ACS CAN Summary and Reaction CY2024 CMS Physician Fee Schedule Final Rule

On July 13, 2023, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule on the CY2024 Physician Fee Schedule (PFS). Included in the proposed rule was new reimbursement for certain patient navigation services. In September 2023, the American Cancer Society Cancer Action Network (ACS CAN) issued a letter to CMS, which 59 partner organizations signed on to, as well as a second letter commenting on the then proposed rule to CMS in support of the patient navigation provisions along with specific recommendations on how the new reimbursement should be implemented. On November 2, 2023, CMS released the final payment rule which takes effect on January 1, 2024. The following summary compares the final rule to the recommendations made by ACS CAN and other organizations specifically regarding the Principal Illness Navigation provisions.

Policies included in the ACS CAN sign on letter:

Principal Illness Navigation (PIN) Services	*CMS PFS Proposed Rule*	*ACS CAN Sign on Comments*	*CMS PFS Final Rule*
PIN Service Codes	CMS proposed two new codes for patient navigation services, or PIN services, as a parallel set of services to the proposed CHI services, but PIN services would focus on clinical aspects – rather than social aspects – of care for patients with a serious, high-risk illness who may not have SDOH needs.	ACS CAN applauded the creation of PIN codes as an important first step to help ensure that every cancer patient everywhere will have access to the navigation services needed for a better care experience and improved health outcomes.	CMS finalized the creation of four new codes, including (1) G0023 for PIN services by a certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist, for 60 minutes per calendar month per beneficiary; (2) G0024 for an additional 30 minutes of PIN services per calendar month per beneficiary as well as (3) G0140 for PIN Peer Support by a certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist, for 60 minutes per calendar month per beneficiary; and (4) G0146 for an additional 30

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			minutes of PIN Peer Support services per calendar month per beneficiary. The two peer support codes G0140 and G0146 are limited to the treatment of behavioral health conditions and were additional codes CMS added and finalized in response to comments to the proposed rule.
Certification or training of auxiliary personnel in PIN services	CMS proposed that PIN services must be provided by certified or trained personnel who can perform all included service elements and are authorized to perform them under applicable State laws and regulations. In states where there are no applicable licensure or other laws and regulations related to individuals performing PIN services, auxiliary personnel providing PIN services would need to be trained.	ACS CAN agreed with CMS' proposal to require that all auxiliary personnel who provide PIN services must be certified or trained to provide all PIN services elements and that such personnel must be authorized to perform these services under applicable State law or regulations. ACS CAN also provided information on other existing evidence-based training and/or certification programs that could help to inform CMS's decisions regarding certification. ACS CAN also suggested to CMS that there must be baseline cancer-specific training and education of auxiliary personnel on how	CMS finalized that all auxiliary personnel who provide PIN services must be certified or trained to provide all PIN services elements and that such personnel must be authorized to perform these services under applicable State law or regulations as proposed. CMS disagreed with the idea that all auxiliary personnel providing PIN services should be trained in oncology navigation, as the agency expects "PIN services to be focused on the principal illness for which PIN services are being furnished." CMS offered that a patient receiving PIN for one condition that were to be diagnosed with cancer would likely qualify for a

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		to address the holistic needs of the patient.	second, oncology specific PIN navigator.
Time and duration of PIN services	CMS sought comment on what is the typical amount of time practitioners spend per month providing PIN services as well as the typical duration, in terms of the number of months. CMS proposed that PIN services include 60 minutes per calendar month and that only one practitioner per beneficiary per calendar month can bill for PIN services, and that each additional 30 minutes per calendar month is then billed separately under a different billing code.	Like CHI services, ACS CAN encouraged that CMS consider whether the one hour per month time and duration limitations for PIN services could be increased to 120 minutes per month as well as broken down into 15 or 30 minute time increments to accommodate more visits per month.	ACS CAN's suggested increase in time and frequency was not incorporated into the final rule. CMS stated that if a patient requires less than 60 minutes per month for PIN services, then their needs may be best addressed by other types of care management services. CMS finalized there is no frequency limitation for the add-on code as long as the time spent is reasonable and necessary.
Patient consent for PIN services	CMS sought comments on whether it should require patient consent for PIN services. Although CMS did not propose to require consent for PIN because it believed these services typically involve direct patient care and are largely provided in-person, if commenters indicated that PIN services would not involve direct contact with the patient, or could extend for periods of time, CMS would require patient consent to receive PIN services in the final rule.	Like CHI services, ACS CAN strongly urged CMS to require that PIN services require advance patient consent before services can be provided to meaningfully inform the patient of the benefits of PIN services, the limitation of those services, and the patient cost-sharing responsibilities.	CMS finalized that patient consent is required in advance of providing PIN services either in writing or verbally, as long as the consent is documented in the medical record. Consent may be obtained by auxiliary personnel and a new consent must also be obtained if there is a change in the billing practitioner. The consent process must include explaining to the patient that cost sharing applies and that only on practitioner may furnish

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			and bill the services in a given month. CMS also finalized that consent must be obtained annually.
Documentation in the medical record	CMS proposed that time spent furnishing PIN services be documented in the medical record in its relationship with the serious, high-risk illness.	ACS CAN supported CMS' proposed requirement that time spent furnishing PIN services be documented in the medical record in its relationship with the serious, high-risk illness.	CMS finalized the requirement that time spent furnishing PIN services be documented in the medical record in its relationship with the serious, high-risk illness, as proposed.
Service elements in the proposed PIN services code	CMS requested comments on whether there are other elements that should be included in the proposed PIN services code.	ACS CAN suggested that CMS consider the entire continuum of cancer care as the proposed rule limited PIN services to services that practitioners would only provide during active cancer treatment (i.e., services for a serious, high-risk condition expected to last at least 3 months that places the patient at significant risk of hospitalization, acute exacerbation, functional decline or death), so as to also include prevention, early detection, and survivorship services.	CMS finalized that PIN services are limited to services that practitioners would only provide during active cancer treatment (i.e., services for a serious, high-risk condition expected to last at least 3 months that places the patient at significant risk of hospitalization, acute exacerbation, functional decline or death). Although PIN services are limited to during active treatment, CMS clarifies that a definitive diagnosis is not required before the practitioner makes a clinical determination that the patient has a serious high-risk condition.
Where and how PIN services will be provided	CMS sought confirmation of where and how PIN services would be typically provided (e.g., in-person, audio-video, two-way audio).	ACS CAN commented on how for many underserved and rural areas in particular direct contact via two-way audio and audio-video may be more	CMS did not finalize PIN services on the Medicare Telehealth Services List, which ACS CAN recommended.

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		common than in-person patient navigation given the patient burden and arranging services to support their care (e.g., transportation), and therefore it would be important to allow sites to provide PIN in the most impactful and efficient direct contact modalities. As such, ACS CAN encouraged CMS to include PIN services on the Medicare telehealth list and urged Congress to take up permanent telehealth legislation to ensure Medicare beneficiaries continue to have the option to see their providers in a manner that is most convenient to them.	However, CMS will consider this issue for future potential rulemaking.

Conclusion

The American Cancer Society and ACS CAN stand ready to assist with implementation of next steps to build on the progress of this work. Should you have any questions or need additional information, please contact Gladys Arias, Principal for Health Equity Policy Analysis and Legislative Support at ACS CAN at gladys.arias@cancer.org.

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