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Medicare Payable Health Equity Services for Community Health Workers

Healthy Equity Services in the 2024 Physician fee Schedule

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Links in the Presentation

CMS Framework for Health Equity | CMS

CMS Health Equity Fact Sheet

ICD-10-CM Coding for Social Determinants of Health AHA

Social Determinants of Health Codes (hmsa.com)

SDOH Risk Assessment in 2024 PFS final rule

Community Health Integration in 2024 PFS final rule

Principal Illness Navigation in 2024 PFS final rule

Caregiver Training Services in 2024 PFS final rule

List of Telehealth Services | CMS

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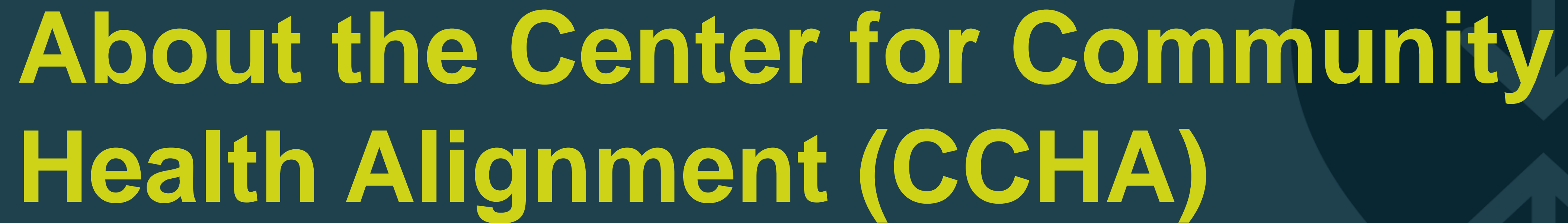

Our Impact

Longstanding history…

- of providing direct support to public health departments, healthcare systems, community-based organizations (CBOs), and other community stakeholders on effectively integrating and working with CHWs

Staff of experienced CHWs and CHW allies…

- with expertise in planning, implementing, and showing the impact of the CHW model at local, state, regional, and national levels

Recognized track record…

- Of providing thought leadership and innovative strategies across the multifaceted components needed to address health inequities in South Carolina

What We Do

What We Do

Training

At CCHA we provide trainings for community health workers, people and organizations that work with CHWs, and those interested in advancing community engagement and health equity.

Capacity Building

CCHA's focus is first and foremost to support communities that want to address inequities. We provide technical assistance and capacity development for organizations and community change agents to drive, develop and sustain their change goals.

Focus Areas

From maternal and child health to addressing the COVID-19 crisis, CCHA supports a variety of important programs that address vital community needs by building on existing assets and emerging opportunities. Learn more about our ever expanding focus areas.

Who are Community Health Workers (CHWs)?

- Frontline public health worker
- Trusted member of and/or has an unusually close understanding of the community served.
- Serves as an intermediary between health and social services and the community
- Facilitates access to services and improves the quality / cultural competence of services
- Builds individual and community capacity by increasing health knowledge and self-sufficiency
- Outreach, community education, informal counseling, social support and advocacy.

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Learning Objectives

- Understand the Centers for Medicare & Medicaid Services (CMS) health equity framework.
- Identify the new billable services that address the health equity framework.
- Describe the documentation needed to ensure payments.

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"…the conditions in the environment where people are born, live, learn, work, play, worship and age that affect a die range of health, functioning and quality-of life-outcomes and risks"

CMS Health Equity Framework

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

CMS Framework for Health Equity | CMS

Read the CMS Framework for Health Equity 2022-2032. (PDF)

CMS Health Equity Achievements

✓ **Establish advanced investment payments** that new Accountable Care Organizations can use to address health-related social needs

✓ **Support states in addressing enrollees' unmet health-related social needs (HRSN)**, such as housing insecurity and nutrition insecurity, through innovative policies in Section 1115 demonstrations, managed care in-lieu-of services and supports (ILOS), and other Medicaid and CHIP authorities.

✓ **Finalized health equity-focused measures** in all care settings, including a measure of hospital commitment to health equity, a measure of the percent of adults screened for social drivers of health, and a measure of those who have been screened positive for harmful social drivers of health.

✓ **Work with states to identify opportunities to connect justice-involved individuals with community-based services** immediately upon release, including through section 1115 demonstration approaches that provide individuals with pre-release services and transitional services upon re-entry.

