Funding Community Health Workers and Patient Navigators in Cancer Care: Understanding New Medicare Billing Codes

February 20, 2024

Katie Garfield, JD
Director, Whole Person Care
Center for Health Law and Policy Innovation
Harvard Law School

Mandi Pratt-Chapman, PhD
Associate Professor
Associate Director, Community Outreach, Engagement, and Equity
GW Cancer Center

Elizabeth A. Rohan, PhD, MSW
Health Scientist
Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, Comprehensive Cancer Control Branch

CENTER *for* HEALTH LAW *and* POLICY INNOVATION

HARVARD LAW SCHOOL

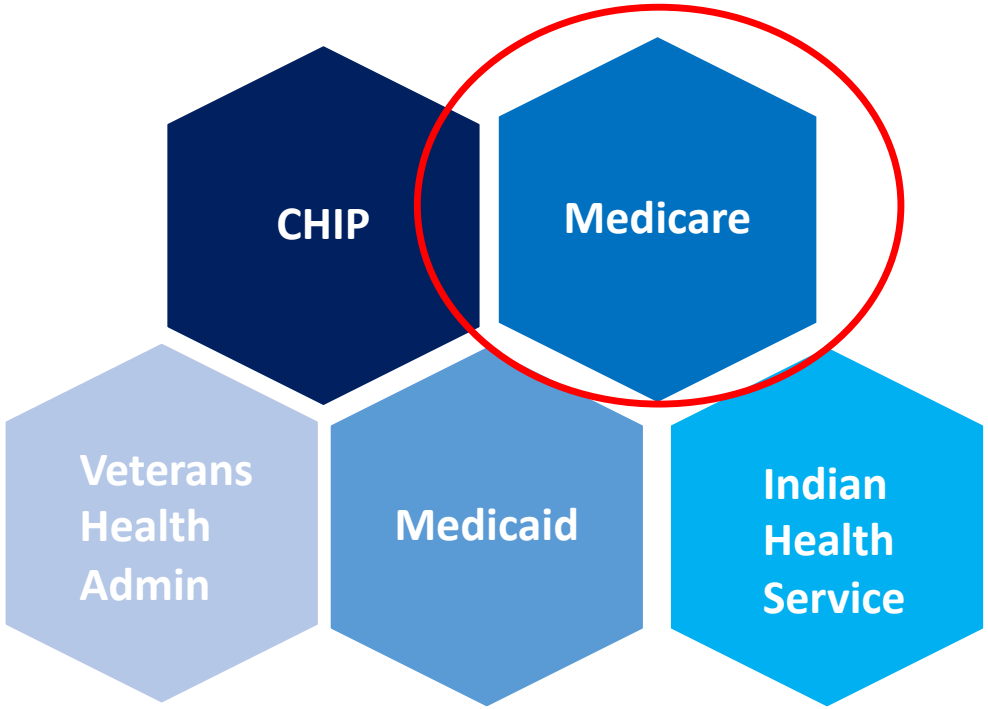
NEW MEDICARE BILLING CODES

Funding Patient Navigators and Community Health Workers

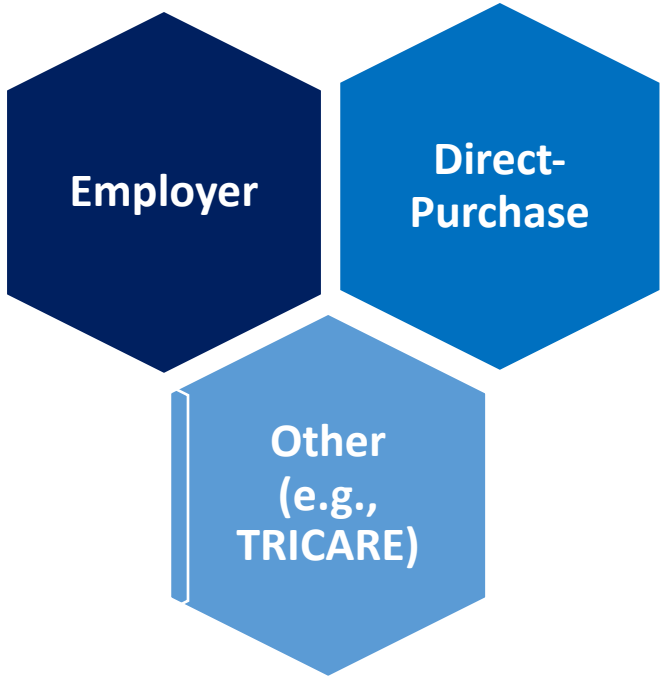
Katie Garfield, JD
Director, Whole Person Care, CHLPI
February 20, 2024

U.S. Health Insurance Landscape

Public Health Insurance



Private Health Insurance



Medicare: An Overview

- **Medicare:**
  - Serves individuals aged 65+ or who are living with disabilities or End Stage Renal Disease (ESRD)
- **Broken into 4 Parts:**
  - **Part A:** Hospital Insurance
  - **Part B:** Medical Insurance
  - **Part C:** Medicare Advantage (Private Health Plans)
  - **Part D:** Prescription Drug Coverage

Background

- **Medicare Physician Fee Schedule (PFS)**
  - **Medicare** reimburses physicians (and other enrolled health care providers) for services provided under Medicare Part B based on the Physician Fee Schedule
  - Lists more than 10,000 unique covered service codes and their payment rates
  - Payment policies in the PFS are updated **annually** via the rulemaking process (i.e., the process used to create new regulations)

Medicare Physician Fee Schedule

Background

- **Calendar Year 2024 PFS Rule**
  - Introduced new payment policies (i.e., billing codes) relevant to HRSN supports
  - **Proposed Rule**: Released July 2023 for Comment
  - **Final Rule**: Released November 2023
  - **Implementation**: January 1, 2024

Key Takeaway:

Beginning in 2024, ***Medicare providers*** *can use these new billing codes to seek payment for community health worker and patient navigation services provided to* ***Medicare enrollees***

Medicare Physician Fee Schedule

Rule Summary

	Purpose	HCPCS Codes (i.e., billing codes)
Principal Illness Navigation (PIN) Services	Assist Medicare enrollees **with high-risk conditions** identify and connect with clinical and support services	**G0023** – PIN services 60 minutes/month **G0024** – PIN services, additional 30 minutes **G0140** – PIN- Peer Support, 60 minutes/month **G0146** – PIN- Peer Support, additional 30 minutes **G0511 –** Payment of PIN services in FQHCs/RHCs
Community Health Integration (CHI) Services	Address **unmet health-related social needs (HRSN)** that affect diagnosis and treatment of a Medicare enrollee's medical conditions	**G0019 –** CHI services 60 minutes/month **G0022** – CHI services, additional 30 minutes **G0511 –** Payment of CHI services in FQHCs/RHCs
Social Determinants of Health (SDOH) Risk Assessment	**Assessment** of Medicare enrollee's SDOH/social risk factors that influence diagnosis or treatment of medical conditions	**G0136 –** SDOH risk assessment 5-15 minutes, not more than every 6 months

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0 .

WHO Can Receive PIN Services?

- **Medicare patient**
- **Who has a "serious high-risk condition"**
  - Expected to last at least **3 months**
  - Places patient at "significant risk of hospitalization, nursing home placement, acute exacerbation/decomposition, functional decline or death"
  - Requires disease-specific care plan, and may require frequent adjustment in medication or treatment regimen or substantial assistance from a caregiver

***Note on Peer Support PIN**: Limited to behavioral health conditions*

PIN Services - Eligibility

WHAT Can PIN Services Look Like?

Overview - Categories of Services*
Person-centered assessment
Identifying or referring patient (and caregiver or family) to appropriate supportive services
Practitioner, home, and community-based care coordination
Health education
Building patient self-advocacy skills
Health care access / health system navigation
Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
Facilitating and providing social and emotional support
Leveraging knowledge of the condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

***Note:** Categories of services differ slightly for Peer Supports PIN*

PIN Services - Services

WHO May Provide PIN Services?

- **Certified or trained** auxiliary personnel under the **direction** of a physician or other practitioner, including a **patient navigator** or certified peer specialist
  - "Incident to" billing
  - Auxiliary personnel may be **external** to/under contract with the practitioner or practice (e.g., a CBO) if there is "clinical integration"

WHO May Provide PIN Services? - Training

Training Competencies*
Patient and family communication
Interpersonal and relationship-building
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 training on the condition addressed in the initiating visit

**__Note__: Where states already have certification requirements, CMS __defers__ to those requirements*

PIN Services – Providers

PROCESS of Providing PIN Services

PIN Services - Process

Starting Out – Initiating Visit + Treatment Plan

- Before PIN services can begin, billing practitioner must perform an “initiating visit”
  - **Visit types:** Evaluation and management (E/M) visit; annual wellness visit; psychiatric diagnostic evaluation; or visit involving Health Behavior Assessment and Intervention services
  - **Visit elements:** Establish medical necessity, develop treatment plan

PIN Services – Initiating Visit

Starting Out – Consent

- Before PIN services can begin, must obtain **patient consent**
  - Written or verbal
  - Documented in patient medical record
  - Must explain that cost-sharing applies
  - Must be obtained annually
  - Can be obtained by auxiliary personnel

Provision of Services - PIN Services

Overview - Categories of Services
Person-centered assessment
Identifying or referring patient (and caregiver or family) to appropriate supportive services
Practitioner, home, and community-based care coordination
Health education
Building patient self-advocacy skills
Health care access / health system navigation
Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
Facilitating and providing social and emotional support
Leveraging knowledge of the condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

PIN Services - Services

Documentation

- **Billing practitioner must document in the medical record:**
  - Time spent providing PIN services
  - Activities performed by auxiliary personnel
  - How activities are related to the treatment plan
  - Identified SDOH needs, if present

Billing

	HCPCS Codes (i.e., billing codes)
PIN Services	**G0023**: PIN services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities…
	G0024: Principal Illness Navigation services, additional 30 minutes per calendar month
PIN - Peer Support Services	**G0140**: PIN- 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, in the following activities…
	G0146: PIN - Peer Support, additional 30 minutes per calendar month
PIN Services when Offered at FQHCs/RHCs	**G0511:** General care management (code that can be used to support PIN services in FQHCs/RHCs)

***Note:** The final rule does not impose a practitioner, frequency, or duration limit for PIN services.*

PIN Services - Billing

SWITCHING GEARS

Community Health Integration (CHI) Services

WHO Can Receive CHI Services?

- Medicare patient
- Who has social determinants of health needs that significantly limit the practitioner's ability to diagnose or treat the patient's medical problem(s)

WHAT Can CHI Services Look Like?

Overview - Categories of Services
Person-centered assessment
Practitioner, home, and community-based care coordination
Health education
Building patient self-advocacy skills
Health care access / health system navigation
Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
Facilitating and providing social and emotional support
Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

CHI Services - Services

WHO May Provide CHI Services?

