September 10, 2026

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-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
91 Fed. Reg. 43842 (July 16, 2026)

Dear Secretary Kennedy and Administrator Oz:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the calendar year (CY) 2027 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:

- Smoking and Tobacco Use Cessation Codes
- Changes to Payments Using Modifier -25 (same-day procedures)
- Payment for Physician-Patient Clinical Trial Discussions
- The Care Management Code 'Family'
- Community-Based Palliative Care

II. Provisions of the Proposed Rule

D. Valuation of Specific Codes Including Potentially Misvalued Services Under the PFS

3. *Methodology for the Direct PE Inputs to Develop PE RVUs*

c. Valuation of Specific Codes for CY 2027

(50) Smoking and Tobacco Use Cessation CPT Codes 99406, 99407) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) (HCPCS codes G2011, G0396, G0397)

The Centers for Medicare and Medicaid Services (CMS) proposes to increase the valuation of the CPT codes for smoking and tobacco use cessation counseling. This aligns with a similar increase the

agency has been implementing for other time-based psychotherapy codes.

ACS CAN appreciates CMS' recognition that using evidence-based methods to help people quit using tobacco is an integral goal in preventing and managing chronic disease, and we support the agency ensuring that the tobacco cessation counseling codes are valued in such a way that clinicians are encouraged to provide this counseling and use the codes.

Tobacco use is the leading cause of preventable death in the U.S., with more than 480,000 deaths each year, including about a third of all cancer deaths and 80% of lung cancer deaths.[1] Effective evidence-based proven cessation resources currently available include three different types of behavioral counseling (individual, group, and phone counseling-inclusive of state Quitlines) and seven Food and Drug Administration (FDA)-approved pharmacological interventions (e.g., five nicotine replacement therapies and two additional prescription medications).

Research has shown FDA-approved cessation medications and counseling improve the chances of long-term cessation among adults, especially when used in combination.[2,3,4] The 2020 Surgeon General's Report on smoking cessation concluded that comprehensive, barrier-free health insurance coverage of evidence-based tobacco cessation therapies and services is one of the most effective ways to increase their availability and use, which will continue to drive down tobacco use and save lives.[5]

ACS CAN supports CMS' efforts to improve the availability and use of evidence-based tobacco cessation services. We encourage CMS to continue to focus on increasing access to evidence-based cessation services to support individuals in their quit journeys, including by 1) considering new reimbursement and payment models to improve access and utilization of cessation treatments to all enrollees at no cost; and 2) considering a strategy to specifically support individuals who live in rural settings with their cessation efforts.

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[1] American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2026. Atlanta: American Cancer Society; 2026.
[2] U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020.
[3] U.S. Preventive Services Task Force, Krist AH, Davidson KW, et al. Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons: US Preventive Services Task Force Recommendation Statement. JAMA. 2021;325: 265-279.
[4] U.S. Preventive Services Task Force, Owens DK, Davidson KW, et al. Primary Care Interventions for Prevention and Cessation of Tobacco Use in Children and Adolescents: US Preventive Services Task Force Recommendation Statement. JAMA. 2020;323: 1590-1598.
[5] U.S. Department of Health and Human Services. Smoking Cessation. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2020.

(58) Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

CMS proposes to reduce payment when a separately identifiable Office/Outpatient (O/O) E/M visit (identified by Modifier -25) is furnished by the same physician or group practice on the same day as a 0-, 10-, or 90-day global procedure. Under the proposal, the highest-paid service is reimbursed at 100%; all other surgical procedures and E/M visit(s) are reduced by 50%.

ACS CAN is concerned that this policy will result in people with cancer – or who are being evaluated for possible cancer – having challenges accessing timely care because it potentially disincentivizes multiple visits or procedures occurring on the same day. When a clinician thinks a patient may have cancer based on screening results, symptoms or other evaluations, further diagnostic testing is required until a diagnosis can be made. All parties involved want a possible diagnosis as quickly as possible. When cancer diagnoses are delayed, patients' cancer can grow or their symptoms get worse, and they have worse outcomes overall.[6] Lengthening time to diagnosis can also cause and prolong significant anxiety and other psychological effects for the patient and their family.[7]

This policy change has the potential to disincentivize certain care – including diagnostic testing – being performed on the same day as other procedures. For example, an otolaryngologist recommends their patient receive a biopsy for a lump in their throat that is suspected to be cancerous after a clinical evaluation. Under this new policy, the provider would receive significantly reduced payment if they conducted that biopsy on the same day as the evaluation – so the provider would either accept a lower payment, or, more likely, would require the patient to schedule a new appointment on a future day for the biopsy. Being forced to come back on a different day for this procedure would increase barriers to access for the patient in many ways, in addition to delaying the potential diagnosis. These access barriers are even more concerning for patients who have to travel long distances to see specialist providers, or patients who have difficulty arranging time off work or transportation to appointments.

