Partnership
to Align Social Care
A National Learning
& Action Network

Understanding the Medicare Physician Fee Schedule Billing Codes for:

- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)
- Principal Illness Navigation – Peer Support (PIN-PS) Services

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Background

For over a decade, efforts to improve the U.S. health care system have centered on achieving the quadruple aims (improved population health outcomes, value of care, patient experience, and workforce development). Since the COVID-19 Pandemic, the importance of health equity to each of these aims has become increasingly clear. Achieving optimal population health outcomes at the community level is largely dependent on addressing upstream, community-level social determinants of health (SDOH) such as food deserts and lack of affordable housing as well as downstream, individual health-related social needs (HRSNs) such as food insecurity and housing instability. Research has shown that SDOH can impact as much as 50% of the variation in population health outcomes while clinical care has a relative 20% impact on variable population health outcomes.[1] Based on this evidence, interventions that are deployed to directly address HRSNs can improve clinical outcomes and reduce the total cost of health care service delivery.

As the health care system increasingly reflects the Centers for Medicare & Medicaid Services' (CMS) goal of moving from a fee-for-service payment system to a value-based payment system, providers increasingly request interventions that can address drivers of cost such as unmet HRSNs. To meet the challenge, the health care system must have the capacity to assess and address HRSNs one person at a time through partnerships within communities to improve the health and well-being of all people.

In November 2023, the U.S. Department of Health and Human Services (HHS) released a Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation. A complementary U.S. Playbook to Address Social Determinants of Health was released by the White House. The Call to Action and associated Playbook both highlight the need for the health care system to improve the identification and resolution of unique social risk factors through the creation of cross-organizational and cross-sector collaboration. Successful implementation of interventions to address HRSNs for a defined population requires processes to align health and social care to promote equitable, high-quality clinical outcomes. Integrating health and social care requires a partnership between the health care system and community-based organizations (CBOs) who understand unique community characteristics and offer critical expertise to address health disparities and connect people to social services. CBOs have successfully helped people to connect to resources, change the behaviors that impact health, increase functional capacity, and improve social connection and they often can achieve these outcomes at lower cost than when health care systems implement similar but overly medicalized approaches.

1 SDOH-Evidence-Review.pdf (hhs.gov)

Under the Calendar Year (CY) 2024 Medicare Physician Fee Schedule, CMS adopted a new set of Healthcare Common Procedure Coding System (HCPCS) codes—the collection of standardized billing codes that represent medical procedures, supplies, products, and services—that provide a pathway to reimburse a range of activities to address the HRSNs of Medicare Part B beneficiaries. This Primer provides a snapshot of the new Community Health Integration (CHI), Principal Illness Navigation (PIN), and Principal Illness Navigation – Peer Support (PIN-PS) HCPCS codes. These codes advance opportunities to integrate health and social care to improve clinical outcomes. This Primer explores implementation opportunities at a local level.

Today's Public Health Insurance Market

Applying CHI, PIN, and PIN-PS HCPCS codes to everyday clinical practice requires understanding the context of public health insurance programs. The largest payer of public health insurance programs is the federal government. The U.S. health care system spent $4.5 trillion in 2022, with Medicare, Medicaid, and other federal public health insurance programs such as the Veterans Administration and the Children's Health Insurance Program (CHIP) constituting a 43% share of all health insurance spending. This exceeded private health insurance (29%) and a mix of other third-party payers and out of pocket spending (28%).[2] CMS is the agency within the U.S. Department of Health and Human Services that administers and operates federally funded health insurance programs as summarized in **Table 1**.

Each year since 1992, CMS reviews payment practices under Original Medicare. The annually updated Medicare Physician Fee Schedule (PFS) also outlines significant policy changes for Medicare Part B. In the CY 2024 PFS, CMS created a new Medicare Part B benefit for CHI, PIN, and PIN-PS. The HCPCS codes that were established for CHI, PIN, and PIN-PS are reimbursable when applicable services are delivered to persons with Original Medicare, including persons with both Medicare and Medicaid eligibility (dual eligibles). Additionally, as a Medicare Part B benefit, all Medicare Advantage and Special Needs Plans have a statutory requirement to cover all Medicare Part A and Part B services. Furthermore, the new Medicare Part B benefit for CHI, PIN, and PIN-PS provides payment for the labor extended to support persons who have unmet HRSNs or require case management or health navigation services to address complex health conditions.