- **Certified or trained** auxiliary personnel, including a community health worker, under the **direction** of a physician or other practitioner
  - "Incident to" billing
  - Auxiliary personnel may be **external** to/under contract with the practitioner or practice (e.g., a CBO) if there is "clinical integration"

WHO May Provide CHI Services? - Training

Training Competencies*
Patient and family communication
Interpersonal and relationship-building
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

**__Note__: Where states already have certification requirements, CMS __defers__ to those requirements*

CHI Services – Providers

PROCESS of Providing CHI Services

CHI Services - Process

Starting Out – Initiating Visit + Treatment Plan

- Before CHI services can begin, billing practitioner must perform an "initiating visit"
  - **Visit types:**
    - Evaluation and management (E/M) visit (other than low-level visit performed by clinical staff)
      - CAN be an E/M visit provided as part of Transitional Care Management
    - Annual wellness visit;
  - **Visit elements:** Identify SDOH needs significantly limiting ability to diagnose or treat the patient, establish treatment plan

CHI Services – Initiating Visit

Starting Out – Consent

- Before CHI services can begin, must obtain **patient consent**
  - Written or verbal
  - Documented in patient medical record
  - Must explain that cost-sharing applies
  - Can be obtained by auxiliary personnel
  - *Must explain that only 1 practitioner can bill for CHI services per month*
  - *Only needs to be obtained once (unless billing practitioner changes)*

Provision of Services - CHI Services

Overview - Categories of Services
Person-centered assessment
Practitioner, home, and community-based care coordination
Health education
Building patient self-advocacy skills
Health care access / health system navigation
Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
Facilitating and providing social and emotional support
Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

CHI Services - Services

Documentation

- **Billing practitioner must document in the medical record:**
  - **Time spent providing CHI services**
  - **Activities performed by auxiliary personnel**
  - **SDOH needs that the CHI services are addressing (can use ICD-10 Z-codes)**

Billing

	HCPCS Codes (i.e., billing codes)
CHI Services	**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:…
	G0022: Community health integration services, each additional 30 minutes per calendar month
CHI Services when Offered at FQHCs/RHCs	**G0511:** General care management (code that can be used to support CHI services in FQHCs/RHCs)

Note:** The final rule does not impose a frequency or duration limit for PIN services. But DOES limit billing for CHI to **1 practitioner per month

CHI Services - Billing

Switching Gears

Social Determinants of Health (SDOH) Risk Assessment

WHO can receive an SDOH Risk Assessment?

- Medicare patient
- When the billing practitioner has reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment of a condition or illness or will influence choice of treatment or plan of care
  - *Not* intended for routine screening

SDOH Risk Assessment - Eligibility

WHAT can the SDOH Risk Assessment Look Like?

- **Must use a standardized, evidence-based SDOH risk assessment tool (though flexible on which tool) that includes:**
  - Food insecurity, housing insecurity, transportation needs, utility difficulties
- **Must be documented in the medical record**
- **Can be provided via telehealth**

SDOH Risk Assessment - Service

WHEN can the SDOH Risk Assessment Occur?

- **Can be provided no more often than every 6 months per practitioner, per beneficiary**
- **Can be provided in association with:**
  - An evaluation and management (E/M) visit (which can include hospital discharge or transitional care management)
  - Behavioral health office visits (psychiatric diagnostic evaluation and health behavior assessment and intervention)
  - Annual wellness visit

SDOH Risk Assessment – Timing

Billing

	HCPCS Codes (i.e., billing codes)
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

SDOH Risk Assessment - Billing

Questions?

	Purpose	HCPCS Codes (i.e., billing codes)
Principal Illness Navigation (PIN) Services	Assist Medicare enrollees **with high-risk conditions** identify and connect with clinical and support services	**G0023** – PIN services 60 minutes/month **G0024** – PIN services, additional 30 minutes **G0140** – PIN- Peer Support, 60 minutes/month **G0146** – PIN- Peer Support, additional 30 minutes **G0511 –** Payment of PIN services in FQHCs/RHCs
Community Health Integration (CHI) Services	Address **unmet health-related social needs (HRSN)** that affect diagnosis and treatment of a Medicare enrollee's medical conditions	**G0019 –** CHI services 60 minutes/month **G0022** – CHI services, additional 30 minutes **G0511 –** Payment of CHI services in FQHCs/RHCs
Social Determinants of Health (SDOH) Risk Assessment	**Assessment** of Medicare enrollee's SDOH/social risk factors that influence diagnosis or treatment of medical conditions	**G0136 –** SDOH risk assessment 5-15 minutes, not more than every 6 months

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0 .

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Training and Resources to Position Cancer Navigators for Success and "Incident to" Billing

February 20, 2024
Centers for Disease Control and Prevention Live Webinar

Mandi L. Pratt-Chapman, PhD (she/her)
Associate Professor, Medicine
Associate Professor, Prevention & Community Health
Associate Director, Community Outreach, Engagement and Equity

GW Cancer Center

Disclosures

I receive funding from the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH),the American Society of Clinical Oncology, and Gilead. I discuss technical assistance materials developed through support from the CDC, the Patient Centered Outcomes Research Institute, Genentech, and Pfizer. My views are my own and do not necessarily represent the views of my institution, my colleagues, or my funders.

CMS Training Requirement

"In States that do not have applicable licensure, certification, or other laws or regulations governing the certification or training of auxiliary personnel, we proposed to require auxiliary personnel providing PIN services be trained to provide all service elements. **Training must include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base**, including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit."

FR Doc. 2023–24184 Filed 11–2–23; 4:15 pm

How do I find my state's requirements?

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

https://nashp.org/state-tracker/state-community-health-worker-policies/

https://chwtraining.org/core-competencies-to-start-your-chw-program/

CMS Required Domain from Physician Payment CY2024 Final Rule	**C3 CHW Competencies (2022) -** cited in the Physician Payment CY2024 Final Rule	**GW Oncology Patient Navigator Core Competencies (2015) –** aligned with ACGME domains for health professions	**Oncology Standards of Professional Practice (PONT) Standards (2022) –** promoted in Biden Moonshot
Patient and family communication	Professional Conduct and Interpersonal Skills; Communication Skills	Interpersonal and Communication Skills	Communication
Patient and family capacity building	Community Capacity Building; Community Outreach and Engagement	Patient care; Interpersonal and Communication Skills	Treatment, Care Planning, and Intervention; Survivorship (coaching and preparing patients)
Interpersonal and relationship-building	Communication Skills	Interpersonal and Communication Skills; Interprofessional Collaboration	Interdisciplinary and Interorganizational collaboration
Service coordination and health systems navigation	Service Coordination	Systems-Based Practice (care transitions, coordination, provision of services, resource stewardship)	Continuum of care domains (care transitions, coordination, provision of services); Evidence-Based Care
Patient advocacy facilitation	Advocacy	Patient Care (support patient empowerment and communication)	Advocacy

CMS Required Domain from Physician Payment CY2024 Final Rule	**C3 CHW Competencies (2022) -** cited in the Physician Payment CY2024 Final Rule	**GW Oncology Patient Navigator Core Competencies (2015) –** aligned with ACGME domains for health professions	**Oncology Standards of Professional Practice (PONT) Standards (2022) –** promoted in Biden Moonshot
Individual and community Assessment	Individual and Community Assessment	Patient Care (barriers assessment, resource acquisition)	Prevention, Screening, and Assessment; Treatment, Care Planning and Intervention; Psychosocial Assessment and Intervention (assessment)
Professionalism	Professional Conduct and Interpersonal Skills; Organizational Skills; Health Insurance Basics; Teaching Skills	Professionalism; Personal and Professional Development; Practice-Based Learning and Improvement	Qualifications; Professional Development; Supervision; Mentorship and Leadership; Operational management; Practice Evaluation and Quality Improvement
Ethical Conduct	Professional Conduct and Interpersonal Skills; Cultural Competence and Responsiveness	Professionalism (commitment to ethical principles)	Ethics; Self-Care; Cultural and Linguistic Humility
Knowledge Base	Community Outreach and Engagement; Promoting Healthy Lifestyles; Public Health	Knowledge for Practice	Knowledge

Core Credentialing that meet CMS Requirements

Training	Scope	Costs	How to Access	Considerations
Academy of Oncology Nurse and Patient Navigators (AONN+) – OPN-CG certification	National certification that requires successful completion of an examination and a number of years of experience.	$150	Online at aonnffl.org/renew	Currently on hold, but still valid to document appropriate training if you have the credential. Requires renewal after 3 years.
American Cancer Society Leadership in Oncology Navigation (LION)	National training and certification.	$495	Online at cancer.org/health-care-professionals/resources-for-professionals/patient-navigator-training.html	Cost associated. Requires renewal every 3 years. Approximately 10 hours.
Patient Navigation & Community Health Worker Training	A full curriculum for patient navigators, care coordinators and community health workers.	Varies	Sign up at Patientnavigatortraining.org (course is hybrid: in-person and online)	Requests for financial aid considered on a case-by-case basis. May not cover all required competencies for CMS billing with Level 1 training only. Hours vary based on level and degree of tailoring.

Pratt-Chapman et al. (2024, in press). The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What? Oncology Issues.

Core Trainings that meet CMS Requirements

GW Cancer Center Oncology Patient Navigator Training: The Fundamentals	National training for those supporting patients of all cancer types. Certificate provided. Prepares learners for AONN+ OPN-CG certification.	Free	Online at bit.ly/PNTraining	Funded by the Centers for Disease Control and Prevention, this training aims to level set navigator knowledge. Institutions should provide supplemental context-specific and cancer-specific training tailored to the specific duties of the navigator following this foundational training. 10 hours of core requirements plus supplemental reading (estimated 17 hours total).
Susan G. Komen Patient Navigation Training Program	National training for those affected by all cancers with additional breast cancer focused content.	Free	Online at komen.org/about-komen/our-impact/breast-cancer/navigation-nation-training-program/	Originally adapted from GW Cancer Center Oncology Patient Navigator Training: The Fundamentals with additional unique content developed by Komen. Features virtual ongoing educational events and peer networking. 10 hours of core requirements plus special topics

Pratt-Chapman et al. (2024, in press). The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What? Oncology Issues.

Oncology Patient Navigation Training Fundamentals

https://bit.ly/PNTraining

Created and maintained with support from the CDC (#U38DP004972, #NU58DP006461 and #NU58DP007539).

Patient Navigation Guides in English & Spanish

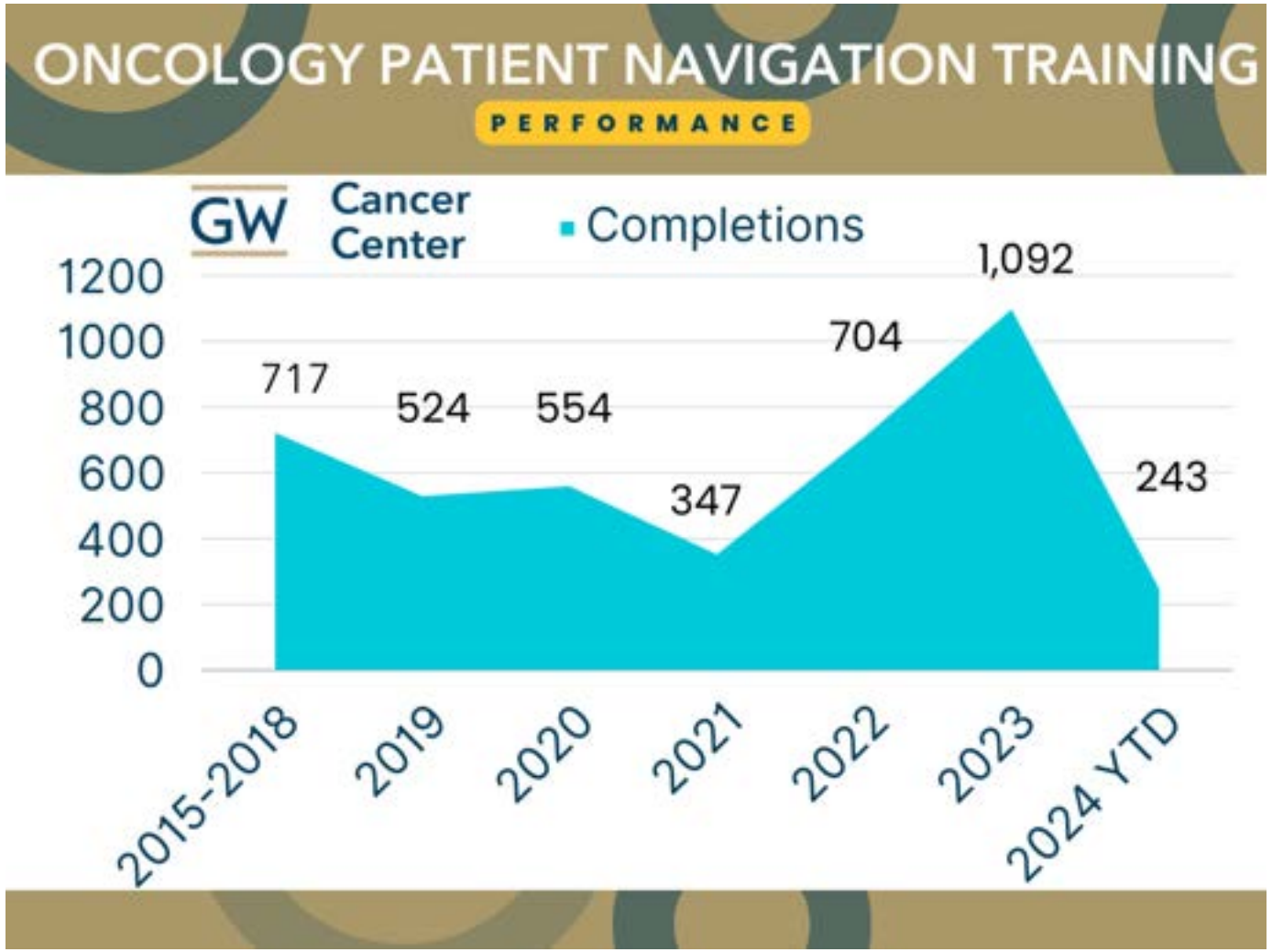
bit.ly/PNGuides2023

Created and maintained with support from the CDC (#NU58DP006461 and #NU58DP007539).

