HEALTHCARE REGULATORY ROUND-UP #72

Getting Paid To Address Social Determinants of Health

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Introductions

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Today's Agenda

1. CMS Health Equity Strategy
2. New Medicare Reimbursement for SDOH-Related Services
   - SDOH Risk Assessment
   - Community Health Integration (CHI)
   - Principal Illness Navigation (PIN)
   - PIN Peer Support (PIN-PS)
   - FQHC/RCH reimbursement
3. Overcoming Challenges in Providing SDOH-Related Services

1. CMS Health Equity Strategy

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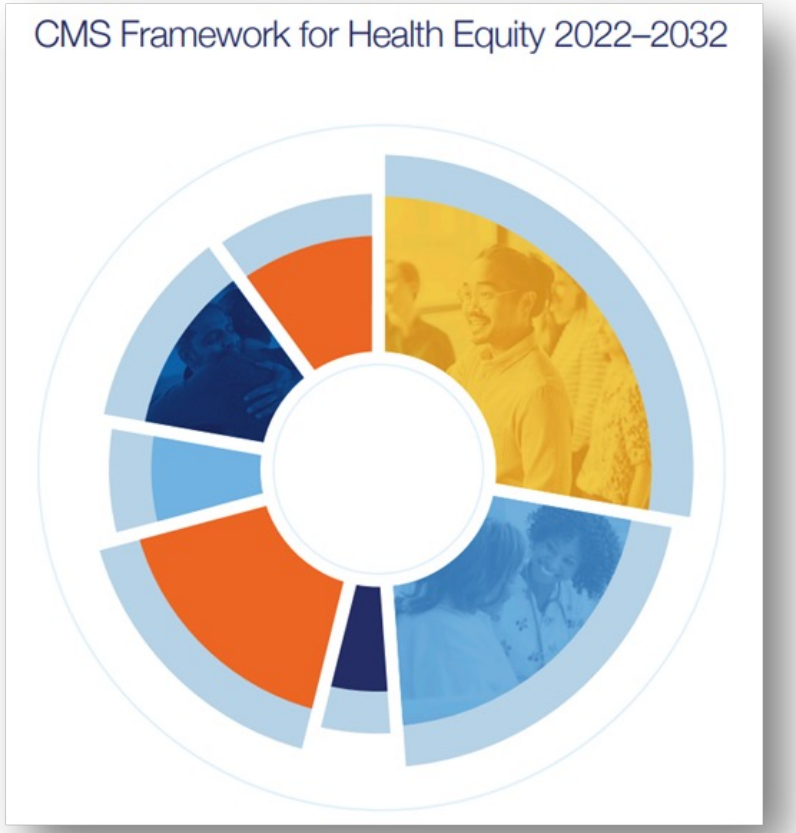
CMS Framework for Health Equity

"CMS recognizes that addressing health and health care disparities and achieving health equity should underpin efforts to focus attention and drive action on our nation's top health priorities."

The Framework "brings focus to CMS's work supporting health care organizations, health care professionals and partners … in activities to achieve health equity"



https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/framework-for-health-equity

CMS Health Equity Priorities

01
Expand collection, reporting, and analysis of standardized data

02
Assess causes of disparities within CMS programs and address inequities in policies and operations to close gaps

03
Build provider capacity to reduce health and healthcare disparities

04
Advance language access, health literacy, and provision of culturally tailored services

05
Increase all forms of accessibility to healthcare services and coverage

Hospital IQR Measure – Commitment to Health Equity

Domain	Elements
Equity is a Strategic Priority	Our hospital strategic plan – (A) Identifies priority populations who currently experience health disparities (B) Identifies healthcare equity goals and discrete action steps to achieving these goals (C) Outlines specific resources which have been dedicated to achieving our equity goals (D) Describes our approach for engaging key stakeholders
Data Collection	(A) Our hospital collects demographic information, including self-reported race and ethnicity and/or SDOH on the majority of patients (B) Our hospital has staff training in culturally sensitive collection of demographic and/or SDOH information (C) Our hospital inputs demographic and/or SDOH information collected from patients into structured, interoperable data elements using a certified EHR technology.
Data Analysis	Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards
Quality Improvement	Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities
Leadership Engagement	(A) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. (B) Our hospital senior leadership (including executives and trustees) annually reviews key performance indicators stratified by demographic and/or social factors.

