Implementation Key for the Delivery of Evidence-Based Programs and CHI / PIN Services as Part of a Whole-Person Health Strategy

Partnership to Align Social Care

A National Learning & Action Network

Contents

Overview

Chronic diseases such as cardiovascular diseases, chronic respiratory conditions and diabetes contribute to a higher rate of death and disability.[1] The Centers for Medicare and Medicaid Services released the 2025 Medicare Physician Fee Schedule providing reimbursement for services and interventions to address the health related social needs (HRSNs) of people experiencing chronic diseases. Notably, these services and interventions are critical to the mitigation of health disparities and equitable access to health and social care outcomes for all people. This document provides an implementation key to those services and interventions.

SDoH Risk Assessment

The SDoH Risk Assessment is a service that provides reimbursement for conducting an assessment to determine if a person is impacted by health-related social needs. The SDoH Risk Assessment occurs when an approved Medicare provider conducts an assessment using an evidence-based screening tool such as the CMS Accountable Health Communities HRSN Screening Tool or PRAPARE. CMS created a new HCPCS code (G0136) to define SDOH Risk Assessment.

For a provider to submit for G0136, he or she must personally assess the beneficiary as part of a regular medical visit to include one or more of the following:

- Evaluation and Management (E/M) visit,
- Transitional Care Management (TCM),
- Annual Wellness Visit (AWV),
- Psychiatry visit, or
- Health Behavior and Assessment Intervention (HBAI).

SDOH Risk Assessments can be performed by the following Medicare provider types:

- Physician (MD or DO)
- Non-Physician Provider (Nurse Practitioner or Physician Assistant)
- Clinical Psychologist
- Licensed Clinical Social Workers

When an approved clinical service is performed by an eligible provider, the provider can add an additional SDOH Risk Assessment to the list of services performed during that clinical visit. The SDOH Risk Assessment is expected to extend 5-15 minutes as an add-on service to the clinical visit.

1 Fast Facts: Health and Economic Costs of Chronic Conditions | Chronic Disease | CDC

Health Behavior and Assessment Intervention (HBAI)

Health Behavior and Assessment Intervention (HBAI) CPT codes are intended to be used for psychological assessment and treatment, when the primary diagnosis is a medical condition. The HBAI codes apply to services that address psychological, behavioral, emotional, cognitive, and interpersonal factors in the treatment/management of people diagnosed with physical health issues. The HBAI codes capture services related to physical health, such as adherence to medical treatment, symptom management, health-promoting behaviors, health related risky behaviors, and adjustment to physical illness.

Qualified healthcare professional for HBAI include the following:

- Clinical psychologists
- Clinical Social Workers (CSWs)
- Marriage and Family Therapists (MFTs)
- Mental Health Counselors (MHCs)

Use: Can be used in conjunction with other care management services such as CHI, PIN, PIN-PS.

Example: A person with a congestive heart failure diagnosis and housing insecurity. The person can receive HBAI is they have perceived barriers to managing their CHF. Separately, the person can receive direct assistance with addressing their housing insecurity as long as all of the CHI requirements are met.

Billing Tip: The time spent providing HBAI cannot be counted towards time billed under CHI as they are separate benefits and the time cannot be double counted.

Diabetes Self-Management Training (DSMT)

Individual and group interventions to provide diabetes education and self-management supports to persons with a diabetes diagnosis. The DSMT benefit is a ten (10) hour lifetime benefit. Once the person has exhausted their lifetime benefit, they are eligible for 2 hours of refresher training every calendar year after the initial year that the lifetime benefit was exhausted. Providers that deliver the DSMT benefit must have accreditation from one of the approved National Accrediting Organizations (NAOs). A person with diabetes and HRSNs, such as food insecurity, can receive DSMT and separately obtain assistance with the social needs.

Qualified Healthcare professional for DSMT include the following:

- Registered Dietitian or Nutritionist (RDN)
- Organization with current accreditation from a National Accrediting Organization

Use: DSMT can be provided in conjunction with other care management services such as CHI, PIN, or PIN-PS.

Example: A person with a diabetes diagnosis and food insecurity. The person can receive diabetes education and support using their DSMT benefit. Separately, the person can receive direct assistance with addressing their food insecurity as long as all of the CHI requirements are met.

Billing Tip: The time spent providing DSMT cannot be counted towards time billed under CHI as they are separate benefits and the time cannot be double counted.