CMS Health Equity Fact Sheet

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A Briefer on Codes

- HCPCS codes are used to report medical procedures and services to Medicare, Medicaid, and other health insurance programs. Cover products, supplies, and services not included in the CPT codes.
- CPT codes are used to report medical, surgical, and diagnostic services performed by healthcare professionals
- ICD-10 codes are used to classify and code all diagnoses, symptoms and procedures for claims processing.

Social Determinant ICD-10 Codes

Z55 Problems related to education and literacy
Z56 Problems related to employment and unemployment
Z57 Occupational exposure to risk factors
Z58 Problems related to physical environment
Z59 Problems related to housing and economic circumstances
Z60 Problems related to social environment
Z62 Problems related to upbringing
Z63 Other problems related to primary support group, including family circumstances
Z64 Problems related to certain psychosocial circumstances
Z65 Problems related to other psychosocial circumstances

Social Determinants of Health Codes (hmsa.com)

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Incident-to Services

- Services provided as an integral, although incidental, part of the physician’s or nonphysician practitioner’s personal professional services during diagnosis and treatment.

- Requirements for Incident-To Billing
  - The supervising practitioner must have personally performed an initial service and remain actively involved in the course of treatment.
  - The auxiliary personal provide the service under supervision of and as documented by the billing provider**

- Services are provided in a non-facility setting

Auxiliary Personnel

- Can be employed by a practice or under contract through community-based organizations*
- Must meet state requirements including licensure
- If no state requirements exist, must be **certified** and **trained** in:
  - 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

Health Equity Services

Social Determinants of Health Risk (SDOH) Assessment

SDOH Risk Assessment in 2024 PFS final rule

Community Health Integration

Community Health Integration in 2024 PFS final rule

Principal Illness Navigation

Principal Illness Navigation in 2024 PFS final rule

Caregiver Training Services

Caregiver Training Services in 2024 PFS final rule

Health Equity Services in the
2024 Physician Fee Schedule Final Rule

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Federally Funded Insurance Programs

Program	Eligibility	Financing
Medicare Enacted in 1965 through Title XVIII of the Social Security Act (SSA)	Health insurance program administered by CMS for people who are age 65 or older, under age 65 with certain disabilities, or all ages with End-Stage Renal Disease. Medicare has different parts that align with insurance needs: Medicare Part A: Hospital Insurance; Medicare Part B: Medical Insurance; Medicare Part D: Drug Coverage.	Funded through two trust accounts: Hospital Insurance Trust Fund comprised of payroll taxes, income taxes paid on Social Security Benefits, and Medicare Part A premiums from people not eligible for premium-free benefits; Supplementary Medical Insurance Trust Fund comprised of funds authorized by Congress and premiums from people enrolled in Part B and Part D.
Medicare Advantage Enacted in 1997 through the Balanced Budget Act under Title XVIII of the SSA	Health insurance program administered by private insurance companies. To qualify, a person must have Original Medicare (Part A and Part B) and live in a service area of a Medicare Advantage insurance provider that is accepting new beneficiaries during an enrollment period.	Also known as Part C, Medicare Advantage is funded through the same sources as Parts A, B, and D in proportion to the overall spending of each. Beneficiaries may also pay a separate premium to enroll in a Medicare Advantage plan in certain circumstances.
Medicaid Enacted in 1965 through Title XIX of the SSA	Health insurance program administered by states through fee-for-service or managed care authorities for mandatory eligibility groups such as low-income families and persons receiving Supplemental Security Income. States have options to cover additional groups of people such as persons in need of home and community-based services or children in foster care. Financial eligibility is based on Modified Adjusted Gross Income (MAGI) and non-financial eligibility requirements such as age, diagnoses, or condition.	Medicaid is a federal and state funded program. The program, overseen by CMS, matches state spending for specific services and types of beneficiaries through a formula established in statute. The formula results in a higher federal share for states with lower average per capita income. Known as the Federal Medical Assistance Percentage (FMAP), states receive a range of 50% to 78% in match funds (as of FFY 2023). Additional funds are available to states through disproportionate share hospital payments, ACA expansion groups, and through select Medicaid authorities (e.g., 1915(k) Community First Choice which provides a 6% increase).
Health Insurance Exchange Enacted in 2010 under the Patient Protection and Affordable Care Act (ACA)	A health insurance exchange, also known as a health insurance marketplace, is where people can purchase health insurance from private health insurance companies during annual or special open enrollment periods. People using the exchange must live in the U.S., have U.S. citizenship, and not have Medicare. Some people qualify for premium subsidies (income between 100% and 400% of the federal poverty level) and cost-sharing (income between 100% and $250% of the federal poverty level).	In most states, the exchange is operated through a federal platform called healthcare.gov. When the federal platform is used, a percentage of the exchange plan premium is charged. Premium subsidies and cost-sharing are funded by the federal government through congressional appropriations.

