CANCER NATION

September 14, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD. 21244-1850

Re: CMS-1848-P, Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

Cancer Nation represents the more than 18 million cancer survivors in the United States living with, through, and beyond cancer. We engage in public policy activities to ensure that each and every member of Cancer Nation – each and every cancer survivor in this nation – gets whole person care, survivorship care plans, and financial protections.

Over many years, Cancer Nation – including during its four decades as the National Coalition for Cancer Survivorship (NCCS) – has participated in the rulemaking process related to the Medicare physician fee schedule. We have encouraged reforms in physician payment policies that will improve coordination of complex cancer care, ensure availability of cancer care planning for all patients, and improve access to cancer clinical trials. Cancer Nation has also had the opportunity, along with other patient advocates, to consult with the Centers for Medicare & Medicaid Services (CMS) regarding alternative payment models advancing episodes of care for cancer patients.

We have seen some modest improvements in payment for cancer care that foster coordination and navigation of care. The Medicare physician fee schedule now includes chronic care management and complex chronic care management codes, as well as principal illness navigation codes. The principal illness navigation codes, recently added to the payment system, are not being widely adopted, with practices noting documentation challenges. Oncologists also note documentation challenges associated with the complex chronic care management codes that limit utilization.

Cancer Nation can also report, based on findings from its annual Survivorship Survey, that a minority of survivors receive cancer care plans, with those receiving them reporting advantages from receipt. Cancer survivors also report gaps in their post-treatment care. In 2026, Cancer Nation supplemented its survey of survivors with a survey of clinicians. This survey also revealed stresses and strains in the delivery of post-treatment care to survivors, with confusion among both oncologists and primary care providers regarding ownership of post-treatment survivorship care and barriers to coordinating care.

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Two decades after the release of the Institute of Medicine/National Cancer Policy Board report, From Cancer Patient to Cancer Survivor: Lost in Transition, too many cancer survivors remain "lost in transition" from active treatment to post-treatment survivorship care. This report, the product of Institute of Medicine collaboration with the American Society of Clinical Oncology (ASCO) and the National Coalition for Cancer Survivorship (NCCS), (now Cancer Nation), detailed the care of survivors and recommended steps to address the gaps in care. This report, subsequent research, and the surveys and monitoring of survivorship care by Cancer Nation have informed our reimbursement advocacy.

We appreciate the opportunity to comment on the Medicare physician fee schedule proposed rule for CY 2027 and will focus our comments on opportunities to provide input, specifically including the comment solicitation on payment for physician-patient clinical trial discussions, the request for information on Redesigning Primary Care to Make America Healthy Again, and the Current Procedural Terminology (CPT) request for information.

Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions

As the Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions notes, fewer than 7 percent of adult cancer patients enroll in clinical trials.[1] The request for comments identifies the failure of physicians to initiate conversations with their patients about clinical trials as a central reason for such low rate of participation. This conclusion is consistent with Cancer Nation survey data. Few cancer patients in our surveys were clinical trial participants, and the vast majority of those surveyed say that the opportunity for clinical trials participation was never raised with them.

Our colleagues who are cancer care clinicians have over the years identified for Cancer Nation the difficulties associated with offering clinical trial enrollment opportunities. They cite first the time that these conversations take, due to the complexity of identifying and conveying clinical trial opportunities and assessing patient eligibility and interest in enrollment. We are persuaded that it is appropriate to pay for these services. We note that the solicitation of comments suggests a minimum of 20 minutes should be reimbursed for these conversations. Based on feedback from both cancer survivors and their cancer clinicians, we suggest that 20 minutes is a low minimum for a clinical trials discussion.

Although Cancer Nation lends its support to reimbursing for a clinical trials discussion, we offer an alternative for an interaction between cancer survivors and clinicians regarding clinical trials. Cancer Nation has for decades supported reimbursement for a cancer care planning process that results in the development of a specific and concrete (also subject to updating) care plan document. A cancer care plan was recommended by the National Cancer Policy Board, and we saw progress in the adoption of cancer care planning for a short period of time. We have seen that progress practically evaporate, with clinicians saying that they were not reimbursed for the significant time required for development of a personalized care plan. The parallels between

[1] Unger JM, Shulman LN, Facktor MA, Helson H. Fleury ME. National estimates of the participation of patients with cancer in clinical research studies based on commission on cancer accreditation data. J Clin Oncol. 2024;42:2139-2148.

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clinical trials discussions and cancer care planning discussions are obvious – these discussions are hard, time-consuming, and not reimbursed.

A cancer care planning process would include discussion of clinical trial enrollment opportunities as part of the evaluation of all treatment options. We will discuss below (again) the need for cancer care planning as an element of quality cancer care.