CMS Required Domain	Relevant Module in GW Oncology Patient Navigator Training: The Fundamentals	CMS Required Domain	Relevant Module in GW Oncology Patient Navigator Training: The Fundamentals
Patient and family communication	Communicating with Patients Culturally Competent Communication	Patient advocacy facilitation	Patient Advocacy
Patient and family capacity building	Communicating with Patients Shared Decision Making Patient Advocacy	Individual and community assessment	Identifying resources Program Evaluation and Quality Improvement
Interpersonal and relationship-building	Patient Assessment Shared Decision Making Culturally Competent Communication Practicing Efficiently and Effectively Health Care Team Collaboration Personal and Professional Development	Professionalism	Scope of Practice Practicing Efficiently and Effectively Personal and Professional Development
		Ethical Conduct	Ethics and Patient Rights
Service coordination and health systems navigation	Clinical Trials US Healthcare System Health Care Payment and Financing Health Care Team Collaboration	Knowledge Base	Overview of Patient Navigation and Competencies Medical Terminology Cancer Basics Impact of Cancer The Role of the Patient Navigator

Pratt-Chapman et al. (2024, in press). CMS Payment for Principal Illness Navigation: How do I Credential My Navigators? Journal of Oncology Navigation & Survivorship.

GW Oncology Patient Navigator Training Participation



Supplemental Resources

View Lesson 1 An Overview of Patient Navigation and Competencies (PPT) >

View Lesson 2 Medical Terminology (PPT) >

View Lesson 3 Cancer Basics (PPT) >

View Lesson 4 Clinical Trials (PPT) >

View Lesson 5 Impact of Cancer (PPT) >

View Lesson 6 U.S. Health Care System (PPT) >

bit.ly/PNGuides2023

View the 2024 Update to the Oncology Patient Navigator Training: The Fundamentals (PDF) >

Location	Update	For Navigators outside of the U.S.
Module 3: The Basics of Healthcare **Lesson 2: Cancer Basics**	**Current cancer screening guidelines:** American College of Radiology guidance on transgender breast cancer screening USPSTF – Breast Cancer: Screening Guidelines (currently being updated) USPSTF – Cervical Cancer Screening Guidelines (currently being updated) USPSTF – Colorectal Cancer Screening Guidelines USPSTF – Lung Cancer Screening Guidelines USPSTF – Prostate Cancer Screening Guidelines (currently being updated; see Clinical Considerations section for special considerations for African American individuals with a prostate and those with a family history of prostate cancer) **Current data on cancer risk factors and outcomes:** US Cancer Statistics Data Visualization Tool	**International learners should refer to relevant guidelines and well as statistics for their region.** WHO – Report on Traditional and Complementary Medicine: National practices, providers, and education. WHO – Screening Programmes: A Short Guide: Provides international screening-specific guidance. ESMO – Interactive Guidelines: Recommendations for helping patients with the best care options. ICISG – Cancer Information in Other Languages webpage: Cancer organizations with information in >20 languages ACS – Cancer Information in Other Languages webpage: Information about cancer in >10 languages.

bit.ly/PNGuides2023

Adaptation for Noncommercial Purposes

Please include the following acknowledgment if materials are adapted:

This content was adapted from the GW Cancer Center the Oncology Patient Navigation Training: The Fundamentals (PI: Pratt-Chapman) developed and maintained by CDC cooperative agreements #NU38DP004972, #5NU58DP006461 and #NU58DP007539. The content added, changed, or adapted by our organization do not necessarily represent the views of the GW Cancer Center or the CDC.

https://bit.ly/PNTraining

bit.ly/PNGuides2023

Trainings: Affirming Care for Priority Populations

Population	Training	How to Access
Black, Latino, LGBTQI persons	GW Cancer Center Together-Equitable-Accessible-Meaningful (TEAM) Training	Free, self-paced, online; Access at bit.ly/GWCCTEAMtraining
Elderly persons from thirteen diverse ethnic backgrounds	Stanford Internet-Based Successful Aging (iSAGE)	Free, but limited capacity; Includes community of practice with secure interaction forum and dialogue; Access at https://geriatrics.stanford.edu/about.html
LGBTQI persons	National LGBT Cancer Network Welcoming Spaces Training	Free, self-paced, online; Access at https://cancer-network.org/welcoming-spaces/
Native American/ Alaska Native persons	Native American Cancer Research Corporation	Cost associated; Access at https://natamcancer.org/Patient-Navigator-Training

Pratt-Chapman et al. (2024, in press). The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What? Oncology Issues.

Resources: TEAM Training & I Want You to Know Cards

bit.ly/GWCCTEAMtraining

bit.ly/TEAMPatientCards

Created with support from the Pfizer Foundation. Maintained by Cooperative Agreement #NU58DP006461 from the CDC.

PN-BOT™: A Free Resource for Data Tracking

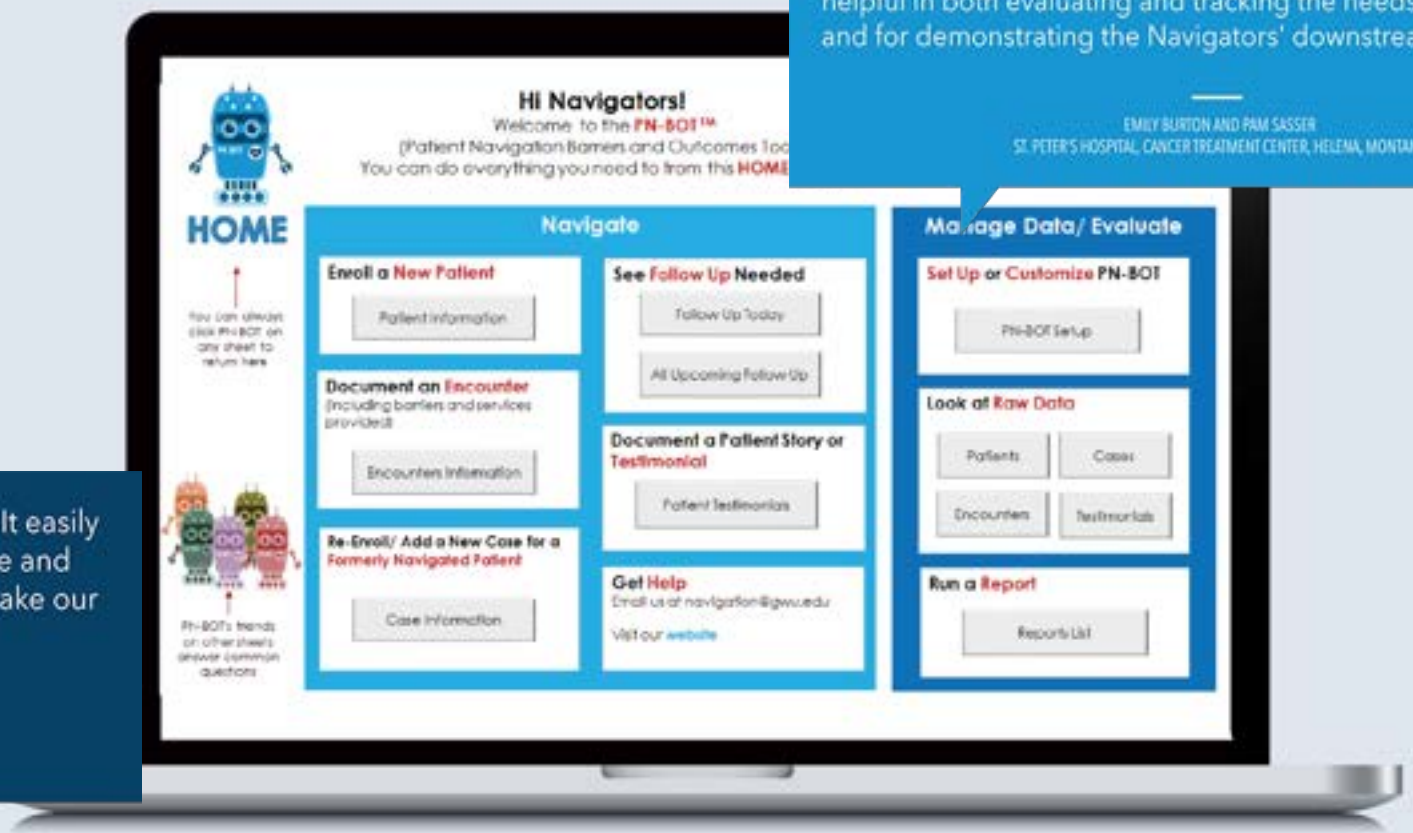
bit.ly/PN-BOT

"The Barriers Tool is perfect for non-profit organizations. It easily tracks all our clients' information and their barriers to care and also produces great reports with ease. This system will make our jobs easier."

NANCY LA JOY
PACIFIC CANCER FOUNDATION

"GW's PN-BOT is an invaluable tool for our hospital based cancer program. As Nurse Navigators, we found the tool to be very helpful in both evaluating and tracking the needs of our patients and for demonstrating the Navigators' downstream revenue."

EMILY BURTON AND PAM SASSER
ST. PETER'S HOSPITAL CANCER TREATMENT CENTER, HELENA, MONTANA



Created with support from Genentech.

GW Cancer Center. (n.d.) Patient Navigation Barriers and Outcomes Tool (PN-BOT). https://smhs.gwu.edu/gwci/BarriersTool

Resources: Cancer Survivorship Toolkits & Training

Created with support from the CDC (#5U55DP003054 and #NU58DP006461) and the Patient Centered Outcomes Research Institute (#EADI-12744).

