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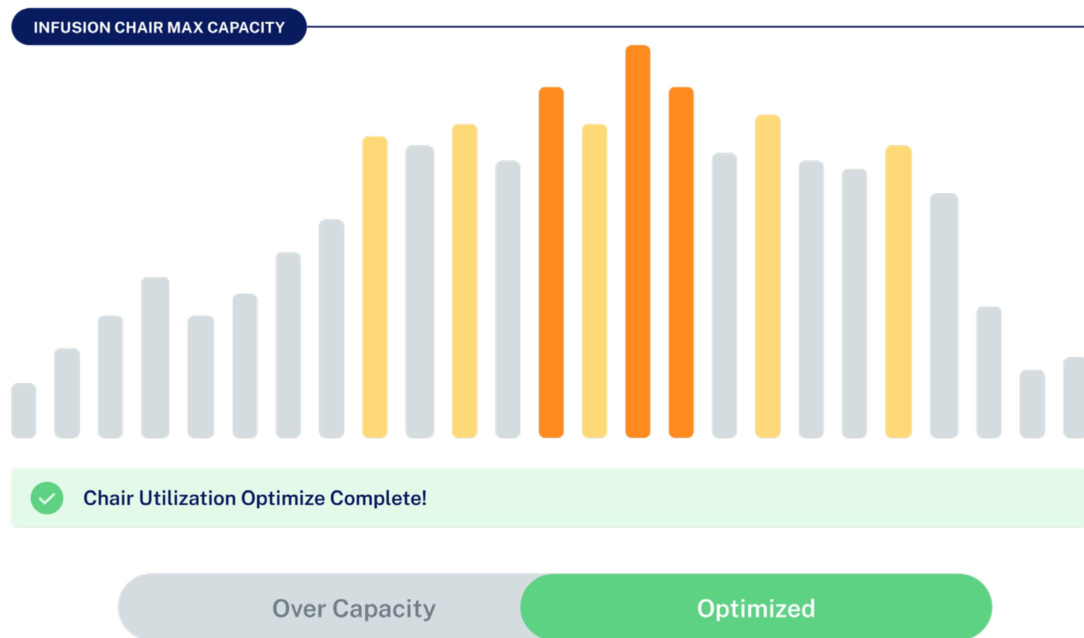

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issues

2024 Policy Wrap-Up

BY NICOLE TAPAY, JD

In 2024, policymakers advanced several of the Association of Cancer Centers' (ACCC's) federal policy priorities. Many of these changes—notably including reimbursement for patient navigation, protections for patients and providers during prior authorization processes, and reduction of out-of-pocket medication expenses for Medicare Part D beneficiaries—occurred through federal regulatory actions. Additionally, important pieces of legislation addressing prior authorization,[1] Medicare physician payment,[2] and cancer screening[3] among other issues, advanced to the final stages in the legislative process with broad bipartisan support, although they ultimately were not passed into law. ACCC hopes Congress will renew these legislative efforts and enact these provisions in the 119th Congress. Finally, important telehealth flexibilities were extended for several months into early 2025.[4] ACCC will continue to advocate for those provisions that were not enacted in 2024 during the 119th Congress.

Patient Navigation

Historically, Medicare did not reimburse services provided by patient navigators. Instead, cancer programs and practices offering patient navigation services often relied upon charitable funding or paid for these critical supportive care services out of operating budgets. Fortunately, developments at the end of 2023 and the beginning of 2024 provided additional payment sources for these services.

First, in January of 2024, several new Healthcare Common Procedure Coding System codes went into effect, allowing Medicare to reimburse for certain patient navigation services. These included new codes for:

- Principal Illness Navigation (PIN) and Principal Illness Navigation-Peer Support (PIN-PS) services
- Assessments relating to social determinants of health (SDOH)
- The provision of community health integration services (CHI).

These new codes were a much-needed step in supporting and expanding access to services that help patients and caregivers navigate the health care system. These include, but are not limited to, prevention, screening, and diagnosis; psychosocial issues; and economic and SDOH factors.

Furthermore, at the end of 2023, the American Medical Association issued updated guidance on the appropriate use of Current Procedural Terminology codes used by providers and a range of payers when they bill for and report clinical navigation services. Clinical navigation is typically provided by such clinical staff as nurses and licensed clinical social workers. This guidance enables providers to bill and receive reimbursement for patient navigation services from many payers, including commercial health insurers.