2 National Health Expenditures 2022 Highlights | CMS and nations-health-dollar-where-it-came-where-it-went.pdf (cms.gov)

Therefore, inclusion of CHI, PIN, and PIN-PS HCPCS codes in the CY 2024 PFS has implications far beyond beneficiaries covered under Original Medicare. However, adequate implementation of these codes is essential to realizing meaningful advancements in alignment between clinical and social care. Community-based organizations are uniquely positioned to support the health care system to address HSRNs.

According to A Snapshot of Sources of Coverage Among Medicare Beneficiaries | KFF (**Exhibit 1**), more than 30.6 million people have coverage through traditional (Original) Medicare and 27.6 million are covered through Medicare Advantage. Many people with Medicare also have access to other coverage. Medicare Advantage has expanded over time, with 51% enrollment in 2023[3] compared to 19% enrollment in 2007. While the Medicare Part B benefit is applicable to persons that are Medicare eligible based on age or disability, other health insurers can exercise discretion to adopt the CHI, PIN, and PIN-PS HCPCS codes as a benefit in non-Medicare health insurance programs.

An analysis of the needs of Medicare beneficiaries demonstrates that there is a disproportionate number of Medicare beneficiaries that are impacted by one or more chronic conditions and require help with activities of daily living such as bathing and dressing (Exhibit 2). Successful management of chronic conditions is negatively impacted by unresolved HRSNs.

3 Medicare Advantage in 2023: Enrollment Update and Key Trends | KFF

Table 1. Summary of Public Health 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.