Social Determinants of Health Risk Assessment

- Initiated when there is reason to believe SDOH needs which interfere with diagnosis and treatment exist, not a screener*
- Generally, should be done at the time of the visit
- Must be a validated screening tool evaluating, at a minimum:
  - Food Insecurity
  - Housing Insecurity
  - Transportation needs
  - Utility Difficulties

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

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Social Determinants of Health Risk Assessment

- G0136 – Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months
- Can be provided at
  - E/M visit including hospital discharge or transitional care management services
  - Behavioral Health Office Visits
  - The Annual Wellness Visit (Cost sharing would not apply)
- Can be provided via Telehealth but not by audio-visual only

List of Telehealth Services | CMS

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, 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.
Z59 – Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, lack of adequate food and safe drinking water, extreme poverty, low income, 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, Z62.819 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, 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.

ICD-10-CM Coding for Social Determinants of Health AHA Coding Clinic https://www.codingclinicadvisor.com › sites › files (google.com)

IMPROVING THE COLLECTION OF

Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

What Are Z Codes?

- SDOH-related Z codes range from ICD-10-CM categories Z55-Z65 and are used to document SDOH data (e.g., housing, food insecurity, lack of transportation)
- Z codes refer to factors influencing health status or reasons for contact with health services that are not classifiable elsewhere as diseases, injuries, or external causes

What Are SDOH & Why Collect Them?

- SDOH are the conditions in the environment 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[1]
- The World Health Organization (WHO) estimates that SDOH accounts for **30-55% of health outcomes[2]**

Collecting SDOH can improve equity in health care delivery and research by:

- Empowering providers to identify and address health disparities (e.g., care coordination and referrals)
- Supporting quality measurement
- Supporting planning and implementation of social needs interventions
- Identifying community and population needs
- Monitoring SDOH intervention effectiveness for patient outcomes
- Utilizing data to advocate for updating and creating new policies

Using Z Codes for SDOH

- SDOH information can be collected before, during, or after a health care encounter through structured health risk assessments and screening tools
- These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor that influences the patient's health
- Coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record
- SDOH information can be collected through person-provider interaction or self-reported, as long as it is signed-off on and incorporated into the medical record by a clinician or provider
- It is important to screen for SDOH information at each health care encounter to understand circumstances that may have changed in the patient's status

VIEW JOURNEY MAP

ICD-10-CM Z Codes Update

- New SDOH Z codes may become effective each April 1 and October 1. New codes are announced prior to their effective date on CDC website
- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for all the current Z codes.
- Join the public process for SDOH code development and approval through the ICD-10-CM Coordination and Maintenance Committee

[1] Healthy People 2030 [2] World Health Organization

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Community Health Integration (CHI)

- Created to recognize the tailored support and system navigation necessary to help address unmet social needs
- Recognition that unmet social needs significantly limit a practitioner's ability to create and carry out a treatment plan
- Includes items such as:
  - Person-centered planning
  - Health system navigation
  - Facilitating access to community-based resources
  - Practitioner, home and community-based care coordination
  - Patient self-advocacy promotion

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CHI Codes

Community Health Integration services are intended to "address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems."	
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.
G0022	Community Health Integration services, subsequent 30 minutes per calendar month (list separately in addition to G0019).
G0511	Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) bill for Community Health Integration services using a separate code G0511. FQHCs/RHCs use the same code for the first 60 minutes and for each subsequent 30 minutes of services rendered.

