healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Medicare Health Equity Services		
Policy Number:	PO-RE-124v1		
Effective Date:	12/01/2024	**Last Approval Date:**	10/28/2024

I. Policy Description

This policy outlines the reimbursement guidelines for services related to the Health Equity Services framework established by the Centers for Medicare & Medicaid Services (CMS). The framework aims to address health-related social needs (HRSNs) that may hinder an individual's access to healthcare, resulting in poor health outcomes and increased medical costs.

The information below applies to the following lines of business:

- Medicaid Advantage Plus/MAP (CompleteCare)
- Medicare PPO
- Medicare Advantage

Health Equity Services are defined 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.”

Policy Scope

This policy applies to all healthcare providers, caregivers, care navigators, and peer support specialists participating in programs that offer services related to the Health Equity Services framework. The reimbursement guidelines outlined herein are designed to encourage the identification and addressing of social determinants of health needs to improve health outcomes and reduce healthcare expenses for individuals.

1. **Caregiver Training Services (CTS):**

   CTS equips caregivers with the necessary skills to assist the member in complying with their treatment plans. Reimbursement for CTS will be provided based on the completion of CMS-approved caregiver training programs.

- Frequency: Although there are no frequency restrictions on how often CTS can be billed, medical necessity should determine the frequency of services provided.
- CTS is covered when a physician or a non-physician practitioner (NPP) provides this training. NPPs include:
    - Nurse practitioners (NPs)
    - 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)
- Group Training: Providers should bill for one training service when multiple caregivers are trained in the same session, rather than billing separately for each caregiver.
- Telehealth: CTS is not reimbursable when provided through telehealth.
- 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 members represented by caregivers receiving training. If multiple caregivers for the same member are trained in a group, you would not bill individually for each caregiver. Where more than 1 member caregivers are trained at the same time, you must bill under the group code for each member represented, regardless of the number of caregivers. The member's or representative's consent is required for the caregiver to get CTS, and you must document this in the member's medical records.

CPT code listing:

Caregiver Training Services (CTS)		
Code	**Description**	**Frequency**
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	No frequency limit
96203	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis. Each additional 15 minutes (Use 96203 in conjunction with 96202)	No frequency limit
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community. Initial 30 minutes	No frequency limit

97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community. Each additional 15 minutes (Use 97551 in conjunction with 97550)	No frequency limit
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community; with multiple sets of caregivers	No frequency limit

2. Social Determinants of Health (SDOH) Risk Assessment:

The SDOH Risk Assessment helps providers identify social determinants of health needs that may impact the diagnosis and treatment of medical conditions. 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, or utility difficulty.

- Frequency: An SDOH Risk Assessment can be reimbursed once every six (6) months per patient.

- SDOH risk assessments that you furnish as part of an Evaluation and Management (E/M), or behavioral health visit is not 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, member 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 member 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 member hasn't gotten an SDOH risk assessment in the past 6 months, you could have the member 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.

- Any SDOH need identified through the risk assessment (HCPCS code G0136) must be documented in the member's medical records.

- Practitioners 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)

- Modifier 33 must be submitted on the claim to waive the cost-share once per year for a SDOH Risk Assessment (G0136) when done in conjunction with an AWV done on the same day.

CPT code listing:

Social Determinants of Health (SDOH) Risk Assessment		
Code	**Description**	**Frequency**
G0136	Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes	Once every six (6) months per practitioner, per beneficiary

3. Community Health Integration (CHI):

CHI services are necessary when a provider identifies an SDOH need that limits the diagnosis or treatment of a member. 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 member. The same practitioner bills for the subsequent CHI services provided by the auxiliary personnel. Initiating visits are 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)
- Frequency: Only 1 practitioner can bill for CHI service per month
- Telehealth: CHI can be performed in a telehealth setting.

Practitioners must see the member for a CHI initiating visit prior to furnishing and billing CHI services. There are 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 member. 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.

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

The practitioner or the auxiliary personnel under supervision must get advance member's consent before furnishing CHI services. Consent can be written or verbal, so long as you document it in the member's medical record. As part of the consent, you must explain to the member 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.

