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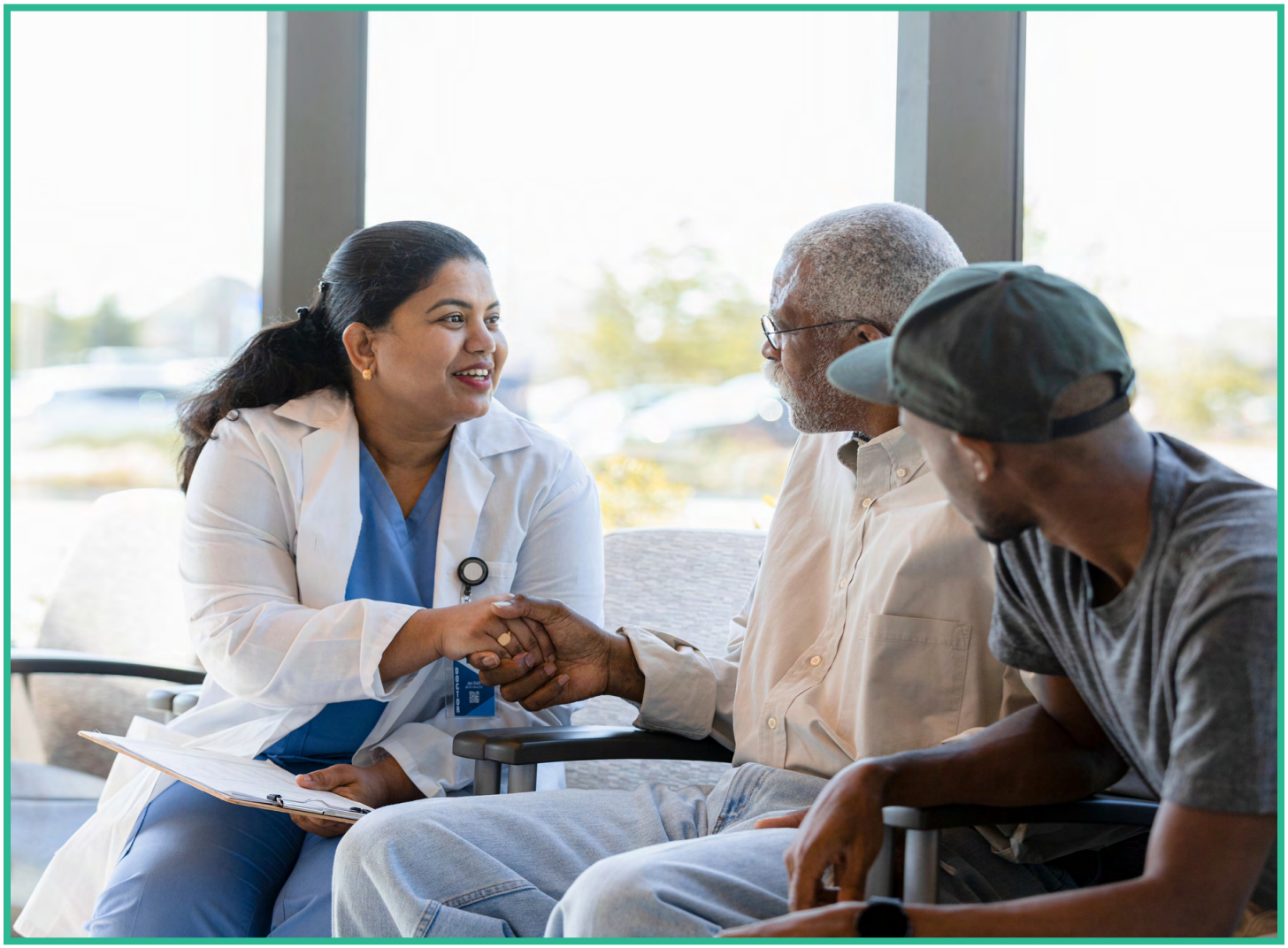
Health Equity Services in the 2024 Physician Fee Schedule Final Rule



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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We define health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes."

Our framework for health equity lists 5 priorities for reducing disparities in health. Each priority reflects a key area in which people from underserved and disadvantaged communities ask us to take action to advance health equity. The 5 health equity priorities are:

1. Expand the collection, reporting, and analysis of standardized data
2. Assess causes of disparities within our programs and address inequities in policies and operations to close gaps
3. Build capacity of health care organizations and the workforce to reduce health and health care disparities
4. Advance language access, health literacy, and the provision of culturally tailored services
5. Increase all forms of accessibility to health care services and coverage

Together we can advance health equity and help eliminate health disparities in rural communities, territories, Tribal nations, and geographically isolated communities. Find these resources and more from the CMS Office of Minority Health:

- Rural Health
- CMS Framework for Rural, Tribal, and Geographically Isolated Areas
- Data Stratified by Geography (Rural/Urban)
- Health Equity Technical Assistance Program

The 2024 Physician Fee Schedule (PFS) Final Rule has 4 services to help further address these priorities. These are:

Caregiver Training Services (CTS)

We created new coding to make payment when practitioners train and involve 1 or more caregivers to help patients carry out a treatment plan for certain diseases or illnesses, like dementia. For caregiver training services, we define a "caregiver" as "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" and "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition."