Implementation of these codes is still in the early stages for many providers, but progress is underway. Due to the many questions that have arisen as providers have begun to put the codes into practice, throughout 2024, ACCC provided virtual and in-person education on these codes, their scope, and related requirements, including some events held with partner organizations. ACCC will continue its dialogue with policymakers on these codes, strive to obtain clarification in certain areas, and advocate for needed policy refinements.

Prior Authorization

Prior authorization is a utilization management mechanism used by many payers that generally requires patients or their providers to secure preapproval as a condition of coverage or payment for a specific medication or service. While intended to ensure the provision of medically appropriate and necessary services, these requirements may sometimes delay treatment, result in negative patient outcomes, and increase health care costs and administrative burdens on physicians and their staff.[5]

In January 2024, the US Department of Health and Human Services/Centers for Medicare & Medicaid Services (HHS/CMS) published a rule on prior authorization that applies to many plans regulated by the federal government via HHS; this involves important protections and process improvements, including required time frames for plan decisions and mandatory electronic interoperability. Plans must send decisions within 72 hours for urgent requests and 7 days for nonurgent requests. Plans must also provide a reason for denials and publicly report certain metrics. The rule applies to Medicare Advantage plans, Medicaid, and Children's Health Insurance Program fee-for-service and managed care plans, as well as private plans (*qualified health plans*) sold on the Affordable Care Act exchanges. Most of these policies will go into effect on January 1, 2026, with reporting of metrics required by March 2026. The requirements to implement standardized application programming interfaces for prior authorization (enabling different computer programs to speak to one another) have an effective date of January 1, 2027.[6] While this rule

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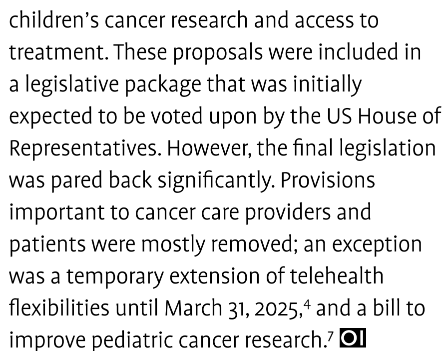
makes significant progress, it doe not apply to prior authorization decisions for prescription drugs nor does it apply to employer-sponsored health plans, many of which are regulated by the US Department of Labor.

Out-of-Pocket Expenses Under Medicare Part D

Implementation of the Inflation Reduction Act has resulted in lower out-of-pocket costs for Medicare beneficiaries covered under Medicare Part D. Such costs have been limited to $3250 for 2024 and $2000 for 2025.

Other Important Cancer-Related Legislative Proposals

There was significant bipartisan support for a number of ACCC's legislative priorities, including legislation to add protections to prior authorization processes for Medicare Advantage plans, the extension of Medicare coverage for telehealth services that began during the COVID-19 public health emergency, the allowance of Medicare to cover multi-cancer early detection screening tests after FDA approval is received, and legislation to promote breast cancer screening and children's cancer research and access to treatment. These proposals were included in a legislative package that was initially expected to be voted upon by the US House of Representatives. However, the final legislation was pared back significantly. Provisions important to cancer care providers and patients were mostly removed; an exception was a temporary extension of telehealth flexibilities until March 31, 2025,[4] and a bill to improve pediatric cancer research.[7] OI



Nicole Tapay, JD, is the director of cancer care delivery and health policy for the Association of Cancer Care Centers in Rockville, Maryland.

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1. Seniors Timely Access to Care Act of 2024 (S. 4532/H.R. 8702).

2. The earlier version of the continuing resolution would have prevented much of the planned Medicare physician payment cut from going into effect, reducing the final cut to 0.3% instead of 2.83%. Davis J. Regulatory implications of the continuing resolution healthcare package. McDermottPlus Blog. December 19, 2024. Accessed January 7, 2025. https://www.mcdermottplus.com/blog/regs-eggs/regulatory-implications-of-the-continuing-resolution-healthcare-package/

3. Several cancer screening related bills were included in the end-of-year package, including, but not limited to, the Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act (H.R. 2407) / the Medicare Multi-Cancer Early Detection Screening Coverage Act (S. 2085).

4. Telehealth provisions originally set to continue until the end of 2026 (Davis J.) were instead extended until March 31, 2025. Spending package extends Medicare telehealth flexibilities 3 months. Bill provides flat funding for NIH, NCI till March 2025. American Society of Clinical Oncology. December 23, 2024. Accessed January 7, 2025. https://society.asco.org/news-initiatives/policy-news-analysis/spending-package-extends-medicare-telehealth-flexibilities-3.

5. 2023 AMA prior authorization physician survey. American Medical Association. 2024. Accessed January 7, 2025.https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

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