the patient to have a single point of contact for all their CHI services during a given month.

We are proposing that the practitioner could separately bill for other care management services during the same month as CHI services, if time and effort are not counted more than once, requirements to bill the other care management service are met, and the services are medically reasonable and necessary.

We propose that CHI services could not be billed while the patient is under a home health plan of care under Medicare Part B, since we believe there would be significant overlap between services furnished under a home health plan of care and CHI services, particularly in the home health services referred to as ''medical social services,'' and in comprehensive care coordination. For example, medical social services can be furnished to the patient's family member or caregiver on a short-term basis when the home health agency (HHAs) can demonstrate that a brief intervention by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to the patient's rate of recovery. Additionally, the home health agency (HHA) conditions of participation require that HHAs coordinate all aspects of the beneficiary's care while under a home health plan of care, such as integrating services, whether provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines; and involvement of the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.

Also, we note that when Medicare and Medicaid cover the same services for patients eligible for both programs, Medicare generally is the primary payer in accordance with section 1902(a)(25) of the Act. Based on the specificity of the coding for our proposal, we do not expect that CHI services will neatly overlap with any other coverage for patients who are dually eligible for Medicare and Medicaid. However, we are seeking public comment regarding whether States typically cover services similar to CHI under their Medicaid programs, and whether such coverage would be duplicative of the CHI service codes. We also seek comment on whether there are other service elements not included in the proposed CHI service codes that should be included, or are important in addressing unmet SDOH need(s) that affect the diagnosis or treatment of medical problems, where CMS should consider coding and payment in the future.

c. Proposed CHI Services Valuation

For HCPCS code GXXX1, we are proposing a work RVU of 1.00 based on a crosswalk to CPT code 99490 (*Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month*) as we believe these values most accurately reflect the resource costs incurred when the billing practitioner furnishes CHI services. CPT code 99490 has an intraservice time of 25 minutes and the work is of similar intensity to our proposed HCPCS code GXXX1. We are, therefore, proposing a work time of 25 minutes for HCPCS code GXXX1, based on this same crosswalk to CPT code 99490. We are also proposing to use this crosswalk to establish the direct PE inputs for HCPCS code GXXX1.

For HCPCS code GXXX2, we are proposing a crosswalk to the work RVU and direct PE inputs associated with CPT code 99439 (*Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)*) as we believe these values reflect the resource costs incurred when the billing practitioner furnishes CHI services. Therefore, we are proposing a work RVU of 0.70 and a work time of 20 minutes for HCPCS code GXXX2.

d. Social Determinants of Health (SDOH)—Proposal To Establish a Stand-Alone G Code

i. Background

As previously discussed, there is increasing recognition within the health care system of the need to take SDOH into account when providing health care services, given that it is estimated [10] that around 50 percent of an individual's health is directly related to SDOH. Healthy People 2030 define the broad groups of SDOH as: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context, which include factors like housing, food and nutrition access, and transportation needs. Many Federal agencies are also developing policies to better address the impact SDOH have on patients, in support of HHS's Strategic Approach to Addressing Social Determinants of Health to Advance Health Equity,[11] as well as the CMS Framework for Health Equity.[12]

ii. Proposed SDOH Risk Assessment Code

Over the past several years, we have worked to develop payment mechanisms under the PFS to improve the accuracy of valuation and payment for the services furnished by physicians and other health care professionals, especially in the context of evolving models of care. Section 1862(a)(1)(A) of the Act generally excludes from coverage services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Practitioners across specialties have opined and recognized the importance of SDOH on the health care provided to their patients, including by recommending the assessment of SDOH through position or discussion papers,[13] [14] [15] organizational strategic plans,[16] and provider training modules.[17] Previously in this section of our proposed rule, we discuss how the practice of medicine currently includes assessment of health-related social needs or SDOH in taking patient histories, assessing patient risk, and informing medical decision making, diagnosis, care and treatment. The taking of a social history is generally

[10] *https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.*

[11] *https://aspe.hhs.gov/sites/default/files/documents/aabf48cbd391be21e5186eeae728ccd7/SDOH-Action-Plan-At-a-Glance.pdf.*

[12] *https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf.*

[13] *https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html.*

[14] *https://doi.org/10.7326/M17-2441.*

[15] *https://nam.edu/social-determinants-of-health-201-for-health-care-plan-do-study-act/.*

[16] *https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf.*

[17] *https://edhub.ama-assn.org/steps-forward/module/2702762.*

performed by physicians and practitioners in support of patient-centered care to better understand and help address relevant problems that are impacting medically necessary care. We believe the resources involved in these activities are not appropriately reflected in current coding and payment policies. As such, we are proposing to establish a code to separately identify and value a SDOH risk assessment that is furnished in conjunction with an E/M visit.