Hospital IQR Measure
Screening for Health-Related Social Needs (HRSNs)

- Percentage of inpatients age 18+ screened for one or more or the following: (1) food insecurity, (2) housing instability, (3) transportation needs, (4) utility difficulties, (5) interpersonal safety
  - Use self-selected screening tool (e.g., AHC Health-Related Social Needs Screening Tool*)
  - Exclude from denominator (1) patients who opt-out of screening; and (2) patients unable to complete screening during inpatient stay who have no guardian/caregiver able to complete on patient's behalf
- Separately report positive screening rate for each of 5 domains

*https://www.cms.gov/priorities/innovation/media/document/ahcm-screeningtool-companion

What's a Social Determinant of Health (SDOH)?

- Non-medical factors that may influence individual's health status – no definitive list
- Reported using ICD-10-CM codes included in categories Z55-Z65

ICD-10-CM Code Category	Problems/Risk Factors Included in Category
Z55 – Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, less than a high school diploma, no general equivalence degree (GED), educational maladjustment, and discord with teachers and classmates.
Z56 – Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.
Z57 – Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.
Z58 – Problems related to physical environment	Inadequate drinking-water supply, and lack of safe drinking water.
Z59 – Problems related to housing and economic circumstances	Sheltered homelessness, unsheltered homelessness, residing in street, inadequate housing, housing instability, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, inadequate food, lack of adequate food, food insecurity, extreme poverty, low income, and insufficient social insurance and welfare support.
Z60 – Problems related to social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.
Z62 – Problems related to upbringing	Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility towards and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, personal history of unspecified abuse in childhood, parent-child conflict, and sibling rivalry.
Z63 – Other problems related to primary support group, including family circumstances	Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, and alcoholism and drug addiction in family.
Z64 – Problems related to certain psychosocial circumstances	Unwanted pregnancy, multiparity, and discord with counselors.
Z65 – Problems related to other psychosocial circumstances	Conviction in civil and criminal proceedings without imprisonment, imprisonment and other incarceration, release from prison, other legal circumstances, victim of crime and terrorism, and exposure to disaster, war and other hostilities.

https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM diagnosis codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- Identify individuals' social risk factors and unmet needs.
- Inform health care and services, follow-up, and discharge planning.
- Trigger referrals to social services that meet individuals' needs.
- Track referrals between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

CMS

For Questions: Contact the **CMS Health Equity Technical Assistance Program**

[1] https://www.cms.gov/medicare/icd-10/2024-icd-10-cm
[2] https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Reimbursement for Inpatient Services

- Claim includes Z-code for housing instability or inadequacy
- Change severity level designation from non-complication or comorbidity (Non-CC) to complication or comorbidity (CC)
  - Based on claims data analysis of impact on resource use –extended length of hospital stay, increased nursing care or monitoring or both, comprehensive discharge planning
  - Example – simple pneumonia
    - MS-DRG 195 (non-CC) = 0.6256
    - MS-DRG (CC) = 0.8222
- "We will continue to monitor SDOH Z code reporting, including reporting based on SDOH screening performed as a result of new [IQR] quality measures…. We may consider proposing changes for other SDOH codes in the future based on our analysis of the impact on resource use…."

ICD-10-CM Code[a]	Description[b]
Z59.10	Inadequate housing, unspecified
Z59.11	Inadequate housing environmental temperature
Z59.12	Inadequate housing utilities
Z59.19	Other inadequate housing
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified

Transforming Episode Accountability Model (TEAM)

- Proposed mandatory episodic payment program
  - Commencing in January 2026
  - Hospitals in selected CBSAs (25%) required to participate
- Health equity-related provisions
  - Participating hospitals must –
    - Submit health equity plans that demonstrate efforts to address disparities through program participation
    - Complete SDOH screenings and report sociodemographic data
  - Financial benchmarks (target prices) risk-adjusted based on beneficiary SDOHs

2. New Medicare Reimbursement for SDOH-Related Services

Image Source: Shutterstock

New Reimbursement for 4 Services

1. SDOH Risk Assessment – G0136
2. Community Health Integration (CHI) – G0019, G0022
3. Principal Illness Navigation (PIN) – G0023, G0024
4. PIN Peer Support (PIN-PS) – G0140, G0146