Table 1

Codes, Definitions and Rates for HBAI Activities

HBAI Code	Definition	Description	Rate (Non Facility / Facility)
96156	Initial Health and Behavior Assessment/reassessment	Conducted to assess behavioral, cognitive, emotional, or psychosocial factors that may affect the individual's treatment, recovery, or management of the physical health condition. Includes an individualized person-centered plan, based on the assessment findings.	$98.98 / $86.69
96158	HBAI Individual Intervention, initial 30 minutes	One-on-one time spent with an individual after the initial assessment. May be provided during the course of the CDSME workshop and once the workshop ends to assess progress, reinforce goals, and provide recommendations for follow-up care.	$67.93 / $59.52
96159	HBAI Individual Intervention, ea. additional 30 min	Each additional 30 minutes, per encounter, beyond the initial 30 minutes for one-on-one time spent with an individual after the initial assessment.	$23.29 / $20.38
96164	HBAI group, initial 30 minutes	HBAI group intervention provided in a group setting with two (2) or more persons. First 30 minutes, per encounter.	$10.35 / $9.38
96165	HBAI group, each additional 30 minutes	Each additional 30 minutes, per encounter, beyond the initial 30 minutes for a group HBAI intervention. HBAI group intervention provided in a group setting with two (2) or more persons.	$4.85 / $4.21
96167	HBAI family intervention, initial 30 minutes	One-to-one intervention with a beneficiary and the family that is focused on strategies to change family dynamics and behaviors that adversely affect the patient's physical health and coping behaviors. First 30 minutes, per encounter.	$72.13 / $63.08
96168	HBAI family intervention, each additional 30 minutes beyond the initial 30 minutes	Each additional 30 minutes, per encounter, beyond the initial 30 minutes for a one-to-one intervention with a beneficiary, and family members, that is focused on strategies to change family dynamics and behaviors that adversely affect the patient's physical health and coping behaviors.	$25.88 / $22.64

* CY2025 National Payment Amount

Medicare Diabetes Prevention Program (MDPP)

MDPP is a group-based program for persons with prediabetes. The evidence-based program supports the beneficiary with adopting required lifestyle modifications to prevent the development of type 2 diabetes. The focus of the group instruction is on healthy eating, physical activity, and weight loss. The MDPP is a 1 year, lifetime benefit. Persons that receive MDPP and have a health-related social need can receive CHI services outside of the time that they are participating in DPP activities.

Qualified Healthcare professional for MDPP include the following:

- Diabetes Prevention Program with current CDC Recognition status
- Trained Lifestyle Coach

Use: MDPP can be provided in conjunction with other care management services such as CHI or PIN-PS.

Example: A person with a prediabetes diagnosis and transportation insecurity. The person can participate in a DPP cohort and separately receive support to address their transportation insecurity. The interventions to address transportation insecurity can be used to assist the person with attending in-person DPP classes. However, the person receiving direct assistance with addressing their transportation insecurity can only receive CHI as long as all of the CHI requirements are met.

Billing Tip: The time spent providing MDPP cannot be counted towards time billed under CHI as they are separate benefits and the time cannot be double counted.

Community Health Integration (CHI)

Interventions provided by auxiliary personnel, such as community health workers, to address identified health-related social needs (HRSNs) that impact the ability of a provider to treat or diagnose a health condition. Services can be provided by auxiliary personnel but the personnel must operate under general supervision of an eligible provider. Reimburses for labor (time spent) addressing HRSNs. It does not provide reimbursement for services such as food, transportation, or rent.

Eligibility for CHI requires the identification of a health-related social need. The identified need must be added to the problem list and there must be an identified correlation between the health-related social need and the optimal clinical outcome. The health-related social need must have a negative impact on the ability of the beneficiary to achieve the optimal health outcome. While a health-related social need must be identified and be included in the record, there is not a requirement that the person have a prior clinical claim for rendering the social determinants of health risk assessment benefit.

Qualified Healthcare professional for CHI includes the following:

- Physician (MD or DO)
- Nurse Practitioner
- Physician Assistant

Use: CHI provides reimbursement for labor expended to address health-related social needs that have a negative impact on health outcomes.