Other Key Resources

Health Equity Services in the 2024 Physician Fee Schedule Final Rule

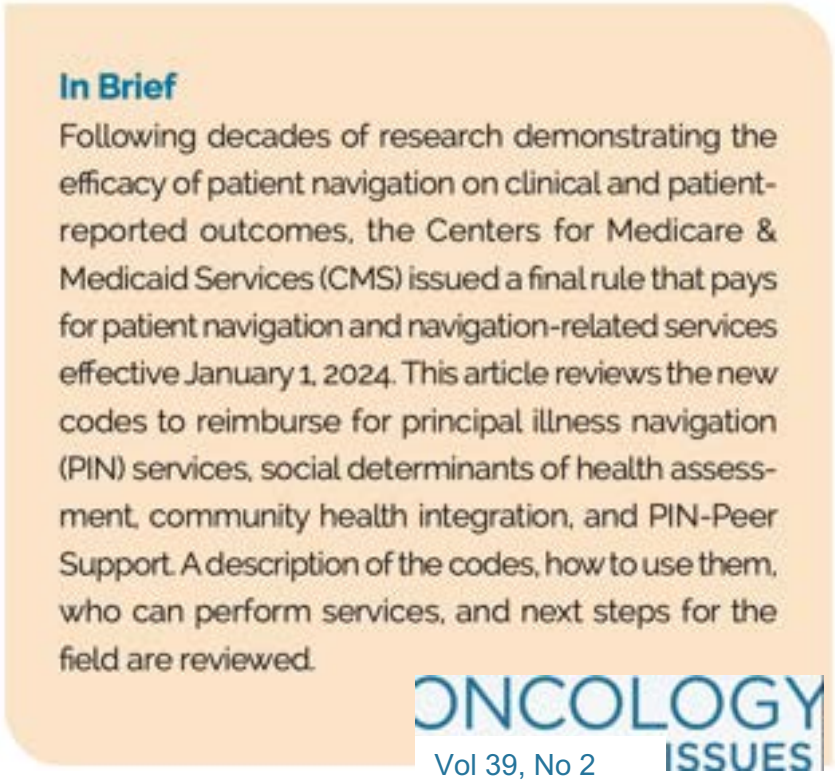
https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

Other Key Resources

- American Society of Clinical Oncology Care Management Services and Proposed SDOH Codes
- Academy of Oncology Nurse & Patient Navigators (AONN+) Navigation Metrics Toolkit
- C3 Project Community Health Worker: Core Competencies - Resource Guide
- Core Competencies for Oncology Patient Navigators. JONS
- Establishing Effective Patient Navigation Programs in Oncology. Supportive Care in Cancer
- Framework Delineating Roles Across Navigator Types. JONS
- National Consortium of Breast Centers (NCBC). (n.d.) Breast Navigator Certification Program
- Patient Navigation in Cancer: The Business Case to Support Clinical Needs. JCO Oncology Practice
- Professional Oncology Navigation Task Force Standards. JONS

Released this week

The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What?



CMS Payment for Principal Illness Navigation: How do I Credential My Navigators?

JONS JOURNAL OF ONCOLOGY NAVIGATION & SURVIVORSHIP
THE OFFICIAL JOURNAL OF THE ACADEMY OF ONCOLOGY NURSE & PATIENT NAVIGATORS

Released Feb 19, 2024: https://www.jons-online.com/issue-archive/online-first/5030-cms-payment-for-principal-illness-navigation-how-do-i-credential-my-navigators

Stay in touch!

Email: Mandi@gwu.edu

LinkedIn

https://www.linkedin.com/in/mandi-pratt-chapman-ba92976

Sign-up for the GW Cancer Center's Patient Navigation and Survivorship E-Newsletter

Sign-up for the GW Cancer Center's Cancer Control Technical Assistance E-Newsletter

Cancer Prevention Works

Funding Community Health Workers and Patient Navigators in Cancer Care: Understanding the New Medicare Billing Codes

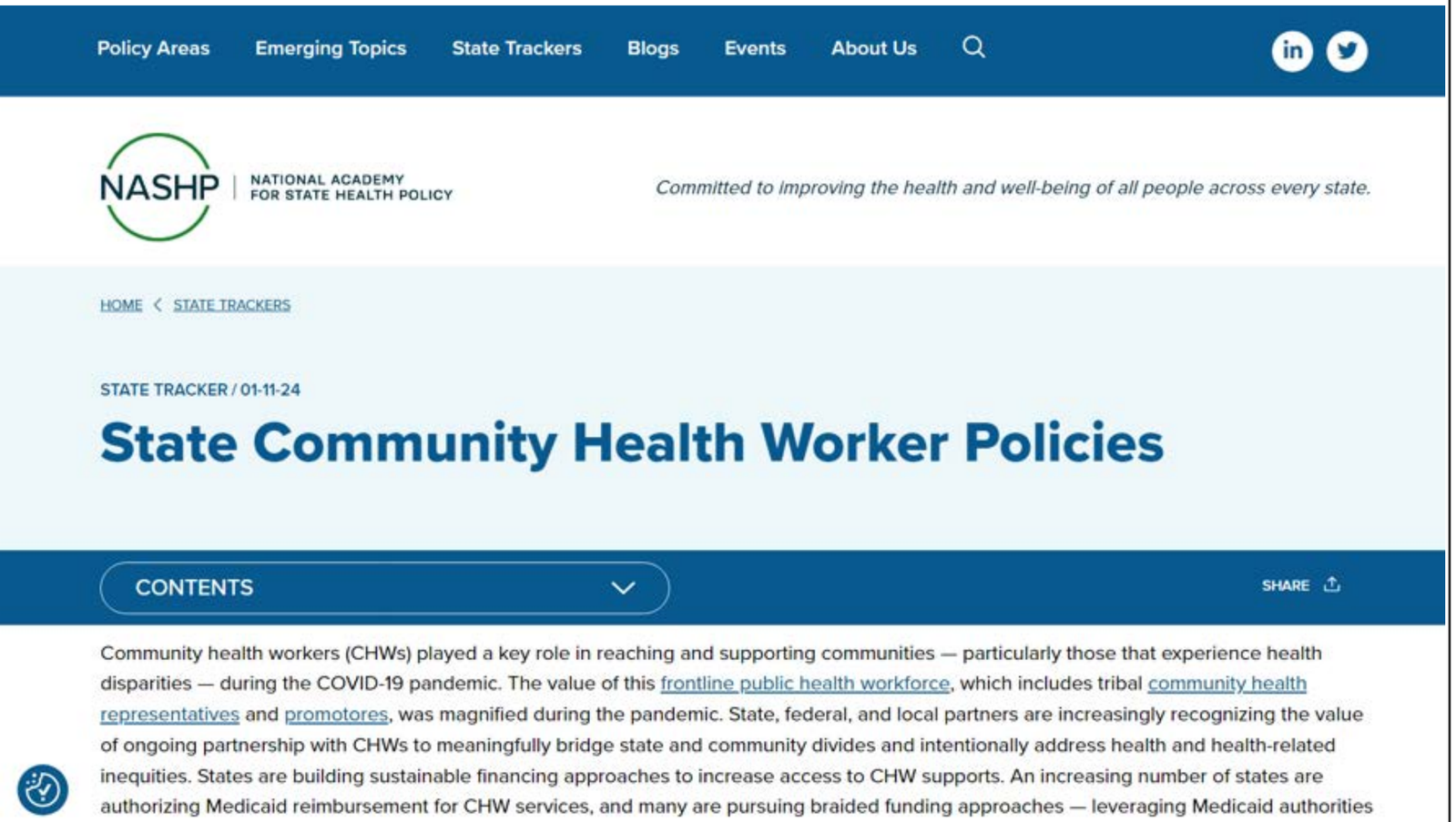
Elizabeth A. Rohan, PhD, MSW
Health Scientist

CHW, PN, CMS Rule Webinar, Part 3
February 20, 2024

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control

What's going on in two states? (and ideas for what you can do next)

- Don't panic!!!
- Because this law defers to **state/jurisdictional** policies:
  - Familiarize yourself with CHW training and certification requirements (if any) in your state/tribe or tribal organization/territory/U.S.-associated Pacific Island
  - Understand if PNs (who are not otherwise licensed) are covered under CHW requirements in your jurisdiction
  - Explore resources within your health department
- Take advantage of existing CHW and PN training resources
- Work with coalition to help educate providers
- Provide comments to CMS



[State Community Health Worker Policies – NASHP]

Supported with funding from the Robert Wood Johnson Foundation

State Overviews

Explore each state's policies and partnerships that support a sustainable CHW workforce. Use the dropdown below to see how each state is defining, training, certifying, and paying CHWs.

SELECT A STATE

Chart

The chart below offers more details on state CHW models, including state definitions, certification and training, Medicaid reimbursement, other funding mechanisms, key partnerships, and state legislation. Use the dropdown below to select the topic you're interested in.

Overview

▼Use the search box to filter information

Search

State	Medicaid SPA Authorizes Reimbursement for CHW Services	1115 Waiver Supports CHW Services	MCOs Encouraged or Required to Support CHW Services	CHW Certification Program	State CHW Association or Organization
Alabama	-	-	-	-	-
Alaska		-	-	-	-
Arizona	✓	-	-	✓	Arizona Community Health Workers Association
Arkansas	-	-	-	✓	Arkansas Community Health Worker Association
California	✓	-	✓	-	Community Health Workers, Promotoras, and Representatives (CHW/P/R) Coalition California Association of Community Health Workers
Colorado	-	-	-	✓	Alliance of Colorado CHWs, Patient Navigators and

State	Medicaid SPA Authorizes Reimbursement for CHW Services	1115 Waiver Supports CHW Services	MCOs Encouraged or Required to Support CHW Services	CHW Certification Program	State CHW Association or Organization
Alabama	-	-	-	-	-
Alaska		-	-	-	-
Arizona	✓	-	-	✓	Arizona Community Health Workers Association
Arkansas	-	-	-	✓	Arkansas Community Health Worker Association
California	✓	-	✓	-	Community Health Workers, Promotoras, and Representatives (CHW/P/R) Coalition California Association of Community Health Workers
Colorado	-	-	-	✓	Alliance of Colorado CHWs, Patient Navigators and Promotores de Salud
Connecticut	-	-	-	✓	Community Health Workers Association of Connecticut
Delaware	-	-	-	-	Community Health Worker Association of Delaware
District of Columbia	-	-	-	-	DC CHW Association
Florida	-	-	-	✓	Florida Community Health Worker Coalition
Georgia	-	✓	-	-	Georgia CHW Network
Hawaii	-	-	-	-	Hawai'i Community Health Worker Association
Idaho	-	-	-	-	Idaho Community Health Workers Association
Illinois	-	-	-	-	Illinois Community Health

COLORADO NAVIGATION/ CHW LANDSCAPE

PNCT
Patient Navigation & Community Health Worker Training

- PNCT is a leader in training and workforce development for health navigation for more than 15 years
- State-recognized Health Navigator credential
- Medicaid reimbursement for CHW services (including health navigation)
  - Full implementation coming in 2025
- Colorado training efforts funded by programs such as:
  - Colorectal Cancer Control Program (CRCCP)
  - National Comprehensive Cancer Control Program (NCCCP)
  - Health Resources and Services Administration (HRSA) - current funder

PNCT

Patient Navigation &
Community Health Worker Training

A skills-based program serving thousands of trainees in Colorado and nationally

COMPETENCY BASED

Curriculum meets state Medicaid and national Medicare training requirements for reimbursement

SKILLED INSTRUCTORS

Trainees learn from expert instructors in-person or virtually

Financial aid available for CO residents; fee-for-service if outside CO

RELEVANT

Program designed to be cross-cutting and applies to principal illness navigation, general care coordination, chronic disease prevention, cancer navigation and more

INCLUSIVE

Entire curriculum soon to be available in Spanish

Of trainees enrolled since Sept 2022, 78% identify as BIPOC

Find out more: patientnavigatortraining.org

Massachusetts CHW Landscape

Mass.gov

Search Mass.gov SEARCH

Professional Licenses & Permits > ... > Community Health Worker Certification > About the Board of Certification of Community Health Workers

OFFERED BY Bureau of Community Health and Prevention | Department of Public Health

Community Health Workers

Information for community health workers, CHW supervisors, CHW employers, and policy makers

Feedback

DPH conducts capacity-building initiatives to strengthen the CHW workforce, leads and participates in strategic partnerships, provides programmatic technical assistance to CHWs and their supervisors, and supports national networking and promotion of the CHW workforce.

