September 12, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1832-P – Medicare and Medicaid Programs; CY 2026 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
90 Fed. Reg. 32352 (July 16, 2025)

Dear Secretary Kennedy and Dr. Oz:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the calendar year (CY) 2026 Medicare Physician Fee Schedule proposed rule. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's (ACS) nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

ACS CAN offers comments on the following policies:

- Request for information related to prevention and management of chronic disease
- Part B Average Sales Price: Units Sold at Maximum Fair Price

II. Provisions of the Proposed Rule

I. Policies to Improve Care for Chronic Illness and Behavioral Health Needs

2. Prevention and Management of Chronic Disease – Request for Information

CMS is soliciting feedback on how the agency could better support management of chronic disease and prevention.

ACS CAN supports efforts to advance evidence-based policies that promote prevention of chronic illnesses. Cancer prevention and early detection are crucial to ending cancer as we know it for everyone. In 2019, an estimated 40% of cancer cases in the United States were attributed to modifiable risk factors such as tobacco use, dietary factors, physical inactivity, etc.[1] Between 1970 and 2020, cancer prevention and screening interventions are estimated to have averted approximately

[1] American Cancer Society. Cancer Prevention and Early Detection Facts & Figures 2025-2026.

4.75 million deaths from breast, cervical, colorectal, lung and prostate cancers.[2] We have several ideas for policies CMS could consider to promote prevention and the management of chronic illness:

Medicare coverage of multi-cancer early detection tests: Earlier screening for cancer is important because when detected at later stages, treatments are more limited, and outcomes are generally poorer. Medicare enrollees should have access to multi-cancer screening tests when the benefit is clinically shown. Multi-cancer early detection tests are innovative tests that have the potential to detect multiple cancers through the use of a single test. Several private and academic entities are currently developing multi-cancer early detection blood-based tests. Published data indicate that some of these tests can screen for many different types of cancers at the same time, including some rare cancers. We encourage CMS to work with Congress to enact the Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act (H.R. 842/S. 339) which would grant Medicare the authority to cover multi-cancer early detection (MCED) tests, once the test has been approved by the Food and Drug Administration (FDA) and clinical benefit is shown. Under the legislation, CMS would determine its coverage parameters through an evidence-based process.

Food is Medicine: "Food is Medicine" (FIM) is a category of tailored food-based nutritional interventions specifically linked to the health care system that are intended to prevent, treat, or manage chronic diseases and often address food and nutrition insecurity. FIM interventions create an essential link between health care and community care to provide comprehensive patient care with support for managing and treating chronic diseases, reducing food and nutrition insecurity, and improving quality of life.

There is promising evidence that the three most common FIM health care system interventions – produce prescriptions, medically tailored groceries (MTGs), and medically tailored meals (MTMs) – are effective in helping to manage chronic diseases.[3] A recent cost analysis from the Tufts Friedman School of Nutrition Policy modeled cost savings in private and public insurance options of an MTM intervention for patients living with chronic diseases, including cancer, who had limited activities in daily living, including an analysis among those who had food insecurity. The study estimated significant cost savings (billions) in each insurer category over one and 10-year intervals.[4]

CMS should examine ways to cover FIM interventions. For example, CMS could work with CMMI to consider incorporating FIM programs into the existing Enhancing Oncology Model or creating a new model to allow hospitals and other Medicare-approved facilities reimbursement for those programs to cancer patients.

Patient Navigation Services: Individuals with serious, high-risk illnesses such as cancer often need additional support to address the social aspects of their care. Since 2024, Medicare has provided reimbursement for principal illness navigation (PIN) codes to allow Medicare enrollees access to

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[2] Goddard KAB, Feuer EJ, Mandelblatt JS, et al. Estimation of Cancer Deaths Averted From Prevention, Screening, and Treatment Efforts, 1975-2020. JAMA Oncol. 2024.doi:10.1001/ jamaoncol.2024.5381

[3] Downer S, Clippinger E, Kummer C. Food is Medicine Research Action Plan. Published Jan. 27, 2022. Retrieved at https://www.aspeninstitute.org/wpcontent/uploads/2022/01/Food-is-Medicine-Action-Plan-Final_012722.pdf.

[4] Sharib, JR (2023, November 28) *True cost of food: Food is Medicine Cost Study*. Food is Medicine. https://tuftsfoodismedicine.org/true-cost-fim-case-study-report/.

patient navigators, professionally trained individuals who offer assistance to patients, families and caregivers to help them overcome health care system barriers and facilitate timely access to quality health care.