Source: www.medicare.gov; www.medicaid.gov

Exhibit 1. Sources of Coverage in 2021

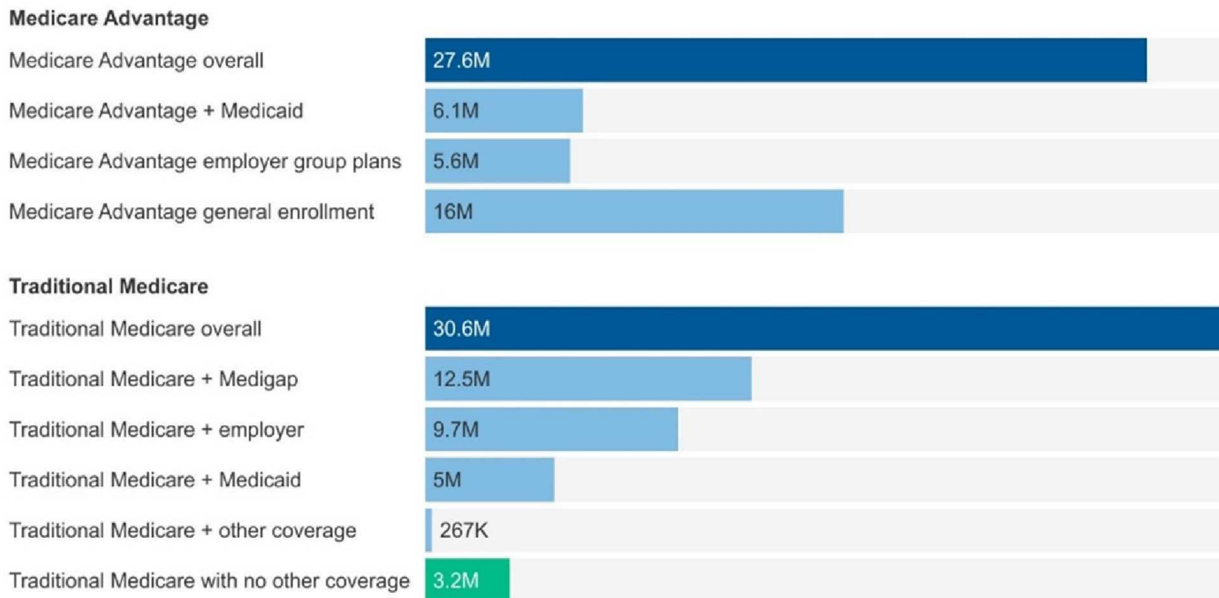

Exhibit 2. Characteristics of Persons Enrolled in a Medicare Program, 2021

				------------------------Traditional Medicare-------------------------				
Characteristics	Overall	Traditional Medicare	Medicare Advantage	Medigap	Employer-Sponsored Insurance	Medicaid	Other	No Supplemental Coverage
Weighted total	58,276,124	30,643,739	27,632,385	12,497,712	9,674,091	4,961,695	267,020	3,243,221
Age Group								
Under 65	12%	12%	13%	2%^	5%^	45%^	NA	21%^
64-74	48%	48%	48%	57%^	50%	29%^	NA	44%
75-84	28%	28%	28%	31%^	32%^	15%^	29%	21%
85 and older	11%	12%	11%^	10%^	13%	11%	53%^	14%
Number of Chronic Conditions								
Zero	7%	7%	6%^	6%	7%	9%	NA	11%^
1 or 2	37%	38%	36%^	40%	39%	32%^	37%	41%
3 or 4	39%	38%	40%	39%	39%	38%	32%	34%
5 or more CCs	17%	16%	18%^	15%	15%	21%^	23%	14%
Number of ADL Impairments								
Zero ADLs	72%	72%	72%	80%^	77%^	46%^	32%^	68%
1 ADL	12%	11%	12%	9%^	12%	14%^	13%	12%
2 ADLs	5%	6%	5%	4%^	5%	9%^	NA	8%
3 or more ADLs	11%	11%	11%	6%^	6%^	31%^	45%^	13%

Source: A Snapshot of Sources of Coverage Among Medicare Beneficiaries | KFF
NOTE: Analysis excludes beneficiaries who were enrolled in Part A only or Part B only for most of their Medicare enrollment in 2021 (n=5.0 million), beneficiaries who had Medicare as a secondary payer (n=1.6 million). Sample size restrictions preclude analysis of groups other than White, Black, or Hispanic. Persons of Hispanic origin may be of any race but are categorized as Hispanic; White and Black beneficiaries are non-Hispanic. *represent a statistically significant difference (p<0.05) between the subgroup and Medicare beneficiaries overall; ^ represent a statistically significant difference (p<0.05) between the subgroup and traditional Medicare beneficiaries overall. For some beneficiary groups, estimates are not shown due to small sample size.

Reimbursement Models

Payment for services received through the public health insurance system varies by program. Traditional reimbursement models are fee-for-service payment structures which means that a specific fee is paid for each service or component of a service. The payment amount for the service is established in advance and is not adjusted for quality or outcome. As a result, a fee-for-service payment model often rewards volume rather than value and emphasizes treatment over prevention and wellness.

As the largest payer of public health benefits, CMS seeks to strengthen the health care delivery system toward patient-centered practice and value. During the last several years, CMS has worked with providers to test new alternative payment models (APMs), also known as value-based care. APMs are performance-based payment models and can apply to a specific clinical condition, care episode, or population.[4] Through promoting innovation, prioritizing prevention and wellness, and improving coordination of care, APMs incentivize improvements in health care quality and reduction of the total cost of care. Providers participating in APMs assume some level of financial risk through payment models including:

- **Pay for performance.** Payment tied to quality indicators.
- **Bundled payment.** Payment made for set of services or comparison of total cost for an episode of care.
- **Shared savings/risk.** Providers keep a percentage of savings if the total cost of care is below established benchmarks.
  - One-sided risk means that if the provider is successful in reducing the total cost of care below an established benchmark, the provider is eligible to share in the savings. In a one-sided risk model, if the cost of care is greater than the benchmark, the provider is not penalized.
  - Two-sided risk means that if a provider is successful in reducing the total cost of care below an established benchmark, the provider is eligible to share in the savings; but if the total cost of care is higher than the benchmark, the provider also shares in the loss through financial penalties.
- **Capitation**. Providers receive a set payment amount per person, per month.

The Health Care Payment Learning and Action Network, a public and private group of health care leaders focused on accelerating APMs, aims to move traditional fee-for-service payment models in Medicare and Medicare Advantage toward a 100% two-sided risk model by year 2030. The intended purpose of an APM is to move from a fee-for-service model to a value-based model where providers and payers share in savings and losses.

4 APMs Overview (cms.gov)

Medicare Physician Fee Schedule Final Rule

The Medicare Physician Fee Schedule determines how much health care providers are reimbursed for services rendered to Medicare beneficiaries. Since the first Physician Fee Schedule final rule was published in November of 1991, this schedule has provided policies and reimbursement requirements for physician services. In November 2023, the CY 2024 Physician Fee Schedule was published, and the policies contained in the CY 2024 Physician Fee Schedule take effect as of January 1, 2024. The final rule made a number of changes, including advancing Medicare's overall value-based care strategy, making payment to practitioners that train caregivers to support certain diseases or illnesses, and addressing HRSNs through services such as CHI, PIN, and SDOH risk assessment when initiated during evaluation and management visits, behavioral health visits, and annual wellness visits.

Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

Effective January 1, 2024, CMS created new codes to support CHI, PIN, and PIN-PS services in alignment with the Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation. **Table 2** provides an overview of the Medicare Physician Fee Schedule relevant to these services.

Treatment and SDOH Intersection
CHI services must address the health-related social need(s) that present as a barrier to the diagnosis and treatment of the presenting problem raised during the initiating visit.

Table 2. CHI and PIN HCPCS 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.

Table 2. Cont.

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. (*FQHCs/RHCs use G0511 when rendering this service.)
G0146	Principal Illness Navigation – Peer Support, subsequent 30 minutes per calendar month. (*FQHCs/RHCs use G0511 when rendering this service.)
Ancillary Codes for Social Determinants of Health Risk Assessment	
G0136	Administration of a standardized, evidence based SDOH risk assessment, 5-15 minutes, not more than every 6 months (per practitioner, per beneficiary). These services are rendered during an evaluation and management (E/M) visit.

Source: https://www.cms.gov/newsroom/press-releases/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

Auxiliary Personnel

- ✓ Any individual who is acting under the supervision of a physician (or other practitioner), and
- ✓ Has not been excluded from the Medicare, Medicaid, and all other federally funded health care programs, and
- ✓ Has not had his or her Medicare enrollment revoked, and
- ✓ Meets any applicable requirements to provide incident to services, including licensure, imposed by the state in which the services are being furnished.

To bill for CHI, PIN, or PIN-PS services, personnel must include a range of services including the following:

- Conduct a person-centered assessment to identify the person's cultural and linguistic requisites, strengths, health and social care needs, goals, preferences, and desired outcomes. The assessment must surface the intersection between the person's health care needs and health-related social needs.
- Promote person-centered action planning tailored uniquely to the person.
- Coordinate connection to, and receipt of, needed services including communication with health and social care providers on the person's strengths, needs, and desired outcomes.
- Facilitate access to community-based services such as housing, utility assistance, transportation, and food.
- Provide health education to support the person's medical and social decision-making.
- Support development of self-advocacy skills.
- Motivate the person to participate and reach their care plan goals resulting in behavioral change.
- Provide social and emotional support throughout the health care journey including leveraging lived experience when possible.

CHI, PIN, and PIN-PS services must accompany an initial visit with a billing practitioner. An eligible Medicare provider can use auxiliary personnel when rendering CHI, PIN, and PIN-PS services, under general supervision. The general supervision guidelines allow for auxiliary personnel to be provided by community-based organizations under a third-party contract relationship. CHI, PIN, and PIN-PS services can be delivered in person, virtually, or through both modalities. CMS requires that providers rendering CHI, PIN, and PIN-PS using auxiliary personnel establish a clinically integrated model of care. CMS also requires that auxiliary personnel receive training in all aspects of the service and, when applicable, perform services under licensure or other state laws, based on the role or title the person maintains as part of the integrated care team. Auxiliary personnel must receive supervision by the billing practitioner, but such supervision does not mean that the billing practitioner's physical presence is required (direct supervision). CHI, PIN, and PIN-PS services follow the CMS general supervision requirements, not direct supervision. Community-based organizations are specifically mentioned as potential auxiliary personnel within the Medicare Physician Fee Schedule Final Rule.

Billing Limit

- CHI, PIN, and PIN-PS services can be rendered each calendar month, based on a defined plan of care.
- There is no limit or cap on services that can be provided per calendar month, as long as the services are medically necessary, appropriately documented, and are delivered in accordance with a defined plan of care.
- The services can be provided concurrently with other care management services such as chronic care management (CCM) and transitional care management (TCM).

Principal Illness Navigation (PIN) services are rendered when an eligible Medicare beneficiary requires services to address a "serious, high-risk condition" that:

- Is expected to last at least three months.
- Places the person at "significant risk for hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death."
- Requires a disease-specific care plan.

Like CHI services, PIN services require an initiating visit, such as an evaluation and management (E/M) visit, transitional care management visit (TCM), annual wellness visit, or a psychiatric diagnostic. Any auxiliary personnel must receive supervision from a billing practitioner. When a Medicare provider uses auxiliary personnel to deliver PIN services, the auxiliary personnel are required to have requisite training in all service elements and, when applicable, meet state laws and regulations (e.g., a state specifies community health worker roles and functions) based on the position or title maintained by the auxiliary personnel.