CHWinfo@mass.gov

Board of Certification of Community Health Workers

We help integrate community health workers into the health care and public health systems. We work to promote health equity, cost containment, quality improvement, and management and prevention of chronic disease.

Who we serve

We work to establish:

- Standards for the education and training of community health workers and community health worker trainers,
- Standards for the education and training program curricula for community health workers
- Requirements for community health worker certification and renewal of certification

Work Experience Pathway

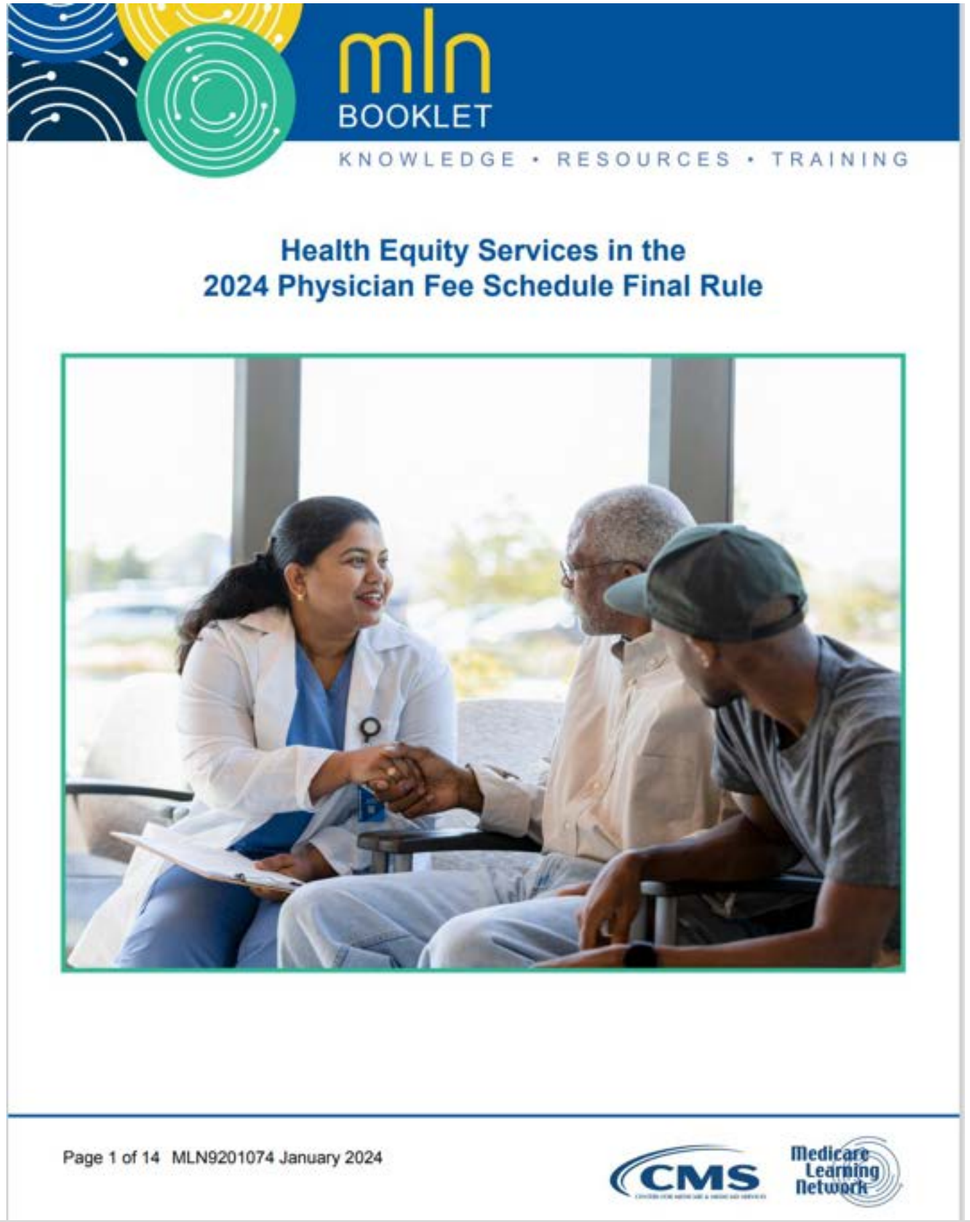
- Once you have completed the required 4,000 hours of work experience, you may apply for a Massachusetts CHW certification via the Work Experience pathway.

Combined Training & Work Experience Pathway

- Once you have completed the 2,000 hours of work experience and obtained certification from a Board Approved Training Program, you may apply for a Massachusetts CHW certification via the Combined Training & Work Experience Pathway.

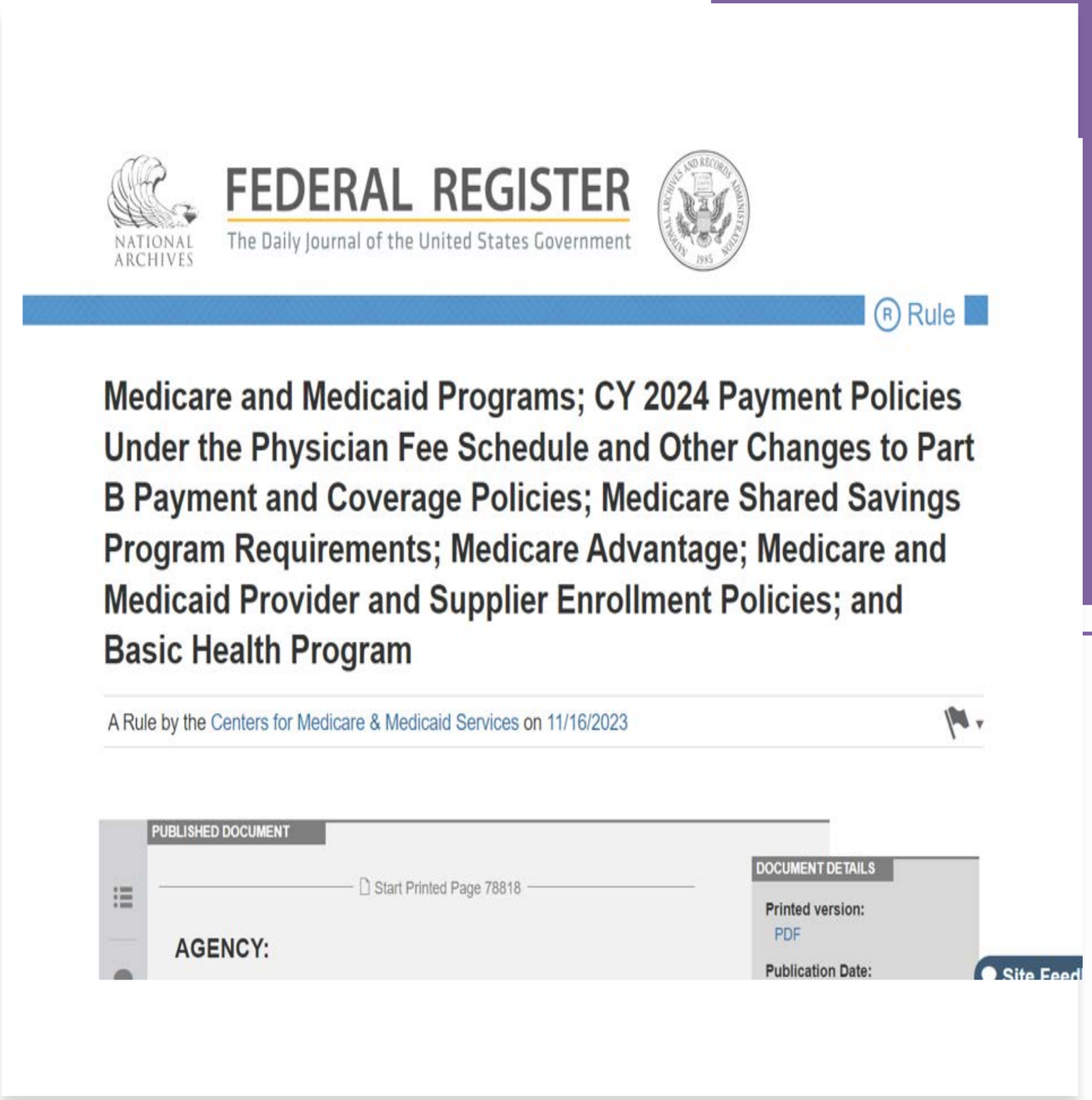
Medicare Learning Network Resource

[MLN9201074 - Health Equity Services in the 2024 Physician Fee Schedule Final Rule (cms.gov)]



Link to the CMS Rule

[Federal Register :: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program]



Thank you!

Go to the official federal source of cancer prevention information:

www.cdc.gov/cancer

Cancer Prevention Works

Division of Cancer Prevention and Control

Reliable. Trusted. Scientific.

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

INSTITUTE FOR
COMPREHENSIVE
CANCER CARE
SERVICES

The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What?

INSTITUTE FOR COMPREHENSIVE CANCER CARE SERVICES

By Mandi L. Pratt-Chapman, PhD, MA, OPN-CG; Gabriel Rocque, MD: Julie McMahon, MPH; Manali Patel, MD, MPH, MS, FASCO; Taneal Carter, MS, MPA; Nancy Pena, OPN-CG, MI, BS; Poorna Kushalnagar, PhD; Lexi Boyd, BSN, NR; Reesa J. Sherin, MSN, RN; Jessica Quiring, BS, CN-BA, OPN-CG, CDP; Zarek Mena, OPN-CG; Linda Burhansstipanov, MSPH, DrPH; Don S. Dizon, MD; Clara Lambert, CPH, BBA, OPN-CG; Samuel Cykert, MD; and Julie E. Bauman, MD, MPH

The Centers for Medicare & Medicaid Services Will Pay for Patient Navigation—Now What?

In Brief

Following decades of research demonstrating the efficacy of patient navigation on clinical and patient-reported outcomes, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that pays for patient navigation and navigation-related services effective January 1, 2024. This article reviews the new codes to reimburse for principal illness navigation (PIN) services, social determinants of health assessment, community health integration, and PIN-Peer Support. A description of the codes, how to use them, who can perform services, and next steps for the field are reviewed.

The evidence is overwhelming that patient navigation improves access to care and health outcomes for patients with cancer. Following decades of research demonstrating the efficacy of patient navigation on clinical and patient-reported outcomes,[1-4] on November 2, 2023, CMS issued a final rule announcing a change to Medicare payments effective January 1, 2024.[5] Published on November 16, 2023, the CY 2024 payment policies under the MPFS[5] allow for payment for PIN services provided by auxiliary health care staff working under a qualifying billing practitioner to help those affected by cancer and other serious illnesses under Medicare Part B.

Under the new rule, health care support staff, such as community health workers, patient navigators, and peer navigators, can now be reimbursed for their time supporting patients with "serious, high-risk disease"[5] that is expected to last at least 3 months and require ongoing monitoring of a treatment plan. Examples of qualifying conditions include but are not limited to cancer, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder.

What Are the New Billable Services?