New reimbursement also available for Caregiver Training Services (CPT 96202-03, 97550-52)

For Your Reference

- Q&A discussion of CMS billing rules and reimbursement rates
  - 2024 MPFS Final Rule
  - January 2024 MLN booklet on Health Equity Services*
  - March 2024 Health-Related Social Needs FAQs**

*https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

**https://www.cms.gov/files/document/health-related-social-needs-faq.pdf

SDOH Risk Assessment - G0136

- Administration of standardized, evidence-based SDOH risk assessment tool, 5-15 minutes, not more often than once every 6 months
  - ***Not routine screening; administer when practitioner has reason to believe unmet SDOH needs interfering with ability to diagnose and/or treat patient***
    - Medical necessity (scope of Medicare Part B benefit under Social Security Act)
    - Documentation of reasons?
  - Permissible tools: CMS AHC Health-Related Social Needs Screening Tool, PRAPARE tool, instruments identified for MA Special Needs Population Risk Assessment
  - Identified needs must be documented in medical record
    - Encourage but do not require use of Z-codes
  - May be completed after date of E/M visit (but rarely in advance)
  - May be furnished by auxiliary personnel if 'incident to' requirements satisfied
    - Requires direct (not general) supervision
  - Included on Medicare Telehealth Services List
    - Must be audio/visual connection
- Payment rates: Non-facility - $18.67; Facility- $8.84 (+ APC 5821 - $28.29)

Community Health Integration (CHI) – G0019, G0022

- CHI Initiating Visit - E/M visit, TCM, or AWV in which billing practitioner identifies presence of SDOH need(s) that limit ability to diagnose/treat problem(s) addressed in visit
  - ED, inpatient/observation, and SNF E/M visits cannot serve as CHI initiating visits
  - Document beneficiary's unmet SDOH need(s) and how addressing need(s) will help accomplish practitioner's treatment plan for beneficiary
  - Limited to providing services relating to SDOHs identified by billing practitioner
- Performed by certified or trained auxiliary personnel under general supervision of billing practitioner (non-clinical; community health worker)
  - G0019 = 60 minutes per calendar month; G0022 – each add'l 30 minutes (no frequency limitation)
  - Auxiliary personnel must be certified or trained to perform all included service elements + authorized to perform then under applicable state law/regulation
- Service elements include 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 as necessary for meeting diagnosis and treatment goals; facilitating and providing social and emotional support

CHI Specifications

- Auxiliary personnel must document activities (including time, relationships to treatment plan) in billing practitioner's EHR
- Only one practitioner can bill for CHI services during given month (first to file)
- Must obtain one-time oral/written consent following notice of cost-sharing + only one practitioner can bill for CHI services during given month;
- Not covered if patient under home health plan of care
- Can bill in same month as care management services (no double-counting)
- Billing practitioner can arrange to have services furnished by third party provided there is sufficient clinical integration between third party and billing practitioner
- Payment rates
  - G0019 – Non-facility - $79.23; Facility - $48.78 (+ APC 5822 -$86.86)
  - G0022 – Non-facility - $49.44; Facility - $34.05 facility (no APC)

Principal Illness Navigation (PIN) - G0023, G0024

- Patients diagnosed with serious high-risk disease (e.g., cancer, COPD, dementia, SMI, SUD)
  - Expected to last at least 3 months that places patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decomposition, functional decline, or death
  - Requires development, monitoring, or revision of disease-specific care plan; may require frequent adjustment in medication/treatment regimen or substantial assistance from caregiver
- PIN Initiating Visit - E/M visit, TCM, or AWV in which billing practitioner identifies medical necessity for services, establishes treatment plan, and specifies how services would help accomplish that plan
- Like CHI, performed by certified or trained auxiliary personnel under general supervision of billing practitioner
  - G0023 = 60 minutes per calendar month; G0024 – each add'l 30 minutes (no frequency limitations)
  - Service elements include person-centered assessment; health education; health care access/health system navigation; facilitating and providing social and emotional support; identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services; building patient self-advocacy skills; facilitating behavioral change as necessary for meeting diagnosis and treatment goals; leverage knowledge of condition and/or lived experience to provide support to meet treatment goals