When a state does not have regulations, auxiliary personnel delivering PIN services must have training in patient and family communication and capacity-building, relationship-building, service coordination and system navigation, advocacy, facilitation, individual and community assessment, professionalism, ethical conduct, and training or certification in applicable high-risk conditions, illnesses, or diseases. One exception to this training is the provision of PIN-Peer Support. Providers of this service must have training consistent with SAMHSA's National Model Standards for Peer Support Certification.

Eligible Providers of CHI and PIN Services

Physicians, non-physician practitioners (nurse practitioners and physician assistants), and clinical psychologists are eligible to render CHI and PIN services.

Time-Based Billing Requirements

Billing for CHI, PIN, and PIN-PS services occurs under an eligible rendering provider. Eligible rendering providers can use auxiliary personnel to provide CHI and PIN services if they have relevant training and meet all applicable licensure or certification requirements in the state where the beneficiary is receiving the service. The state-level requirements apply to the location of the beneficiary when services are rendered and not the location of the rendering provider.

CMS requires that the medical record includes all time spent providing CHI, PIN, and PIN-PS services, including the activities of the auxiliary staff. The time of each encounter should include the start time, stop time, and total time spent providing services on behalf of the beneficiary. The total time spent each month should be the aggregate of each eligible encounter. The medical record must reflect the connection of CHI, PIN, or PIN-PS to the clinical problem presented during the initiating visit. CMS further recommends that the medical record and the claim contain associated ICD-10 Z-codes (Z55-Z65).

Conclusion

In the CY 2024 Physician Fee Schedule Final Rule, CMS established a new set of HCPCS codes to screen for and address unmet HRSNs and provide case management and navigation services for persons with complex medical conditions. The purpose of these new codes is to promote "person-centered assessment to better understand the patient's life story, care coordination, contextualizing health education, building patient self-advocacy skills, health system navigation, facilitating behavioral change, providing social and emotional support, and facilitating access to community-based social services to address unmet social determinants of health (SDOH) needs". [5]

5 Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule | CMS

In summary, these codes are expected to advance integrated health and social care contributing to improved clinical outcomes, reduced health disparities, and overall health and well-being for each person along their health care journey.

These codes describe the following services: Community Health Integration (CHI), Principal Illness Navigation (PIN), and Principal Illness Navigation-Peer Support (PIN-PS). CMS has established that these services fall under the incident-to benefit of Medicare. The new HCPCS codes represent a significant opportunity to align medical and social care to drive improved clinical outcomes and reduce total cost of care.

The community-integrated models discussed above are exciting innovations in health care delivery. They can also be challenging to implement. Common pitfalls often stem from an underestimate of the work needed to convene, negotiate, and establish trust between CBOs and traditional health care delivery systems. The “wrong pocket problem” is frequently encountered, whereby savings produced through these models are only captured by the health care system and not reinvested in the community. This leads to distrust, low utilization, and issues with sustainability. Those who aim to implement these new models would be well-advised to attend to the processes (e.g., collective impact) needed to keep community/clinic relationships at the center of their governance and decision-making. Insurers, hospitals, accountable care organizations, and other providers are encouraged to recognize and address power inequities between the parties involved, and to strive to inform, develop, and align sustainability plans with the value being produced by non-traditional health partners.

Partnership to Align Social Care
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About the Authors

The Partnership to Align Social Care ("Partnership") is a national learning and action network whose purpose is to advance the alignment of healthcare and social care service delivery to individuals through contracted partnerships between healthcare entities and social care providers, particularly community-based organizations organized into networks led by community care hubs. The Partnership consists of leaders from across the healthcare and social care sectors, including health plans, health systems, providers, community-based organizations, national associations, and government. The Partnership has constituted a cross-sector planning committee and working groups in the areas of contracting, billing and payment, and community care hubs to co-design standards, resources, and tools to accelerate healthcare - social care collaborations in practice.

Freedmen's Health Consulting is a Washington, DC healthcare consulting firm specializing in implementation of innovative models of care. Freedmen's Health Consulting CEO, Timothy McNeill, RN, MPH and the firm's consulting efforts have a long history of serving customers including the U.S. Department of Health and Human Services (HHS), U.S. Administration on Aging (AoA)/Administration for Community Living (ACL) and various Foundations and National Non-profit organizations. Under an HHS/ACL contract, Mr. McNeill has been the lead technical assistance provider to establish and support integrated networks to deliver new models of care that address medical risks and social determinants of health supporting value-based contracting in 26 States. Timothy McNeill serves as a co-chair leading the work of the Partnership to Align Social Care.

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