CMS created new codes to reimburse for the support services needed to assist patients with health-related social barriers that interfere with treatment adherence for cancer and other serious illnesses. The rule includes several types of reimbursement under the supervision of a qualifying billing practitioner. These include:

- Social determinants of health (SDOH) risk assessment
- Community health integration (CHI) service coordination responsive to SDOH assessment
- PIN (principal illness navigation) services to help patients complete a treatment plan for a serious condition expected to last at least 3 months
- Principal illness navigation— Peer support (PIN-PS) that aligns with rigorous training, primarily for behavioral health support, such as peer-led mental health and substance use programs under the Substance Abuse and Mental Health Services Administration.[6,7]

Services that are necessary to help improve adherence to treatment plans that are typically provided by oncology patient navigators and community health workers are now reimbursable as PIN services. The rule provides a number of examples of qualifying activities, including provision and facilitation of: [5,8]

- Person-centered assessments, which involve assessing how SDOH might affect a person's health care adherence and outcomes
- Patient-driven goals of care
- Care planning
- Care coordination
- Communication, including in-system navigation and coordination of community-based care
- Health education
- Coaching and mentoring to support patient self-advocacy
- Collection of health outcomes data.

Who Can Provide Services?

CMS uses various codes for billing, including Current Procedural Terminology (CPT) codes for medical procedures and services and G-codes for functional limitation reporting. The new G-codes for PIN may be used by anyone performing these services, provided they are appropriately trained. However, CMS does not endorse any specific organization, certification process, or credential, deferring to state-based credentialing requirements where they exist.[5]

The rule defines patient navigation, "[i]n the context of healthcare" as "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…and includes identifying or referring to appropriate supportive services."[5, p. 361] While advance care planning, chronic care management, behavioral health, psychiatric care, transitional care, and home health and hospice supervision were already reimbursable services, the new codes effective January 1, 2024 are specifically for patient navigation services not previously covered.

These codes can be used by any staff performing eligible services (SDOH assessment, CHI, PIN, PIN-PS), including nurses or social workers, as well as oncology patient navigators who are based in clinic or in community settings, community health workers, and other auxiliary personnel.[5-8] The codes do not specify any particular role or profession. Recognizing that social needs have a major influence on access to and completion of cancer care, the new rule provides two new G-codes for CHI services that can be performed by appropriately trained personnel, including community health workers and navigators, to assess and address patient SDOH affecting a practitioner's ability to diagnose or treat a major illness. An initial CHI assessment by the billing practitioner (**G0023**) is required before follow-up CHI services by non-clinical, auxiliary staff can use code **G0024** as "incident to" billing under the practitioner who performed the initial assessment.[5]

How Do I Bill for Navigation Services?

To bill for PIN services, the person being navigated must have a health condition that the practitioner expects to require management for at least 3 months. PIN services can be performed by a patient navigator, community health worker, or other auxiliary staff member working on a health care team or under an agreement with a health care practice, if there is a supervising practitioner. Besides physicians, clinicians that qualify as supervising practitioners vary based on state scope of practice laws for advanced practice registered nurses (APRNs) and physician assistants (PAs).[9,10] In addition to PIN services, codes for CHI services, PIN-PS, and SDOH assessment are also new (Table 1).

Documentation for CHI, PIN, and SDOH risk assessment must include time spent providing services, documentation of patient consent (which can be verbal), description of services performed, and associated ICD-10, ICD-10 Z, and G-Codes.[5,11] The initiating visit can be an office visit or an annual wellness visit.[5]

Importantly, patient consent is required for CHI and PIN services as there is cost-sharing associated with all Medicare billing. Standard cost-sharing for Medicare is 20% after the deductible has been met. Medicare Advantage beneficiaries are responsible for coinsurance after the deductible has been met. Consent may be obtained by auxiliary personnel, including a navigator, nurse, or social worker. Only 1 practitioner a month may bill. If this provider changes, another consent must occur.[5]

CMS requires institutions to document credentialing first based on existing individual state requirements. CMS also requires documentation of sufficient knowledge for practice, which state requirements would not necessarily demonstrate.

It is important to note that these new codes do *not* replace codes for Chronic Care Management (**99437, 99439, 99490, 99491**), Complex Chronic Care Management (**99487, 99489**), and Principal Care Management (**99424-99427**).[5,11]

Nor do these codes replace health behavior assessment and intervention services that can be provided by clinical social workers and other trained mental health professionals (**96156, 96158, 96159. 96164, 96165, 06167, 96168**).

In addition to the new CHI, PIN, PIN-PS, and SDOH codes, the 2024 MPFS rule also includes codes for group behavior training (**96202, 96203**), caregiver training to facilitate in-home and community-based supports (**97550, 97551**), and group caregiver training (**975552**).[5] In addition, while **G0511** previously could be used for general care management from Federally Qualified Health Centers, starting January 1, 2024, remote patient monitoring (RPM) is also acceptable.[12]

Finally, the 2024 MPFS rule delayed any permanent decision about virtual supervision (telehealth) established under the Consolidated Appropriations Act of 2023, extending approval for telehealth services through December 31, 2024.[13]

How Much is Reimbursement?

CY 2024 rates for select codes are included in Table 1. The American Society of Clinical Oncology (ASCO) also publishes a reimbursement breakdown by for various services.[12] Given that these rates will change each calendar year, we refer

readers to the ASCO annual updates for guidance on future reimbursement rates.[11]

Navigator Credentialing

Credentialing can be confusing. Regardless of the auxiliary health personnel title or professional role, CMS requires institutions to document credentialing first based on existing individual state requirements.[14,15]

For example, New Mexico has existing state requirements for community health worker training and practice with oversight from the New Mexico Department of Health, Office of Community Health Workers.[16,17] Community health worker certification costs about $100 and requires either: 1) completion of a specific training provided by the New Mexico Department of Health or from an approved Department of Health training partner along with field experience,

TABLE 1. PATIENT NAVIGATION-RELATED G-CODES AND 2024 MEDICARE RATES FOR SELECT SERVICES

Code	How to Use	2024 Rate[12]	Minimum Time to Bill	Training Required
G0136	Risk Assessment based on a practitioner's reason to believe there are unmet SDOH needs, not intended for routine screening for patients at every visit or for every patient. Typically not administered in advance of the visit. If conducted during an annual wellness visit, cost-sharing does not apply. If conducted at a visit for any other reason, cost-sharing applies. CMS does not require a particular tool, but cites the CMS Accountable HealthCommunities Tool and Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) as appropriate tools. This code is permanently added to telehealth visits, as well.	$18.67	5-15 minutes not more than every 6 months per practitioner per beneficiary	State-based requirements OR documentation of key competency domains
G0019	Community Health Integration (CHI) initiating visit with assessment by a clinical health worker under the direction of a billing practitioner to document and address SDOH needs that significantly interfere with a patient's ability to complete diagnosis or treatment of the chronic health condition. Examples of CHI services include person-centered care planning, health system navigation, referral and coordination to community-based resources, care coordination, and patient self-advocacy promotion.	$78.92	60 minutes (once/month)	State-based requirements OR documentation of key competency domains
G0022	CHI services to address SDOH needs that are significantly interfering with a patient's ability to complete diagnosis or treatment of the chronic health condition after an initial assessment under supervision of a billing practitioner.	$49.45	Additional 30-minute increments (unlimited)	State-based requirements OR documentation of key competency domains
G0023	Initial person-centered assessment for PIN services: should assess SDOH, facilitate patient-driven goal setting, and establish an action plan for tailored support. Support can include coordination of community-based services and care transitions, health education, patient self-advocacy skill coaching, active navigation of the health care system, facilitating behavior change, providing social and emotional support, mentorship, and inspiration to help patients meet treatment goals.	$78.92	First 60 minutes per calendar month (once/month)	State-based requirements OR documentation of key competency domains
G0024	PIN services after the initial assessment is billed using G0023. Note that "incident to" billing can used for services provided by navigators working within the cancer care setting, but also for navigation conducted external to the cancer care setting with appropriate agreements with trained staff at community-based organizations. Clear integration of community-based services with the supervising practitioner are required for billing.	$49.45	Additional 30-minute increments per calendar month (unlimited)	State-based requirements OR documentation of key competency domains
G0140	PIN services by peers—intended for mental and substance abuse support based on training from SAMHSA.	$78.92	First 60 minutes per calendar month (once/month)	SAMHSA standards[6]
G0146	PIN services by peers - intended for mental and substance abuse support based on training from SAMHSA.	$49.45	Additional 30-minute increments per calendar month (unlimited)	SAMHSA standards[6]

or 2) 2,000 hours of experience in the last 2 years plus 2 letters of reference. Although CMS does not require field experience, the State of New Mexico Community Health Worker Certification does require field experience within the structure of approved training programs. University and community college-based approved trainings have required practicums or clinical agency components.[16,17]

It is unclear if navigators seeking to be newly credentialed in New Mexico would need field hours in addition to training if that training is obtained outside of the approved list of New Mexico Department of Health, Office of Community Health Workers programs. Certification regulations for community health workers imply that navigators seeking to be credentialed in New Mexico must look to satisfy the state's requirement and have some field-based experience.[17-18] While a patient navigator completing the community health worker certification in New Mexico would be satisfying the minimum requirement credentialing, CMS also requires documentation of sufficient knowledge for practice, which state requirements would not necessarily demonstrate.[18,19]

Effective, consistent navigation services elevate the reputation of a cancer program or practice and can potentially save institutions money. Navigation is optimal when its delivery is cost-effective, time-efficient, and compassionate.

In another example from the state of California, Medi-Cal covers community health worker services to help control and prevent chronic, infectious, mental health, perinatal, sexual, reproductive, and other conditions with a written recommendation from a supervising practitioner.[20] California requires community health workers to share lived experience with the population being served and complete an approved curriculum that comes with a certificate of completion. Community health workers may practice for a maximum of 18 months under a supervising practitioner without a certificate of training if the community health worker can demonstrate appropriate skills and document 2,000 hours of work, including paid or volunteer roles, within the previous 3 years. All community health workers must complete 6 hours of continued education training annually.[20] Unlike many other states, California also specifies that "health navigators, health coaches, community outreach workers, recovery specialists, and family support workers" fall under the same credentialing requirements as community health workers.[21]

In states that do not specifically include "navigators" within the definition of community health workers for payment credentialing, it is currently unclear whether navigators with a more focused scope of practice are required to fulfill state-specific community health worker requirements.[22] We do, however, know that obtaining community health worker credentialing based on state requirements and documenting training in appropriate competencies for the oncology navigator role should be sufficient. Specific competencies that must be met include: "patient and family communication, interpersonal and relationship-building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit."[5, p. 389] Cancer programs and practices can comply with the rule by documenting that navigators have successfully completed training that meets these competencies (Table 2).

The GW Oncology Patient Navigation Training: The Fundamentals (Principal Investigator: Pratt-Chapman) was created and maintained with support from the Centers for Disease Control and Prevention (cooperative agreements #NU38DP004972, #5NU58DP006461, and #NU58DP007539) and has been available since 2015 at bit.ly/PNTraining. Other excellent state-based or national trainings—with or without a fee—also meet CMS training requirements.[21] Additionally, Gallaudet University Center for Deaf Health Equity has a patient navigation curriculum for speakers of American Sign Language adapted from the GW Cancer Center Oncology Patient Navigator Training: The Fundamentals. This curriculum is currently in use for a clinical trial but is not yet publicly accessible.

Training to Provide Affirming Care to Priority Populations

CMS acknowledges that navigation is most effective when focused on populations that have the greatest need for support. In addition to navigation basics, CMS requires that navigators have content specific knowledge relevant to the type of navigation services they will perform. In the ACCURE Trial,[23] for example, navigators also had critical racial health equity training. Myriad of health equity resources are available, including from the CDC's funded National Networks.[24] In addition to having a strong foundation of cancer patient navigation knowledge, deeply understanding the community being served is critical to effectively navigating patients and families. See Table 3 for training resources on priority populations.