You must document the member'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 member and the nature of the activities.

- **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)

CPT code listing:

Community Health Integration (CHI)		
Code	**Description**	**Frequency**
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:	Monthly by one practitioner per month
G0022	Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)	Monthly by one practitioner per month
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month	Monthly by one practitioner per month

4. **Principal Illness Navigation (PIN):**
   PIN services address serious high-risk conditions, illnesses, or diseases expected to last at least three months.
   - Frequency: Once per practitioner per month for any single serious high-risk condition
   - Telehealth: While some service codes may not be covered in a telehealth setting, there are others that are more impactful when provided in person. It is the provider's responsibility to determine which services codes are appropriate for the telehealth setting.
   - Consent must be obtained before or at the time that services commence, and annually thereafter by the billing practitioner. If the billing practitioner changes, obtain a new consent. Consent can be written or verbal, so long as it is documented in the patient's medical record.
   - The amount of time spent by the auxiliary personnel, and the activities they performed in relation to the practitioner's plan of care, should be reflected in the patient's medical record.
   - When unmet social determinants of health (SDOH) needs are being addressed, those must be documented in the patient's medical record.
   - 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 do not 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.

- 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
  - 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 me et 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)

CPT code listing:

Principal Illness Navigation (PIN)		
Code	**Description**	**Frequency**
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,	Once per month per practitioner
G0024	Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to G0023)	Once per month per practitioner
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month	Once per month per practitioner
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	Once per month per practitioner
G0146	Principal illness navigation-peer support, additional 30 minutes per calendar month (list separately in addition to G0140)	Once per month per practitioner

II. Applicable Codes

The applicable codes listed in this section are categorized into the following categories: Caregiver Training Services (CTS), Community Health Integration (CHI), Principal Illness Navigation (PIN), and Social Determinants of Health Risk (SDOH) Assessment.

Code	Description	Comment
96202	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis. Initial 60 minutes	CTS No frequency limit

96203	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis. Each additional 15 minutes (Use 96203 in conjunction with 96202)	CTS No frequency limit
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community. Initial 30 minutes	CTS No frequency limit
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community. Each additional 15 minutes (Use 97551 in conjunction with 97550)	CTS No frequency limit
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community; with multiple sets of caregivers	CTS No frequency limit
G0136	Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes	SDOH Once every six (6) months per practitioner, per beneficiary
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:	CHI Monthly as medically necessary when the practitioner identifies the presence of SDOH which interferes with diagnosis or treatment.
G0022	Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)	CHI Monthly as medically necessary when the practitioner identifies the presence of SDOH which interferes with diagnosis or treatment.
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month	CHI Monthly as medically necessary when the practitioner identifies the presence of SDOH which interferes with diagnosis or treatment.
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,	PIN Once per month per practitioner
G0024	Principal illness navigation services, additional 30 minutes per	PIN

	calendar month (list separately in addition to G0023)	Once per month per practitioner
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month	PIN Once per month per practitioner
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	PIN Once per month per practitioner
G0146	Principal illness navigation-peer support, additional 30 minutes per calendar month (list separately in addition to G0140)	PIN Once per month per practitioner

III. Definitions

Term	Meaning
AWV	Annual Wellness Visit
CHI	Community Health Integration
CNM	Certified Nurse Midwife
CNS	Clinical Nurse Specialist
CTS	Caregiver Training Services
HCPCS	Healthcare Common Procedure Coding System
NP	Nurse Practitioner
OT	Occupational Therapist
PA	Physician Assistant
PIN	Principal Illness Navigation
PT	Physical Therapist
SDOH	Social Determinants of Health
SLP	Speech-Language Pathologist

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Caregiver Training Services in 2024 PFS final rule
Health equity | CMS
Community Health Integration in 2024 PFS final rule
CMS Health Equity fact sheet
Principal Illness Navigation in 2024 PFS final rule
SDOH Risk Assessment in 2024 PFS final rule

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles,

National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.