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CHI Service Initiation

- Initiated by the billing provider during a visit where unmet SDoH needs are identified
- Billing provider:
  - Establishes and documents a plan of care*
  - Specifies unmet social needs and how addressing would help accomplish that plan (Can be documented or specified through Z-codes)
  - Establish the services that will be provided by CHW
- Provider or CHW:
  - Obtain and document written or verbal consent
  - Explain cost sharing applies for Medicare FFS
  - Explain only 1 provider may bill the service each month*

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Obtaining Consent

1. Explanation of CHI:
   1. CHI focuses on connecting you with community resources that can support your health. This includes assistance with housing, transportation, food security, and other social needs.
   2. Our goal is to enhance your overall health by addressing factors beyond medical care.
2. Cost and Insurance:
   1. Depending on your insurance, there may be associated costs. I recommend contacting your insurance carrier or our billing department for more information.
   2. Please note that we'll do our best to minimize any financial burden.
3. Verbal Consent:
   1. Are you comfortable participating in the CHI program? Your participation is entirely voluntary, and you can withdraw at any time.
   2. By agreeing, you allow us to connect you with community resources and collaborate on improving your health.
4. Documentation:
   1. I'll document your verbal consent in your electronic health record (EHR) to ensure transparency and compliance.

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Principal Illness Navigation (PIN)

- Created to recognize services provided to individuals with “high risk condition/illness/disease” which:
  - Is expected to last at least 3 months and places the patient at serious risk of hospitalization, nursing home placement, acute exacerbation /decompensation, functional decline or death
  - 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
- May not necessarily have SDOH needs

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PIN Example Conditions

- Cancer
- Chronic Obstructive Pulmonary Disease
- Congestive Health Failure
- Dementia
- HIV/AIDS
- Severe Mental Illness
- Substance Use Disorder
- Can include conditions without a definitive diagnosis

PIN Codes

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Principal Illness Navigation and Principal Illness Navigation – Peer Support services are intended to "help people with Medicare who are diagnosed with high-risk conditions (for example, dementia, HIV/AIDS, and cancer) identify and connect with appropriate clinical and support resources."	
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. (*FQHCs/RHCs use G0511 when rendering this service.)
G0024	Principal Illness Navigation services, subsequent 30 minutes per calendar month. (*FQHCs/RHCs use G0511 when rendering this service.)
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,
G0146	Principal illness navigation - peer support, additional 30 minutes per calendar month (List separately in addition to G0140)

* May be billed more than once per month if multiple serious high-risk conditions exist

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PIN Service Initiation

- Initiated by the billing provider during a visit where there are treatment navigation needs
- Billing provider:
  - Establishes and documents a plan of care*
  - Specifies condition specific care needs and how navigation assistance would help accomplish that plan
  - Establish the services that will be provided by CHW
- Provider or CHW:
  - Obtain and document written or verbal consent
  - Explain cost sharing applies for Medicare FFS
  - Explain more than 1 provider may bill the service each month for a specific condition*.

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Person Centered Assessment

- Conducted 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
- 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

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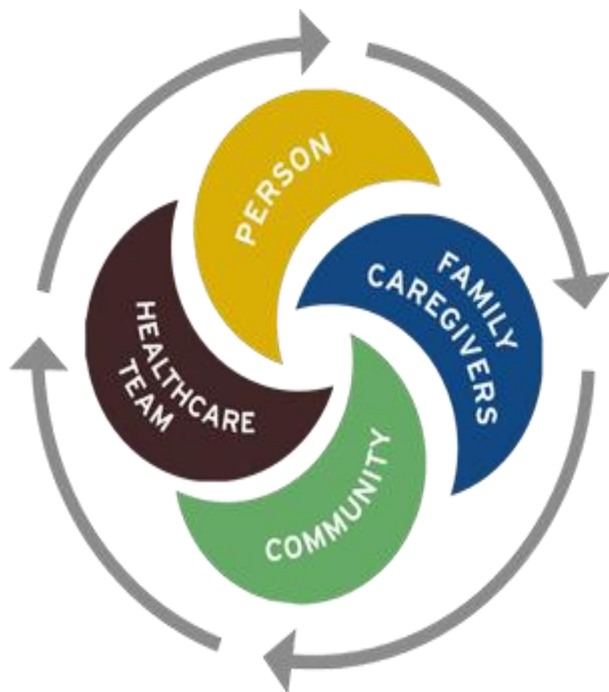
Care Coordination



- Coordinating receipt of needed services from other service providers
- Communication with other service providers and settings regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
- Coordination of care transitions 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)

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Health Education & Self Advocacy