Training is not the only way to demonstrate appropriate expertise for a navigator's knowledge for practice. In 2008, the National Consortium of Breast Centers began providing certification for certain types of breast cancer navigation. In 2020, AONN+ inaugurated the Oncology Patient Navigator - Certified Generalist credential (OPN-CG). Both credentials are helpful to document appropriate knowledge for practice in serving a specific patient population. Supplemental knowledge resources specific to cancer basics are offered from the National Cancer Institute (cancer.gov), the American Society of Clinical Oncology (cancer.net), and the American Cancer Society (cancer.org). For licensed clinical professionals, the authors anticipate that social work licensure and nurse licensure should be sufficient documentation of training given the heightened rigor of these credentials. We will collectively benefit from lessons learned and shared across navigating roles as institutions begin to pilot and roll out billing for PIN services.

Beyond Training: Navigator Professional Development, Program Implementation, and Evaluation

Training is the start, not the end of strong navigation. Expertise in navigation requires ongoing personal and professional development from navigators eager to learn and seek out reliable information such as core competencies for community health workers[25] and oncology patient navigators,[18] as well as the Oncology Navigation Standards of Professional Practice.[19] Navigators should understand the complexities of the health sequelae and social conditions faced by their patients. Effective navigators have strong relationship and

TABLE 2. TRAININGS OR CREDENTIALS THAT MEET CMS REQUIREMENTS FOR REIMBURSEMENT OF SERVICES

Training	Scope	Costs	How to Access	Considerations
Academy of Oncology Nurse and Patient Navigators (AONN+) – OPN-CG certification	National certification that requires successful completion of an examination and a number of years of experience.	$150	Online at aonnffl.org/renew	Currently on hold, but still valid to document appropriate training if you have the credential. Requires renewal after 3 years.
American Cancer Society Leadership in Oncology Navigation (LION)	National training and certification.	$495	Online at cancer.org/health-care-professionals/resources-for-professionals/patient-navigator-training.html	Cost associated. Requires renewal every 3 years. Approximately 10 hours.
GW Cancer Center Oncology Patient Navigator Training: The Fundamentals	National training for those supporting patients of all cancer types. Certificate provided. Prepares learners for AONN+ OPN-CG certification.	Free	Online at bit.ly/PNTraining	Funded by the Centers for Disease Control and Prevention, this training aims to level set navigator knowledge. Institutions should provide supplemental context-specific and cancer-specific training tailored to the specific duties of the navigator following this foundational training. 10 hours of core requirements plus supplemental reading (estimated 17 hours total).
Patient Navigation & Community Health Worker Training	A full curriculum for patient navigators, care coordinators, and community health workers.	Varies	Sign up at Patientnavigatortraining.org (course is hybrid: in-person and online)	Requests for financial aid considered on a case-by-case basis. May not cover all required competencies for CMS billing with Level 1 training only. Hours vary based on level and degree of tailoring.
Susan G. Komen Patient Navigation Training Program	National training for those affected by all cancers with additional breast cancer focused content.	Free	Online at komen.org/about-komen/our-impact/breast-cancer/navigation-nation-training-program/	Originally adapted from GW Cancer Center Oncology Patient Navigator Training: The Fundamentals with additional unique content developed by Komen. Features virtual ongoing educational events and peer networking. 10 hours of core requirements plus special topics.

TABLE 3. TRAINING FOR SPECIFIC PATIENT POPULATIONS

Focused Content	Resources	Type of Resource	Scope	Additional Information
State-based requirements	ASTHO overview of state requirements	Online brief	Reviews state requirements for community health worker credentialing as of June 2022.	Accessible at https://www.astho.org/topic/brief/state-approaches-to-community-health-worker-certification
Breast cancer patients	National Consortium of Breast Centers	Certification	Credential to affirm core knowledge for breast cancer for navigation.	Cost associated. More information: https://www.navigatorcertifications.org
	Susan G. Komen	Online training	Training aligned with CMS requirements plus additional breast-cancer specific lessons.	Free, self-paced, online. Access at https://www.komen.org/about-komen/our-impact/breast-cancer/navigation-nation-training-program
Black, Latino, LGBTQI persons	GW Cancer Center Together-Equitable-Accessible-Meaningful (TEAM) Training	Online training	Training that aims to assist healthcare teams in identifying and implementing changes to advance health equity in black, Latino/a/x, and LGBTQI populations.	Free, self-paced, online. Access at bit.ly/GWCCTEAMtraining
Deaf, Deaf-Blind, Hard of Hearing persons that use American Sign Language	Center for Deaf Health Equity, Gallaudet University	Online training	Training specifically focused on health disparities of people who are deaf and hard of hearing.	In development, will be made available for continuing education.
Elderly persons from 13 diverse ethnic backgrounds	Stanford Internet-Based Successful Aging (iSAGE)	Online training	Training to improve quality of life and care for older persons of diverse backgrounds.	Free, but limited capacity. Includes community of practice with secure interaction forum and dialogue. Access at https://geriatrics.stanford.edu/about.html
LGBTQI persons	National LGBT Cancer Network Welcoming Spaces Training	Online training	Training to elevate cultural humility to serve LGBTQI populations.	Free, self-paced, online. Access at https://cancer-network.org/welcoming-spaces
Native American and Alaska Native persons	Native American Cancer Research Corporation	Virtual and in-person training	Addresses cultural and political issues that impact navigation across the cancer continuum for Indigenous populations.	Cost associated. Modules are competency-based and include personal skills assessment. Ranges from 80-200 hours based on number of modules and tailoring. Access at https://natamcancer.org/Patient-Navigator-Training

team-building skills; assess community resources to ensure responsiveness and credibility of services; and are consistent in their delivery of navigation services to build trust with patients, caregivers, and clinicians. Effective, consistent navigation services elevate the reputation of a cancer program or practice and can potentially save institutions money. Navigation is optimal when its delivery is cost-effective, time-efficient, and compassionate. Professional development, continuing education, and mentorship are critical to supporting the health and growth of the patient navigation workforce. Finally, the scope of navigator practice should be appropriate to licensure, training, and experience.[25-27]

Successful navigation programs require strategic integration of key stakeholders and information technology (IT) support. Focused implementation of risk-stratified patient navigation responsive to specific patient populations and care contexts, as well as IT support to chart, track, and evaluate navigation, are key for optimal program impact.[28-32] Successful pre-implementation planning includes these 4 key steps:

- Convening IT and administrative leaders to build new G-Codes into the electronic health record (EHR)
- Tracking navigation activities either within or outside of the EHR
- Optimizing patient demographic data to stratify outcomes
- Piloting the billing of new codes prior to full implementation.

Early engagement of key stakeholders will improve the incorporation of patient navigation data, streamlining workflows and enhancing reporting capabilities. Recommended key stakeholders to engage include billing specialists, the compliance team, data analysts, and informatics specialists. A practical guide published by the Association of Community Cancer Centers (ACCC) that was cited by CMS in the 2024 MPFS rule provides guidance on refining the focus of a navigation program as well as models and workflows.[30]

A critical part of patient navigation implementation is outcomes tracking. The ACCURE Trial, which eliminated health outcome disparities between White and Black patients with breast and lung cancer, matched their navigation intervention with rapid data reporting through clinical quality dashboards that allowed practitioners to see disparities in real time.[24] The GW Patient Navigation Barriers and Outcomes Tool (PN-BOT) is a free resource for case management and data tracking.[27] While this tool is limited to 1 user and is not integrated into EHRs, the software can be adapted to customize an EHR, and EHR vendors may have examples of templates that have worked to document navigation in various settings. Investments in commercial software and/or tailored EHR fields that support case management and data tracking may help navigators be most efficient and accurate with documentation critical for billing.

Next Steps for the Field

First, future research should include analyses of which states include navigators under the community health worker terminology for purposes of payment credentialing as well as the degree to which state-level requirements for community health worker credentialing fit with oncology patient navigators' scope of practice. Studies on implementing the payment codes, including barriers, facilitators, and lessons learned will also be valuable.

Second, the workforce of community health workers and navigators cannot be sustained without skills-based pay that reflects the experience, knowledge, and expertise of those performing navigation services. Additionally, skills-based pay is essential to avoid the common paradox of an inequitably paid community health worker or health navigator that struggles to pay for basic life expenses while helping patients access much-needed resources. It also should be emphasized that the degree to which current reimbursement rates are sufficient to cover the salary and programmatic costs of providing community health worker and patient navigation services is yet to be determined. More research is needed to optimize appropriate reimbursement rates for patient support that optimally advances health equity based on patient need, navigator training and experience, and costs of providing services.

Third, while these new codes are an important step forward for navigation sustainability, cost-sharing is a real and serious limitation for patients. Based on current CMS policy, patients will need to consent to PIN services, since there will be a 20% cost-share. There is a real risk that those individuals most in need of services could decline assistance due to inability to pay. Additionally, cost-sharing will likely come as a surprise to patients who previously received navigation services free of charge. The field will benefit from research describing reasons for and extent of patient non-consent for services and the amounts patients pay due to cost sharing. Advocacy to close the cost-share gap as well as proactive philanthropy to cover costs for needy patients should be pursued and lessons learned shared with the field.

Fourth, feasibility of effective caseload management that supports the health of patients and the navigation workforce should be further studied to ensure appropriate expectations.[33-36] Appropriate caseload management can be achieved using an acuity based-case weight system.[32] This system provides for equitable distribution of community health worker and patient navigator caseloads considering the navigator's time allocation based on individual patient needs, severity of illness, and social determinants. Smaller caseloads are needed for more complex navigation—such as support for patients who have been historically excluded, marginalized, stigmatized, and/or traumatized. These individuals are more likely to have significant and numerous barriers to care, necessitating more time and resources from the auxiliary health professional to find culturally, economically, legally, and socially-affirming supports.

Fifth, ongoing training, support, mentorship, and counseling for navigation roles on the front line of care should be prioritized, and best practices to accommodate navigators with disabilities should be shared and implemented. As the navigation workforce continues to professionalize, ongoing training and education should support deepening the proficiency of navigators beyond the baseline required by CMS.[27] Institutions should also seek to model supports that allow navigators to actualize their own optimal health while assisting those in need.

Finally, while payment for patient navigation is a thoughtful and laudable start to support much needed health related social needs support to people affected by cancer and other serious illnesses, future research on barriers and facilitators to implementation of the new G-codes for SDOH, CHI, PIN, and PIN-PS will be needed to share lessons learned for cancer programs and practices in the years to come. ■

Mandi L. Pratt-Chapman, PhD, MA, OPN-CG, is associate center director for Community Outreach, Engagement and Equity; associate professor of Medicine; and associate professor of Prevention and Community Health, The George Washington University Cancer Center, Washington, DC. Gabriel Rocque, MD, is assistant professor of Medicine in the Divisions of Hematology & Oncology and Gerontology, Geriatrics, & Palliative Care at the University of Alabama at Birmingham. Julie McMahon, MPH, is director, Patient Navigation, at Susan G. Komen, Washington, DC. Manali Patel, MD, MPH, MS, FASCO, is associate professor of medicine at Stanford University and staff thoracic oncologist at the Veterans Affairs Palo Alto Health Care System in California. Taneal Carter, MS, MPA, is project manager, Cancer Care Equity National Comprehensive Cancer Network, Plymouth Meeting, Pennsylvania. Nancy Pena, OPN-CG, MI, BS, is lead patient navigator at Dana-Farber/Brigham and Women's Cancer Center and director and founder of Navegación de Pacientes Internacional, Inc., Boston, Massachusetts. Poorna Kushalnagar, PhD, is strategic research officer/chief research officer, Center for Deaf Health Equity, Gallaudet University, Washington, DC. Lexi Boyd, BSN, NR, is on staff at The George Washington University Cancer Center, Washington, DC. Reesa J. Sherin, MSN, RN, is director, Clinical Strategy at the Association of Community Cancer Centers. Jessica Quiring, BS, CN-BA, OPN-CG, CDP, is a patient navigation advisor and independent certified oncology navigator, Albuquerque, New Mexico. Zarek Mena, OPN-CG, is a patient navigation advisor and independent certified oncology navigator, Norwalk, Connecticut. Linda Burhansstipanov, MSPH, DrPH, is founder of Native American Cancer Initiatives, Inc., Pine, Colorado. Don S. Dizon, MD, is director, Pelvic Malignancies Program, Lifespan Cancer Institute and professor of Medicine and professor of Surgery at Legorreta Cancer Center at Brown University, Providence, Rhode Island. Clara Lambert, CPH, BBA, OPN-CG, is director of Financial Navigation, TailorMed, New York, New York. Samuel Cykert, MD, is professor of Medicine and co-chair of the UNC-Lineberger Cancer Center, University of North Carolina,Chapel Hill, North Carolina. Julie E. Bauman, MD, MPH, is director of the GW Cancer Center, Washington, DC.