However, reimbursement for patient navigation services is limited, although the use of these services has been shown to improve patient outcomes, reduce unnecessary treatment costs and increase patient satisfaction.[5] Currently, PIN services are limited to services that practitioners would only provide during active cancer treatment. Although PIN services during active cancer treatment are vital, PIN services can also be instrumental throughout a patient's cancer journey starting with prevention, early detection, diagnosis and into survivorship. Patient navigators have been shown to help increase cancer screening rates by providing access to disease prevention education, conducting community outreach, and facilitating public education campaigns.[6,7,8]

Patient navigators can also be an important link to successfully guiding recovering cancer patients into survivorship and through the transition back to their primary care provider. Cancer survivors continue to have health care needs after active treatment, including monitoring for disease progression or recurrence, ongoing side effects from cancer treatment, mental health treatment and other late and long-term effects.[9] ACS CAN urges CMS to expand the use of PIN codes to cover all parts of the cancer care continuum including prevention and survivorship care.

Tobacco cessation products: Medicare Part D does not cover over-the-counter medication. However, Part D plans are permitted to cover prescription-only tobacco cessation products,[10] though coverage of these products will vary depending on the plan. Coverage of tobacco cessation products is important because of the prevalence of tobacco use among individuals over the age of 65 who have Medicare. Approximately 10% of people with Medicare over the age of 65 reportedly currently use a tobacco product.[11] We urge CMS to require that all Part D plans cover prescription tobacco cessation products without cost-sharing.

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[5] Kline, R. et al., (2019). "Patient Navigation in Cancer: The Business Case to Support Clinical Needs", JCO Oncology Practice, https://ascopubs.org/doi/full/10.1200/JOP.19.00230.

[6] Natale-Pereira, A., Enard, K., Nevarez, L., Jones, L. (2011) "The Role of Patient Navigators in Eliminating Health Disparities", Cancer, p. 3543-3552, https://acsjournals.onlinelibrary.wiley.com/doi/epdf/10.1002/cncr.26264.

[7] Guide to Community Preventive Services. Cancer Screening: Patient Navigation Services to Increase Cervical Cancer Screening and Advance Health Equity. https://www.thecommunityguide.org/findings/cancer-screeningpatient-navigation-services-to-increase-cervical-cancer-screening.html. Page last updated: July 25, 2025.

[8] Nelson HD, Cantor A, Wagner J, et al. Effectiveness of patient navigation to increase cancer screening in populations adversely affected by health disparities: a meta-analysis. J Gen Intern Med. 2020;35(10):3026-3035. doi:10.1007/s11606-020-06020-9.

[9] American Cancer Society Cancer Action Network. The Cost of Cancer Survivorship 2022. https://www.fightcancer.org/policy-resources/costs-cancer-survivorship-2022.

[10] Centers for Medicare & Medicaid Services. Medicare Prescription Drug Benefit Manual. Chapter 6 – Part D Drugs and Formulary Requirements. § 20.1.

[11] Cornelius ME, Loretan CG, Jamal A, et al. Tobacco Product Use Among Adults – United States, 2021. *MMWR Mortal Wkly Rep* 2023; 72.

III. OTHER PROVISIONS OF THE PROPOSED RULE

A. Drugs and Biological Products Paid Under Medicare Part B

3. Average Sales Price: Units Sold at Maximum Fair Price

Under the Medicare Drug Price Negotiation Program, CMS negotiates a maximum fair price (MFP) for certain Part B and Part D drugs. CMS proposes to incorporate the MFP of a drug into the product's average sales price (ASP) and only publish the MFP as the Medicare payment amount. This means that CMS will base reimbursement on the Maximum Fair Price (MFP) plus six percent rather than the current Average Sales Price (ASP) plus six percent.

The proposed change will likely significantly reduce payment for Part B drugs – many of which are cancer therapies. The Community Oncology Alliance (COA), the organization representing community oncologists, estimates that this change in reimbursement could result in a reduction in payment of roughly 47% which would have a detrimental effect on community oncology practices. Many cancer patients receive treatment at local oncology practices and could lose access if these facilities were forced to close because of significant reductions in payment.

ACS CAN urges CMS to reconsider this provision. Legislation introduced in 2023 in both the House and Senate could provide another option that would help to provide Medicare with the savings CMS is seeking without penalizing either cancer patients or their physicians. The Protecting Patient Access to Cancer and Complex Therapies Act (S. 2764, H.R. 5391) - introduced by U.S. Senator John Barrasso (R-WY), U.S. Representative Michael Burgess (R-TX) and U.S. Representative Greg Murphy (R-NC), would maintain the current ASP+6 payment and direct drug manufacturers to rebate the Medicare program the difference between the ASP+6 rate and the new negotiated rate. Since Medicare beneficiary coinsurance would still be based on the lower negotiated rate, beneficiaries – including cancer patients – would realize savings.

CONCLUSION

Thank you for the opportunity to comment on the CY2026 Medicare Physician Fee Schedule proposed rule. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org.

Sincerely,

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network