Example: A person with diabetes that also has food insecurity. The person has an elevated HgbA1C but they report that they cannot adopt the required diet and exercise changes to manage their diabetes because of the limited access to the appropriate foods. CHI can be implemented to address the food insecurity because the health-related social need negatively impacts the ability to improve the diabetes clinical measures.

Billing Tip: The health-related social needs should be added to the problem list along with an explanation of the negative impact that the health-related social need will have on the desired health outcomes.

Table 2

HCPCS Code and CY2025 Reimbursement Rate for Community Health Integration Services

HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0019	Community Health Integration Services SDOH 60 min	$80.56	$49.60
G0022	Community Health Integration Services; add 30 min	$50.26	$34.62

Principal Illness Navigation (PIN)

Health navigation services that are provided to assist with the management of a serious high-risk condition, that is expected to last at least three (3) months and could lead to worsening health outcomes such as hospitalization, nursing home placement, disease complications, or even death if not addressed. Health navigation and supports provided by a peer support specialist, operating under general supervision of an eligible provider. Reimburses for labor (time spent) providing eligible PIN services. Services are billed based on the aggregate of time spent per calendar month.

Qualified Healthcare professional for PIN includes the following:

- Physician (MD or DO)
- Nurse Practitioner
- Physician Assistant
- Clinical Psychologist
- Clinical Social Worker*

Use: Health navigation services rendered to a person with a serious high-risk condition

Example: A person with a dementia diagnosis and limited caregiver support. The consumer and the caregiver require assistance with determining their long-term care options and navigating the long-term care system, given the progressive nature of the disease. The medical provider contracts with the Area Agency on Aging that has a dementia navigator to provide support to the family as an auxiliary worker billing incident to the healthcare practitioner.

Billing Tip: PIN services are billed based on the aggregate of time spent per calendar month. PIN services can be billed concurrently with other care management services and transitional care management (TCM).

* Please note that a clinical social worker (CSW) cannot provide general supervision for auxiliary personnel in the delivery of PIN because they are not eligible to provide incident to services. Any PIN billing, for a CSW, must include only the time that the CSW spent directly providing PIN services. A CSW cannot include PIN time performed by auxiliary personnel because a CSW cannot bill for incident to services rendered by auxiliary personnel.

Table 3

HCPCS Code and CY2025 Reimbursement Rate for Principal Illness Navigation Services

HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0023	PIN service, 60 minutes per month	$80.56	$49.60
G0024	PIN service, add 30 min	$50.26	$34.62

Principal Illness Navigation – Peer Support (PIN-PS)

Health navigation and supports provided by a peer support specialist, operating under general supervision of an eligible provider. The person must have a mental health diagnosis of substance use disorder. Reimburses for labor (time spent) providing eligible PIN-PS services. Services are billed based on the aggregate of time spent per calendar month.

Qualified Healthcare professional for PIN-PS include the following:

- Physician (MD or DO)
- Nurse Practitioner
- Physician Assistant
- Clinical Psychologist

Use: PIN-PS is applicable to a person with a behavioral health diagnosis for substance use disorder. The services include work performed by a trained peer support worker.

Example: A person with bipolar disease and a opioid addiction. The person has a history of poor adherence to treatment including medication assisted opioid treatment. A trained peer support worker provides services to the consumer to improve adherence to treatment.

Billing Tip: The time spent providing PIN-PS can be provided concurrently with other care management services including CHI, PIN or transitional care management (TCM).

Table 4

HCPCS Code and CY2025 Reimbursement Rate for Principal Illness Navigation — Peer Support Services

HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0140	Navigation Services, Peer Support, 60 minutes	$80.56	$49.60
G0146	Navigation Services, Peer Support, add 30 min	$50.26	$34.62

Partnership to Align Social Care

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The Partnership to Align Social Care ("Partnership") is a national learning and action network whose purpose is to enable cross-sector collaboration focused on co-designing and sharing solutions that advance sustainable and aligned health and community care delivery systems leveraging community care hubs (CCHs) to promote whole-person health. 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. Partnership stakeholders collectively advance initiatives that build awareness about opportunities to promote whole-person health through coordination across health care providers and CCHs, expand CCH and CBO adoption of opportunities to bill for labor and services that improve whole-person health, and elevate innovative practices among health care sector stakeholders, CCHs, and CBOs pursuing cost-effective partnerships to drive high-quality care.

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For more information about the Partnership to Align Social Care, visit **www.partnership2asc.org**.