References

1. Chan RJ, Milch VE, Crawford-Williams F, et al. Patient navigation across the cancer care continuum: an overview of systematic reviews and emerging literature. CA Cancer J Clin. 2023;73(6):565–589. doi:10.3322/caac.21788

2. Rocque GB, Pisu M, Jackson BE, et al. Patient Care Connect Group. Resource use and Medicare costs during lay navigation for geriatric patients with cancer. JAMA Oncol. 2017 Jun 1;3(6):817-825. doi:10.1001/jamaoncol.2016.6307

3. Patel MI, Kapphahn K, Wood E, et al. Effect of a community health worker-led intervention among low-income and minoritized patients with cancer: a randomized clinical trial. J Clin Oncol. 2024;42(5):518-528. doi:10.1200/JCO.23.00309

4. Kline RM, Rocque GB, Rohan EA, et al. Patient navigation in cancer: the business case to support clinical needs. J Oncol Pract. 2019;15(11):585-591. doi:10.1200/JOP.19.00230

5. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare and Medicaid programs: calendar year 2024 payment policies under the physician fee schedule and other changes to part B payment and coverage policies; Medicare shared savings program requirements; Medicare advantage; Medicare and Medicaid provider and supplier enrollment policies; and basic health program. Federal Register. November 16, 2023. Accessed February 13, 2024. https://www.federalregister.gov/public-inspection/2023-24184/medicare-andmedicaid-programs-calendar-year-2024-paymentpolicies-under-the-physician-fee-schedule

6. Substance Abuse and Mental Health Services Administration. SAMHSA's National Model Standards for Peer Support Certification. Updated April 24, 2023. Accessed February 13, 2024. samhsa.gov/about-us/who-we-are/offices-centers/or/model-standards

7. Peer Recovery Center of Excellence. Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States. Accessed February 13, 2024. peerrecoverynow.org/wp-content/uploads/Comparative-Analysis_Jan.31.2022-003.pdf

8. Pratt-Chapman ML. What does a patient navigator do? Patient navigation core competencies, training, and certification. Oncol Issues 2016;31(1):54-60. https://www.accc-cancer.org/docs/documents/oncology-issues/articles/2003-2016/2016/jf16/jf16-what-does-a-patient-navigator-do.pdf?sfvrsn=1d5651e3_11

9. Wiesen K. Nurse practitioner scope of practice by State - 2024. NursingProcess.Org. Accessed February 13, 2024. nursingprocess.org/nurse-practitioner-scope-of-practice-by-state.html

10. NCSL Scope of Practice Policy. Practitioner: physician assistants. Accessed February 13, 2024. https://scopeofpracticepolicy.org/practitioners/physician-assistants/

11. American Society of Clinical Oncology. (2023). Care management services and proposed social determinants of health codes: a comparison. Published November 2023. Accessed February 13, 2024. https://old-prod.asco.org/sites/new-www.asco.org/files/content-files/practice-patients/documents/Care-Management-SDOH-CHI-PIN-Comparison.pdf

12. CMS. Calendar year (CY) 2024 Medicare physician fee schedule final rule. Published November 2, 2023. Accessed February 13, 2024. https://www.cms.gov/newsroom/press-releases/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

13. American Medical Association. CY 2024 Medicare physician payment schedule and quality payment program (QPP) final rule summary. Accessed February 13, 2024. https://www.ama-assn.org/system/files/ama-summary-2024-mfs-proposed-rule.pdf

14. Association of State and Territorial Health Officials (ASTHO). State approaches to community health worker certification. Published June 14, 2022. Accessed February 13, 2024. https://www.astho.org/topic/brief/state-approaches-to-community-health-worker-certification

15. ASTHO. Financing community health workers through Medicaid. Published March 23, 2021. Accessed February 13, 2024. https://www.astho.org/communications/blog/financing-community-health-workers-through-medicaid

16. New Mexico Community Health Workers Act. New Mexico Code R. § 7.29.5.10. (2015, January 30). https://www.nmlegis.gov/sessions/14%20Regular/final/SB0058.pdf

17. New Mexico Department of Health. Community Health Workers: Trainings. https://www.nmhealth.org/about/phd/pchb/ochw/train/

18. Pratt-Chapman ML, Willis A, Masselink L. Core competencies for oncology patient navigators. J Oncol Nav Surviv. 2015;6(2):16-21. https://www.jons-online.com/issues/2015/april-2015-vol-6-no-2/1320-core-competencies-for-oncology-patient-navigators

19. Franklin E, Burke S, Dean M, Johnston D, Nevidjon B, Simms Booth L. (2022). Oncology Standards of Professional Practice. J Oncol Nav & Surviv. 2022;13(3). https://www.jons-online.com/issues/2022/march-2022-vol-13-no-3/4399-oncology-navigation-standards-of-professional-practice

20. Medi-Cal. Medi-Cal coverage of community health worker (CHW) services is effective July 1, 2022. Updated August 19, 2022. Accessed February 13, 2024. https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/31781_01

21. California Health Care Foundation. Background on CHW/Ps in California. Published October 2021. Accessed February 13, 2024. https://www.chcf.org/resource-center/advancing-californias-community-health-worker-promotor-workforce-medi-cal/introduction/background-on-chw-ps-in-california/

22. Pratt-Chapman ML, McMahon J, Pena N, et al. CMS payment for principal illness navigation: how do I credential my navigator. J Oncol Nav & Surviv. (In press.)

23. Cykert S, Gentry E, Manning M, et al. Reducing racial disparities in cancer care using the ACCURE trial as a model learning guide. J Oncol Nav & Surviv. Published January 18, 2022. Accessed February 13, 2024. https://jons-online.com/special-issues-and-supplements/2022/reducing-racial-disparities-in-cancer-care-using-the-accure-trial-as-a-model-learning-guide

24. Centers for Disease Control and Prevention. Networking2Save: CDC's national network approach to preventing and controlling tobacco-related cancers in special populations. Accessed February 13, 2024. https://www.cdc.gov/tobacco/stateandcommunity/tobacco-control/coop-agreement/index.html

25. CHW Training. Community health Worker: Core Competencies - Resource Guide. Accessed February 13, 2024. https://chwtraining.org/core-competencies-to-start-your-chw-program

26. Willis A, Reed E, Pratt-Chapman ML, et al. (2013). Development of a framework for patient navigation: delineating roles across navigator types. J Oncol Nav & Surviv. 4(6):20-26. Accessed February 13, 2024. https://www.jons-online.com/issues/2013/december-2013-vol-4-no-6/1249-development-of-a-framework-for-patient-navigation-delineating-roles-across-navigator-types

27. Varanasi AP, Burhansstipanov L, Dorn C, et al. Patient navigation job roles by levels of experience: workforce development task group, National Navigation Roundtable. Cancer. 2024 Feb 2. doi:10.1002/cncr.35147

28. GW Cancer Center. Published September 28, 2021. Accessed February 13, 2024. Patient navigation barriers and outcomes tool (PN-BOT). https://cancercontroltap.smhs.gwu.edu/news/patient-navigation-barriers-and-outcomes-tool-pn-bot

29. Astorino J, Pratt-Chapman ML, Schubel L, et al. Contextual factors relevant to implementing social risk factor screening and referrals in cancer survivorship: a qualitative study. Preventing Chronic Disease: Public Health Research, Practice and Policy. (In press.)

30. Association of Community Cancer Centers. Published in 2009. Accessed February 13, 2024. Cancer care patient navigation: a practical guide for community cancer centers. https://www.accc-cancer.org/docs/projects/pdf/patient-navigation-guide.pdf

31. GW Cancer Center. November 29, 2021. Advancing the field of cancer patient navigation: a toolkit for comprehensive cancer control professionals. Published November 29, 2021. Accessed February 13, 2024. https://cancercontroltap.org/news/advancing-field-cancer-patient-navigation

32. Pratt-Chapman ML. President's Cancer Panel: Reducing Cancer Care Inequities: Leveraging Technology to Enhance Patient Navigation. Meeting 3: Policy Considerations at the Intersection of Technology and Patient Navigation. December 7, 2023. Accessed February 13, 2024. https://prescancerpanel.cancer.gov/reports/2023/inequities

33. Ferrant A. (2004). An acuity-based case weight system for equitable clinician case loads. Home Healthc Nurse. 2004;22(12):815-819. https://pubmed.ncbi.nlm.nih.gov/15597001

34. Lopez D, Pratt-Chapman ML, Rohan E, et al. Establishing patient navigation programs in oncology. Supportive Care in Cancer. 2019;43:1985-1996. https://doi.org/10.1007/s00520-019-04739-8

35. Pratt-Chapman ML, Silber R, Tang J, Le PD. Implementation factors for patient navigation program success and sustainability: a qualitative study. Implement Sci Commun. 2021;141. https://doi.org/10.1186/s43058-021-00248-0

36. Johnson D, Strusowski T. Defining the complexity of patients through an acuity tool: a scoping review. J Oncol Nav & Surviv. 2022;13(4). https://www.jons-online.com/issues/2022/april-2022-vol-13-no-4/4495-defining-the-complexity-of-patients-through-an-acuity-tool-a-scoping-review

Acknowledgements

This editorial benefited from work presented by Doug Jacobs, MD and Katie Garfield, JD as well as guidance published by the American Medical Association and the American Society of Clinical Oncology cited in the references.

Additional Resources

GW School of Medicine & Health Sciences. 2021 Updates to the Oncology Patient Navigator Training.

GW School of Medicine & Health Sciences. Financial Navigation Lesson for Oncology Patient Navigators.

GW School of Medicine & Health Sciences. Patient Navigation Guide (English and Spanish) and Companion Resources.

GW School of Medicine & Health Sciences. Reducing Financial Toxicity: Tips for Patient Navigators.

GW School of Medicine & Health Sciences. Advancing the Field of Cancer Patient Navigation: A Toolkit for Comprehensive Cancer Control Professionals.

GW School of Medicine & Health Sciences. Patient Navigation Barriers and Outcomes Tool (PN-BOT).

GW School of Medicine & Health Sciences. Implementing the Commission on Cancer Standard 8.1 Addressing Barriers to Care.

Native American Cancer Initiatives. NACI Care™.: A Patient Navigation Data Entry, Tracking, and Evaluation Tool.

National Comprehensive Cancer Network. NCCN Guidelines Version 1.2024 Distress Management. NCCN Distress Thermometer.

National Comprehensive Cancer Network. Evidence-based Resources for Patients and Navigators.

National Comprehensive Cancer Network. Measuring and Addressing Health Related Social Needs in Cancer: Working Group Recommendations.

In partnership with:

SGO | OCRA ovarian cancer research alliance

This project is made possible by support from:

AstraZeneca | GSK

ACCC
ASSOCIATION OF CANCER CARE CENTERS™

The Association Of Cancer Care Centers (ACCC) is the leading education and advocacy organization for the cancer care community. For more information, visit accc-cancer.org.


ACCC
ASSOCIATION OF CANCER CARE CENTERS™
50 Years
STRONG