We are proposing a new stand-alone G code, GXXX5, *Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5–15 minutes, not more often than every 6 months.* SDOH risk assessment refers to a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions. We are proposing GXXX5 to identify and value the work involved in the administering a SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit. SDOH risk assessment through a standardized, evidence-based tool can more effectively and consistently identify unmet SDOH needs, and enable comparisons across populations. For example, through administration of the SDOH risk assessment for a patient presenting for diabetes management, a practitioner might discover that a patient's living situation does not permit reliable access to electricity, impacting the patient's ability to keep insulin refrigerated. The practitioner may then prescribe a type of insulin that remains stable at room temperature, or consider oral medication instead. In this example, the practitioner could furnish an SDOH risk assessment in conjunction with the E/M visit to gain a more thorough understanding of the patient's full social history and to determine whether other SDOH needs are also impacting medically necessary care.

We further propose that the SDOH risk assessment must be furnished by the practitioner on the same date they furnish an E/M visit, as the SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis, and treatment plan established during the visit. Required elements would include:

- Administration of a standardized, evidence-based [18] SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.

++ Billing practitioners may choose to assess for additional domains beyond those listed above if there are other prevalent or culturally salient social determinants in the community being treated by the practitioner.

Possible evidence-based tools include the CMS Accountable Health Communities [19] tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) [20] tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.[21]

Given the multifaceted nature of unmet SDOH needs, appropriate follow-up is critical for mitigating the effects of the identified, unmet SDOH needs on a person's health. An SDOH risk assessment without appropriate follow-up for identified needs would serve little purpose. As such, CMS is seeking comment on whether we should require as a condition of payment for SDOH risk assessment that the billing practitioner also have the capacity to furnish CHI, PIN, or other care management services, or have partnerships with community-based organizations (CBO) to address identified SDOH needs.

The SDOH needs identified through the risk assessment must be documented in the medical record, and may be documented using a set of ICD–10–CM codes known as ''Z codes'' [22] (Z55–Z65) which are used to document SDOH data to facilitate high-quality communication between providers. We are proposing GXXX5 have a duration of 5–15 minutes for the administration of an SDOH risk assessment tool, billed no more often than once every 6 months. We propose to limit the SDOH assessment service to once every six months, as we believe there are generally not significant, measurable changes to health outcomes impacted by a patient's SDOH in intervals shorter than 6 months.

iii. Proposed Valuation for SDOH Risk Assessment GXXX5

We propose a direct crosswalk to HCPCS code G0444 (*Screening for depression in adults, 5–15 minutes*), with a work RVU of 0.18, as we believe this service reflects the resource costs associated when the billing practitioner performs HCPCS code GXXX5. HCPCS code G0444 has an intraservice time of 15 minutes, and the physician work is of similar intensity to our proposed HCPCS code GXXX5. Therefore, we are proposing a work time of 15 minutes for HCPCS code GXXX5 based on this same crosswalk to G0444. We are also proposing to use this crosswalk to establish the direct PE inputs for HCPCS code GXXX5.

We believe these services would largely involve direct patient contact between the billing practitioner or billing practitioner's auxiliary personnel and the patient through in-person interactions, which could be conducted via telecommunications as appropriate. Therefore, we are proposing to add this code to the Medicare Telehealth Services List to accommodate a scenario in which the practitioner (or their auxiliary personnel incident to the practitioner's services) completes the risk assessment in an interview format, if appropriate. We believe it is important that when furnishing this service, all communication with the patient be appropriate for the patient's educational, developmental, and health literacy level, and be culturally and linguistically appropriate. We are seeking comment on where and how these services would be typically provided, along with other aspects of the proposed SDOH assessment service.

e. Principal Illness Navigation (PIN) Services

i. Background

Experts on navigation of treatment for cancer and other high-risk, serious illnesses have demonstrated the benefits of navigation services for patients experiencing these conditions.[23] Experts have noted the importance of these services for all affected patients, but especially those with socioeconomic disadvantages or barriers to care. Navigation generally means the process or activity of ascertaining one's position and planning and following a route; the act of directing from one place to another; the skill or process of plotting a route and directing; the act, activity, or process of finding the way to get to a place you are traveling. In the context of healthcare, it refers to providing individualized help to the patient (and caregiver, if applicable) to identify appropriate practitioners and providers for care needs and support, and access necessary care timely, especially when the landscape is complex and delaying care can be deadly. It is often referred

[18] *https://health.gov/healthypeople/tools-action/browse-evidence-based-resources/types-evidence-based-resources.*

[19] *https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.*

[20] *https://www.nachc.org/research-and-data/prapare/.*

[21] CMS–10825.

[22] *https://www.cms.gov/files/document/z-codes-data-highlight.pdf.*

[23] See for example, *https://view.ons.org/3hjHjc* and *https://www.accc-cancer.org/docs/projects/pdf/patient-navigation-guide.*