- Educating the patient on how to best participate in medical decision-making based on their cultural and linguistic needs
- Helping the patient understand the education provided by the treatment team within the context of their individual needs, goals and preferences
- Building the patient's skills set and confidence in expressing their SDOH needs to promote personalized and effective diagnosis and treatment

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Health Care Access & System Navigation

- Assisting in identifying needed practitioners / clinical care and helping to secure appointments
- Promoting patient motivation to participate in care to achieve person centered diagnosis and/or treatment goals
- Providing social and emotional support, leveraging lived experience, so support, mentor and inspire

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Documentation – Why it Matters

- Establishes the link between the care plan developed by the practitioner and the services provided to the individual (the incident-to)
- Serves as a tool to communicate the CHW findings/input to the entire care team
- Ensures accurate documentation for correct billing and payment that will stand up to audit
- Helps keep team members on the same page, especially if you are not available to provide an update in person

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The SOAP Note

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Documenting as a SOAP Note

Subjective Data: What the person (or significant other) tells us about their condition

Example: Client reports great concern about getting evicted- can't make rent. Person reports they have no transportation to get to work

Objective: What you observe or find during the CHW visit.

Example: Person is very anxious with agitated movements

Documentation Skills for CHWs: Writing Useful Case Notes

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Documenting as a SOAP Note

Assessment: your opinion or interpretation of the person's situation as reported and based on what you observe.

Example: Person upset about possible loss of housing and lack of transportation to allow for employment

Plan: What do the person and CHW want to do to resolve the issue or situation? How will it be accomplished? Who will do what ?

Example: Provide emotional support regarding fear of losing housing. CHW will prepare referral to housing advocate to minimize disruption and provide hope for new housing option. Client will gather proof of income, etc. to prepare for housing meeting. CHW will update care plan with new housing goal.

Documentation Skills for CHWs: Writing Useful Case Notes

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Sample Case Note Content

- Community Health Worker’s name
- Date of case note
- Client’s name
- Date of visit/session
- Purpose of visit/session
- Observations
- Topics discussed
- Movement toward goals since last visit
- Obstacles toward progress re: goals
- Brief summary, next steps

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Sample Progress Note

CHW PROGRESS NOTE: Participant ID: ______

DATE:		**VISIT TYPE:** ☐ In-Person ☐ Phone
LOCATION:		
TIME START:		**VISIT TYPE:** ☐ Educational ☐ Instrumental
TIME END:		

SHORT-TERM GOAL CHECK-IN:

Short-term Goal #1: (describe goal set by client)

Short-term Goal Progress:	Description of progress w/ Short-Term Goal #1:
☐ Success ☐ Partial Success ☐ No Success ☐ Did not try	

Short-term action plan for future:

☐ Continue same plan	☐ New Plan:	☐ No Plan

Short-term Goal #2: (describe goal set by client)

Short-term Goal Progress:	Description of progress w/ Short-Term Goal #1:
☐ Success ☐ Partial Success ☐ No Success ☐ Did not try	

Short-term action plan for future:

☐ Continue same plan	☐ New Plan:	☐ No Plan

DC 12/4/202

CHW PROGRESS NOTE: Participant ID: ______

LONG-TERM GOAL CHECK-IN:

Long-term Goal: (describe goal set by client)

Client was reminded about long-term goal and stated confidence in achieving goal as:

0 1 2 3 4 5 6 7 8 9 10

(no confidence at all) (Completely Confident)

VISIT CONTENT DISCUSSED:

☐ N/A – Instrumental Visit	☐ HTN 101
☐ Nutrition	☐ HTN 201
☐ Physical Activity	☐ Asthma 101
☐ Stress Management & Family Support	☐ Asthma 201
☐ Smoking Cessation	☐ Diabetes 101
	☐ Diabetes Complications

REQUEST FOR REFERRALS / RESOURCES:

REQUEST:	INFO PROVIDED / TO BE PROVIDED:
1.	
2.	
3.	
4.	
5.	

DC 12/4/202

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Take-Aways

- The newly created Health Equity Services recognize the importance of addressing health related social needs and providing greater navigation to patients
- Health Equity Services is a team effort highly dependent on communication and information sharing
- All services must tie back to the care plan and accomplishing long and short term goals
- If you don’t document it, it didn’t happen!

THANK YOU!

Questions?

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