the serious, high-risk condition.” ○ Performance of services by a third party: CMS proposes that a billing practitioner may arrange to have PIN services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO), if all requirements and conditions for payment of PIN services are met. There must be “sufficient clinical integration between the third party and the billing practitioner.”