We'll pay for CTS when a physician or a non-physician practitioner (NPP) provides this training. NPPs include:

- Nurse practitioners
- Clinical nurse specialists (CNSs)
- Certified nurse-midwives (CNMs)
- Physician assistants (PAs)
- Clinical psychologists
- Therapists, including physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs)

We'll pay for CTS for patients under an individualized treatment plan or therapy plan of care, without the patient present. Use these CPT codes for CTS starting January 1, 2024:

- **96202:** Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
- **96203:** Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service)
- **97550:** Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes
- **97551:** Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use 97551 in conjunction with 97550)
- **97552:** Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers

To bill for CTS, you should select the appropriate group codes, like CPT codes 96202, 96203, or 97552 or individual codes like CPT codes 97550 or 97551, based on the number of patients represented by caregivers receiving training. If multiple caregivers for the same patient are trained in a group, you won't bill individually for each caregiver. Where more than 1 patient's caregivers are trained at the same time, you must bill under the group code for each patient represented, regardless of the number of caregivers. The patient's or representative's consent is required for the caregiver to get CTS, and you must document this in the patient's medical record.

Social Determinants of Health Risk (SDOH) Assessment

We finalized a new stand-alone G code, G0136, to pay for administering an SDOH risk assessment, no more than once every 6 months:

G0136: Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months.

You may provide this service with:

- An evaluation and management (E/M) visit, which can include hospital discharge or transitional care management services
- Behavioral health office visits, such as psychiatric diagnostic evaluation and health behavior assessment and intervention
- The Annual Wellness Visit (AWV)

SDOH risk assessments that you furnish as part of an E/M or behavioral health visit isn't a screening. It may be medically reasonable and necessary as part of a comprehensive social history, when you have reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment of a condition or illness or will influence choice of treatment plan or plan of care. In these circumstances, patient cost sharing will apply, just as it does for any medical service. The risk assessment wouldn't usually be administered in advance of the visit.

Example: A patient who hasn't been seen recently requests an appointment at a specific time or on a specific date due to limited availability of transportation to or from the visit, or requests a refill of refrigerated medication that went bad when the electricity was terminated at their home. If the patient hasn't gotten an SDOH risk assessment in the past 6 months, you could have the patient fill out an SDOH risk assessment 7–10 days in advance of an appointment as part of intake to ensure that you have enough information to appropriately treat them. You may also furnish SDOH risk assessments as an optional element of the AWV, in which case it's a preventive service and cost sharing won't apply.

SDOH risk assessment refers to a review of the individual's SDOH needs or identified social risk factors influencing the diagnosis and treatment of medical conditions. Use a standardized, evidence-based SDOH risk assessment tool to assess for:

- Housing insecurity
- Food insecurity
- Transportation needs
- Utility difficulty

You may choose a tool or ask additional questions that also include other areas if prevalent or culturally important to your patient population. Some tools you may consider that are standardized and evidence-based include the CMS Accountable Health Communities Tool, Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE), and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

Note: G0136 is also added to telehealth services on a permanent basis.

Community Health Integration (CHI)

We created 2 new service codes describing CHI services that auxiliary personnel, including community health workers (CHWs), may perform incidental to the professional services of a physician or other billing practitioner, under general supervision. The billing practitioner initiates CHI services during an initiating visit where the practitioner identifies unmet SDOH needs that significantly limit their ability to diagnose or treat the patient. The same practitioner bills for the subsequent CHI services provided by the auxiliary personnel. Initiating visits are personally performed by the practitioner, and include:

- An E/M visit
  - Can't be a low-level (level 1) E/M visit performed by clinical staff
  - Can be the E/M visit provided as part of Transitional Care Management (TCM) services
- An Annual Wellness Visit (AWV)

You must see a patient for a CHI initiating visit prior to furnishing and billing CHI services. We created CHI service codes for auxiliary personnel, including community health workers, to provide tailored support and system navigation to help address unmet social needs that significantly limit a practitioner's ability to carry out a medically necessary treatment plan. CHI services include items like:

- Person-centered planning
- Health system navigation
- Facilitating access to community-based resources
- Practitioner, home and community-based care coordination
- Patient self-advocacy promotion

You may provide CHI services following an initiating visit where you identify unmet SDOH needs that significantly limit your ability to diagnose or treat the patient. During this visit you'll establish the treatment plan, specify how addressing the unmet SDOH needs would help accomplish that plan, and establish the CHI services as incidental to your professional services. Auxiliary personnel can perform the subsequent CHI services.

