IMPaCT

Medicare Payment for Community Health Worker Services

Calendar Year 2024 Physician Fee Schedule Final Rule Summary

Overview

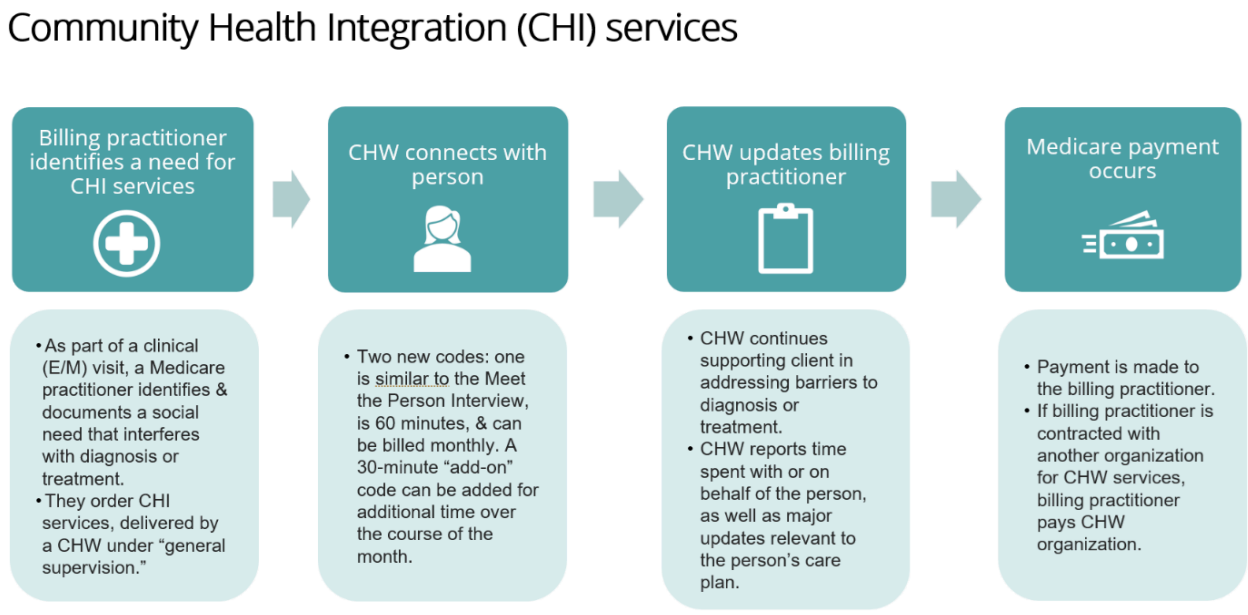
In 2024, for the first time ever, Medicare Part B will pay for Community Health Integration (CHI) services delivered by Community Health Workers (CHWs) delivering services under the general supervision of a Medicare billing practitioner.

Who is eligible for CHI services?

Medicare beneficiaries may receive CHI services if a Medicare billing practitioner identifies that a social determinant of health (SDOH) need presents a barrier to diagnosis or treatment of an illness or injury.

How does it work?

In brief, a Medicare billing practitioner orders CHI services for an eligible beneficiary. That beneficiary can then receive services from a CHW, who can either be employed by the billing practitioner or by another organization, including a community-based organization.



What kinds of providers can initiate CHI services, and under what circumstances?

Medicare billing providers (MD, DO, NP, CNS, CNM, or PA) may order CHI services after an initiating visit at which the billing practitioner identifies an SDOH need that presents a barrier to diagnosis or treatment.

- CHI services may be performed by a CHW incident to the professional services of the billing practitioner, who must provide ongoing general supervision of those services.
- CHI services may be initiated by an Evaluation and Management (E/M) visit, an Annual Wellness Visit, or a Transitional Care Management E/M visit. They cannot be initiated by an inpatient admission or skilled nursing admission.
- Only one billing practitioner may bill for CHI services in a given month.

Can a licensed clinical psychologist order CHI services?

No. CMS is currently not allowing clinical psychologists to initiate CHI services during an evaluation visit. CMS specifically notes that visits during which CPT codes 90791 and 96156 are used cannot be an initiating visit for CHI services.

Who is not eligible for CHI services?

Patients who are also receiving Medicare home health services.

What counts as a social determinant of health need?