PIN Specifications

- Same as CHI, except –
  - More than one practitioner can bill for PIN services during given month in limited circumstances
    - "[W]e 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"
  - Must obtain oral or written patient consent following notice of cost-sharing before or at initiation of PIN services ***and annually thereafter***

PIN Peer Support - G0140, G0146

- PIN services furnished by peer support specialists (vs. CHWs)
  - Limited to beneficiaries with severe mental illness or SUD
  - Like PIN, except tailored scope of services consistent with peer support specialists' scope of practice
    - Specialist must satisfy any applicable state certification requirements or, if no such requirements exist, must have completed training consistent with SAMHSA's National Model Standards for Peer Support Certification
  - PIN and PIN-PS cannot be furnished concurrently for same condition
  - G0140 = 60 minutes per calendar month; G0146 – each add'l 30 minutes (no frequency limitations)
  - Same reimbursement as corresponding PIN codes

FQHC/RHC Reimbursement

- CHI, PIN, and PIN Peer Support added to list of general care management service reimbursable under G0511
  - In addition to transitional care management, chronic care management, principal care management, general behavioral health integration
  - CMS also added remote physiologic monitoring and remote therapeutic monitoring to list of services under Go511
- National payment rate = ~$73.00 (revenue code G0511)
- May bill G0511 multiple times in calendar month, provided all requirements are met + resource costs not double-counted
- No FQHC/RHC reimbursement for SDOH risk assessment

3. Overcoming Challenges in Providing SDOH-Related Services

Image Source: Shutterstock

Inadequate Reimbursement?

- Break-even assumptions
  - 50-patient panel (identified and consented)
  - CHW-related monthly expense - $3,500*
  - Bill and collect for one unit of G0019/G0023 per patient per month ($79.23 – POS 11)
  - Revenue = (50 x $79.23) x 0.90 [billing expense] = $3,565.35
- Other potential returns on investment
  - Providing SDOH-related services reduces burden on providers, office staff
  - Providing services reduces beneficiaries' total cost of care (shared savings/risk-based arrangements)

Workflow Adaptation?

- Hospital capture of the SDOH needs via SDOH screening
- Communication of SDOH needs between providers
- Triage process to identify potential SDOH needs and address thru SDOH Risk Assessment
- Consistent medical record documentation (medical necessity, provision of services)
- Standard ‘indicators’ of SDOH needs? (e.g., address, living conditions)
- Use of Z-codes for billing and data analysis

Engaging Patients?

- Evaluating existing patient panel to identify potentially eligible beneficiaries
- Introducing CHI/PIN services – overcoming patient distrust
  - Experience with care management services
- Obtaining consent
  - Addressing co-pay concerns (supplemental coverage, financial assistance policy)
  - Oral or written consent – must be documented in medical record
- Addressing cultural/language differences
  - Impact on available resources
  - New ACA 1557 Non-Discrimination Rules

Securing Staff?

Build or Buy?

- Hiring certified/trained personnel
  - Cost of certification/training
  - Connection to community resources
  - Job responsibilities (cross-training)
- Contract with community-based organization (CBO)
  - Local CBOs – Area Agencies on Aging, faith-based organizations
  - Negotiating contract terms, payment rates
  - Sufficient degree of integration/oversight by billing practitioner
    - Documentation, time tracking
- Consolidated services (e.g., ACO)

Providing General Supervision?

- General supervision vs. direct supervision
  - No physical (virtual) presence requirement
  - Ensure staff competency, provide program oversight, available to address issues
  - Delegation of responsibility - billing practitioner remains responsible for provision of services
- Engagement in process and informed of patient progress
  - Services not medically necessary unless SDOH needs impacting practitioner's ability to diagnose or treat the patient's condition
- Documentation of supervision/engagement
  - Consider having billing practitioner review/sign staff documentation
  - Other less burdensome ways to document practitioner engagement?

Other Challenges?

- Newness
  - Unanswered billing questions (2025 MPFS Proposed Rule)
  - No proven model to follow (bleeding edge vs. cutting edge)
- Provider resistance
  - Burden of assuming responsibility for SDOH-related services
- Alignment with care management services
  - Managing overlap between services

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