Since there isn't a Medicare benefit for paying community health workers and other auxiliary personnel directly, we'll pay their services as incidental to the services of the health care practitioner who directly bills Medicare. See 42 CFR 410.26 and 42 CFR 410.27 for more information. The auxiliary personnel may be 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, if they meet all "incident to" requirements and conditions for payment of CHI services.

Auxiliary personnel must meet applicable state requirements, including licensure. In states with no applicable requirements, auxiliary personnel must be certified and trained in the following competencies:

- Patient and family communication
- Interpersonal and relationship-building skills
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Development of an appropriate knowledge base, including of local community-based resources

You or the auxiliary personnel under supervision must get advance patient consent before furnishing CHI services. Consent can be written or verbal, so long as you document it in the patient's medical record. As part of consent, you must explain to the patient that cost sharing applies and that only 1 practitioner may furnish and bill the services in each month. You don't need to get consent again unless the practitioner furnishing and billing CHI changes.

Only 1 practitioner can bill for CHI services per month. This helps ensure a single point of contact for addressing social needs that may span other health care needs. It helps to avoid a fragmented approach and duplicative services.

We currently make separate payment under the PFS for a number of care management and other services that may include aspects of CHI services. Those care management services focus heavily on clinical, rather than social, aspects of care. You can furnish CHI services in addition to other care management services if you:

- Don't count time and effort more than once
- Meet requirements to bill the other care management services
- Perform services that are medically reasonable and necessary

You must document the patient's unmet social needs that CHI services are addressing in the medical record. Documenting ICD-10 Z-codes can count as the appropriate documentation. You can bill CHI services monthly as medically reasonable and necessary, billing for the first 60 minutes of CHI services (G0019) and then each additional 30 minutes thereafter (G0022). Also document the amount of time spent with the patient and the nature of the activities.

You don't necessarily need to perform these services in-person. We expect you to perform them using a combination of in-person and virtual via audio-video or via two-way audio since evidence shows that there should be some in-person interaction.

The new G codes for CHI:

- **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 the following activities to address social determinants of health (SDOH) need(s) that significantly limit the ability to diagnose or treat problem(s) addressed in an initiating visit:
  - Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit
    - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
    - Facilitating patient-driven goal-setting and establishing an action plan
    - Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan
  - Practitioner, home-, and community-based care coordination
    - Coordinating receipt of needed services from health care practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable)
    - Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
    - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
    - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s)
  - Health education – helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of SDOH need(s), and educating the patient on how to best participate in medical decision-making
  - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment
  - Health care access/health system navigation
    - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them

  - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
  - Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals
  - Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

- **G0022** – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)

Note: Certain types of E/M visits, such as inpatient and observation visits, emergency department (ED) visits, and skilled nursing facility (SNF) visits, wouldn't serve as CHI initiating visits because the practitioners providing the E/M visit wouldn't typically be the one providing continuing care to the patient, including providing necessary CHI services in the subsequent months.

Principal Illness Navigation (PIN)

We created 4 new service codes describing PIN services that auxiliary personnel, including care navigators or peer support specialists, may perform incidental to the professional services of a physician or other billing practitioner, under general supervision. Two codes describe PIN services, and 2 codes describe Principal Illness Navigation-Peer Support (PIN-PS) services, which are intended more for patients with high-risk behavioral health conditions and have slightly different service elements that better describe the scope of practice of peer support specialists. In general, where we describe aspects of PIN, it also applies to PIN-PS unless otherwise specified.

The billing practitioner initiates PIN services during an initiating visit addressing a serious high-risk condition, illness, or disease, with these characteristics:

- 1 serious, high-risk condition and for PIN-PS, a serious, high-risk *behavioral health* condition expected to last at least 3 months that places the patient at significant risk of:
  - Hospitalization
  - Nursing home placement
  - Acute exacerbation or decompensation
  - Functional decline or death
- A condition that 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

Examples of a serious, high-risk condition, illness, or disease include:

- Cancer
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Dementia
- HIV/AIDS
- Severe mental illness
- Substance use disorder

A health care practitioner initiates PIN services during an initiating visit where they identify the medical necessity of PIN services and establish an appropriate treatment plan. The same practitioner bills for the subsequent PIN services that auxiliary personnel provide. The billing practitioner personally performs initiating visits including:

- E/M visit, other than a low-level E/M visit done by clinical staff
- A Medicare AVW provided by a practitioner who meets the requirements to furnish subsequent PIN services
- CPT code 90791 (Psychiatric diagnostic evaluation) or the Health Behavior Assessment and Intervention (HBAI) services that CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168 describe