Request for Information on Redesigning Primary Care to Make America Healthy Again

We appreciate the efforts of the Centers for Medicare & Medicaid (CMS) to solicit input on the modernization of primary care payment to make primary care more prevention-oriented, team-based, and outcomes-based. We also commend the request for information regarding artificial intelligence-enabled tools in primary care.

Our first observation is that the effort to modernize primary care payment should extend to care offered by cancer care subspecialists, including medical oncologists, radiation oncologists, surgical oncologists, and others. We address the needs for modernization of cancer care because it is our area of experience and expertise, but we think some of our concerns and recommendations apply to other complex chronic diseases.

As part of the primary care modernization effort, CMS has suggested that the family of care coordination codes be reviewed and that the role of electronic tools in care coordination be considered. We have identified above the problems with some care coordination codes and their utilization, and therefore their impact (or limited impact) on patient care. We return to a theme of this comment letter, which is the critical role of cancer care planning for ensuring access to quality care across the cancer care trajectory. We repeat our recommendation that cancer care planning be paid for as a physician service. If cancer patients were provided care plans that outline their treatment plan, explain supportive care options, identify the potential late and long-term effects of their treatment, and outline survivorship care options, the path for care coordination would be smooth(er).

As we have repeated throughout this letter, we can speak to the needs of cancer patients. However, we believe that the concept of care planning is appropriate for additional Medicare beneficiaries with serious and life-threatening illnesses or complex chronic diseases. As we have also expressed in this letter, electronic tools, including those that are artificial intelligence-enabled, may play a role in care planning, if those tools are reliable and accurate.

We observe and have data from our 2026 clinician survey that suggests that team-based care may be the solution to the gaps in care as cancer survivors transition from active treatment to long-term survivorship care and live (in many cases) for years as cancer survivors. There is no clear sense of ownership – whether by primary care physicians or cancer care specialists – of long-term survivorship care, which requires surveillance, monitoring, and care as long as years in duration. However, a team-based approach may address this matter of ownership. As CMS evaluates responses from this request for information, we urge an expansive view of the modernization of primary care payment for the future.

If payment is aimed at Making America Healthy Again, attention must be directed to the more than 18 million Americans surviving cancer.

Cancer Nation is grappling with the role it can play in development and acceptance of artificial intelligence-enabled tools for cancer care coordination and planning. As we confront that issue, we are seeking to understand how to ensure the quality and reliability of such tools, so that we can in turn assure cancer survivors that these tools will assist them in managing their care and making decisions about their care with precision and accuracy. We urge CMS to take steps to ensure that tools eligible for reimbursement are reliable and accurate.

Request for Information Regarding Current Procedural Terminology (CPT)

Cancer Nation appreciates the opportunity to comment on possible revisions to the Current Procedural Terminology (CPT) process. We do not offer comments on whether the role of the American Medical Association in the CPT process should be dramatically revised or even ended.

We do wish to share the information that our medical professional colleagues have shared with us. They have expressed concerns that major changes in the CPT process, if they are advanced and approved, should be implemented with great care. They express concerns that major reforms, if too rapidly implemented, could disrupt payment and care. Cancer survivors would suffer if payment and care were disrupted, so we echo the concerns of our colleagues in medical practice about CPT reform implementation.

Cancer Nation does have advice about ways to make the CPT process more patient-centered, or at least open to patient input. We believe that patient input holds the potential for strengthening coding and making the CPT system reflect real care needs. Cancer Nation again directs attention to information that we have received through years of our Survivorship Surveys. In this comment letter, we offer the advice of survivors in broad strokes. We say as a first matter that cancer survivors are positive about their cancer care teams. These health care professionals have in many cases saved their lives, offered them months of happy times with their families, and helped them through a life-changing diagnosis and care. After patients express their overall positive views of their care teams, they are able to define the specific things in their care trajectory that worked and the shortcomings of the system. They can explain gaps in care, being “lost in transition,” and the need for MORE TIME with their cancer care teams. Cancer survivors are experts in describing the cancer care system, its strengths, and its weaknesses. And they can do it with specificity.

Cancer Nation advises that the input from cancer survivors might best be solicited as part of independent advisory panels to the CPT process. We believe this recommendation is consistent with the panels that have been recommended by the Medicare Payment Advisory Committee (MedPAC) in the past. As we have explained throughout this comment letter, we are most comfortable offering advice about the experience of cancer survivors and the contributions that cancer survivors can make to an advisory process. However, we anticipate that advocates from other communities of people with serious and life-threatening illnesses or complex chronic diseases could fulfill the same role.

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Cancer Nation appreciates the opportunity to comment on the Medicare physician fee schedule for CY 2027 proposed rule.

Sincerely,

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