SDOH refers to economic and social condition(s) that influence the health of people and communities, as indicated in the CPT E/M Guidelines (2023 CPT codebook, page 11).

How should billing practitioners document the SDOH need?

CMS encourages billing practitioners to use Z-codes, but this is not required.

Do CHWs have to work for the billing practitioner?

No, CHWs may work for another organization, such as a community-based organization, as long as they meet state requirements and general supervision requirements.

What services are included in the new codes?

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 are significantly limiting 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 patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not 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 healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregivers (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 the 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.

- Healthcare access/health system navigation - Helping the patient access healthcare, 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 adjusting 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

What requirements must Community Health Workers meet to be eligible for billing?

Community Health Workers must meet any applicable State rules and requirements. In states without state training requirements, CHWs must be trained to provide CHI services and in the following competencies: patient & family communication, interpersonal & relationship-building skills, patient & family capacity-building, service coordination & system navigation, patient advocacy, facilitation, individual & community assessment, professionalism and ethical conduct, and the development of an appropriate community base, including local resources. Program-level accreditation may serve as evidence of appropriate training if it includes these core competencies.

Will the patient have to pay for services?

Yes, CHI claims are subject to standard Part B cost-sharing. (In some cases, this cost-sharing may be covered by a Medigap plan or by Medicaid.)

For a dually eligible beneficiary, does it matter if CHW services are not a Medicaid covered service in my state?

CHI services for dually eligible beneficiaries will be treated like any other covered Part B service. That is, if the beneficiary qualifies for Medicaid to cover their Medicare Part B cost-sharing, Medicaid will cover the cost-sharing regardless of whether the specific state the beneficiary resides in separately covers CHW services in their Medicaid program or not.

Does the patient have to consent to services?

Yes. The patient must provide verbal or written consent to the billing practitioner or the auxiliary personnel (e.g., a CHW), and consent must be documented in the medical record prior to initiating services.

Is there a limit to the number of times each code may be billed?

G0019 may only be billed once per calendar month. There is no frequency limit on G0022. Services may be delivered as frequently and as long as they are medically necessary.

Is there a way to find out if a patient is receiving CHI services from another provider or when the last CHI service was billed for a patient?

CMS has not issued guidance on this. For Medicare FFS beneficiaries, a Medicare Administrative Contractor (MAC) should be able to provide information about when the last G0019 claim occurred.

Do services have to be delivered in person?

No. Services may be delivered in person, via phone, or via telehealth. All modalities are paid at the same rate.

Does the patient have to be present for all services?

No. Services may be directly with the patient or on the patient's behalf, as long as they meet other requirements.

Will Medicare Advantage beneficiaries also be eligible for these billing codes?

Not necessarily. Medicare Advantage plans are not required to pay Physician Fee Schedule billing codes.

What are the documentation requirements?

The patient's medical record must include documentation of the time spent furnishing the services, as well as a description of the services. Documentation does not have to be entered into the medical record by the Community Health Worker, enabling CHWs in community-based organizations to provide CHW services without direct medical record access.

Are there any differences in how FQHCs bill?

In guidance released in January 2024, CMS clarified that FQHCs should bill community health integration (CHI) codes through the general care management code, G0511. The fee schedule amount for this code is the average value of CHI and other services that are billed under it. In 2024, the value is $71.71.

What are the payment rates?

Physician fee schedule payment rates vary geographically. In 2024, the national average for G0019 is $79.24, and the national average for G0022 is $49.44.

Federally qualified health center payment rates also vary geographically. In 2024, the average value for G0511 is $71.71.

About IMPaCT Care

IMPaCT is the leading evidence-based intervention in the U.S. for addressing health inequity and the social determinants of health. IMPaCT's standardized, scalable program selects altruistic people from local communities, trains them as CHWs and connects them with people who are facing health inequity. We then support CHWs as they help their clients improve their lives and health. We have transformed the effectiveness of the CHW workforce by reimagining each step, from how to identify the right CHWs, to how to train, develop, manage, and empower them with technology and evidence-based best practices. We've achieved outcomes frequently believed to be out of reach: across multiple randomized controlled trials, our team has demonstrated dramatic improvements in cost, health, and patient satisfaction – $2,500 saved per patient in year 1, improved mental health, 66% of hospital days compared with matched controls and a 94% net promoter score. Want to know more? Get in touch with us!