You must see a patient for a PIN initiating visit before furnishing and billing PIN services. We created PIN services for auxiliary personnel like patient navigators and peer support specialists to provide navigation in the treatment of a serious, high-risk condition or illness. These services help guide the patient through their course of care, including addressing any unmet social needs that significantly limit the practitioner's ability to diagnose or treat the condition. PIN services include items like:

- Health system navigation
- Person-centered planning
- Identifying or referring patient and caregiver or family, if applicable, to supportive services
- Practitioner, home, and community-based care coordination or communication
- Patient self-advocacy promotion
- Community-based resources access facilitation

The billing practitioner or auxiliary personnel may provide PIN services following an initiating visit where the billing practitioner addresses the serious, high-risk condition. During this initiating visit, the billing practitioner will establish the treatment plan, specify how PIN services are reasonable and necessary to help accomplish that plan, and establish the PIN services as incidental to their professional services. Auxiliary personnel can perform the subsequent PIN services.

Since there isn't a Medicare benefit for paying navigators and peer support specialists directly, we'll pay for their services as incidental to the services of the health care practitioner who directly bills Medicare. The auxiliary personnel may be external to, and under contract with, the practitioner or their practice, such as

through a CBO that employs navigators, peer support specialists or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of PIN services.

Auxiliary personnel must meet applicable state requirements, including licensure. In states with no applicable requirements, auxiliary personnel providing PIN services must be trained or certified in the competencies of:

- Patient and family communication
- Interpersonal and relationship-building
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Developing an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed

For PIN-PS services (HCPCS codes G0140 and G0146), if no applicable state requirements exist, the training must be consistent with the National Model Standards for Peer Support Certification published by Substance Abuse Mental Health Services Administration (SAMHSA). This is the most universally recognized standard for peer support specialists in the country and was developed and is maintained by SAMHSA, who has an expertise in this area.

The billing practitioner or the auxiliary personnel under supervision must get advance patient consent before providing PIN services, and annually thereafter. Consent can be written or verbal, so long as you document it in the patient's medical record. Explain to the patient that cost sharing will apply.

The billing practitioner can't furnish PIN services more than once per practitioner per month for any single serious high-risk condition. This avoids duplication of PIN service elements when utilizing the same navigator or billing practitioner. Don't bill PIN and PIN-PS services concurrently for the same serious, high-risk condition.

We currently make separate payment under the PFS for a number of care management and other services that may include aspects of navigation services. Those care management services focus heavily on clinical, rather than social, aspects of care. You can furnish PIN services in addition to other care management services if you:

- Don't count time and effort more than once
- Meet requirements to bill the other care management services
- Perform services that are medically reasonable and necessary

In the medical record, document the amount of time the auxiliary personnel spent with the patient and the nature of the activities. Document any unmet social needs that PIN services are addressing. Documenting ICD-10 Z-codes can count as the appropriate documentation.

The billing practitioner or auxiliary personnel don't necessarily need to perform these services in-person. We expect that many service elements will involve direct patient contact, especially for PIN-PS services, and may be most impactful when provided in-person.

We finalized the following PIN service codes:

- **G0023:** Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:
  - Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition
    - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
    - Facilitating patient-driven goal setting and establishing an action plan
    - Providing tailored support as needed to accomplish the practitioner's treatment plan
  - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
  - Practitioner, home- and community-based care communication
    - Coordinating receipt of needed services from health care practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable)
    - Communicating with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
    - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
    - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
  - Health education - helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
  - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
  - Health care access/health system navigation
    - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them
    - Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable

  - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
  - Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals
  - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

- **G0024:** Principal illness navigation services, additional 30 minutes per calendar month (List separately in addition to G0023)
- **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, in the following activities:
  - Person-centered interview, performed to better understand the individual context of the serious, high-risk condition
    - Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that aren't billed separately)
    - Facilitating patient-driven goal setting and establishing an action plan
    - Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan
  - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
  - Practitioner, home, and community-based care communication
    - Assisting the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors
    - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
  - Health education
    - Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making

  - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
  - Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals
  - Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals
  - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

- **G0146:** Principal illness navigation - peer support, additional 30 minutes per calendar month (List separately in addition to G0140)

Note: Certain types of E/M visits, like inpatient and observation visits, ED visits, and SNF visits wouldn't serve as PIN initiating visits because the practitioner providing the E/M visit wouldn't typically provide continuing care to the patient, including providing necessary PIN services in subsequent months.

Resources:

- Caregiver Training Services in 2024 PFS final rule
- CMS Health Equity
- Community Health Integration in 2024 PFS final rule
- Health Equity Fact Sheet
- Principal Illness Navigation in 2024 PFS final rule
- SDOH Risk Assessment in 2024 PFS final rule