We urge CMS to address access concerns for cancer patients and individuals undergoing testing for cancer to appropriate same-day treatment before finalizing this change in payment policy.

(63) Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions

CMS seeks comment on the creation of a HCPCS G-code describing a minimum of 20 minutes of physician or other QHP time spent on clinical trial counseling, whether the service should be available as a telehealth service, and what documentation the agency should require for use of this

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[6] Haddadi S, Dehghani M, D'Amato G. Editorial: Delay in cancer diagnosis and factors affecting outcomes. Front Public Health. 2024 Jul 12;12:1442764. doi: 10.3389/fpubh.2024.1442764.

[7] Frosch ZAK, Jacobs LM, O'Brien CS, Brecher AC, McKeown CJ, Lynch SM, Geynisman DM, Hall MJ, Edelman MJ, Bleicher RJ, Fang CY. "Cancer's a demon": a qualitative study of fear and multilevel factors contributing to cancer treatment delays. Support Care Cancer. 2023 Dec 7;32(1):13. doi: 10.1007/s00520-023-08200-9.

code. CMS cites ACS CAN research showing 70% of oncologists discuss trials with less than a quarter of their patients,[8] yet more than 50% of eligible patients enroll when actively offered a clinical trial.[9]

ACS CAN strongly supports CMS' proposal to value clinician time spent discussing and offering clinical trials to patients when appropriate. Clinical guidelines suggest that every patient be offered the chance to participate in a clinical trial as a primary option, and clinical research not only improves overall care for future patients, but it also can provide access to the latest scientific developments. In the case of rural patients with cancer, trial participation has been shown to improve overall outcomes regardless of the clinical trial arm a patient is assigned to.[10]

ACS CAN supports CMS' proposal to create this G-code, and we also support the code being available as a telehealth service. It is not necessary in all cases that a patient be in the same physical space as the clinician for a discussion about whether a cancer patient may qualify for a clinical trial and how a trial might impact their cancer care. Experience during the COVID-19 pandemic illustrated that many aspects of trial enrollment and operations could be successfully performed remotely.[11]

Regarding CMS' request for comment on documentation requirements for this proposed code, ACS CAN encourages the agency to structure these requirements so that they do not unreasonably suppress utilization of the code. Additionally, we encourage the agency to clarify whether the counseling associated with this code applies to participation in specifically identified trials or is related to discussions about clinical trials more generally. Finally, once reimbursement has been established, we encourage CMS to actively monitor use of the code to determine the extent to which it has improved participation in clinical trials and what, if any, additional policies may be needed to accomplish this goal.

E. Request for Information: Redesigning Primary Care to Make American Healthy Again

3. Care Management Code 'Family'

Over the past 14 years, CMS has sought to unbundle care management services previously considered bundled into E/M services through separate coding and payment. Despite these expansions, CMS notes that uptake of care management codes has been limited, and that stakeholders cite cost-sharing and documentation burden as the primary barriers. CMS seeks

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[8] Lee SJC, Murphy CC, Gerber DE, et al. Reimbursement matters: overcoming barriers to clinical trial accrual. Med Care. 2021;59(5):461-466. https://pmc.ncbi.nlm.nih.gov/articles/PMC8026490/.

[9] Unger JM, Vaidya R, Hershman DL, Minasian LM, Fleury ME. Systematic review and meta-analysis of the magnitude of structural, clinical, and physician and patient barriers to cancer clinical trial participation. J Natl Cancer Inst. 2019;111(3):245-255. https://pubmed.ncbi.nlm.nih.gov/30856272/.

[10] Unger JM, Moseley A, Symington B, Chavez-MacGregor M, Ramsey SD, Hershman DL. Geographic Distribution and Survival Outcomes for Rural Patients With Cancer Treated in Clinical Trials. JAMA Netw Open. 2018;1(4):e181235. doi:10.1001/jamanetworkopen.2018.1235.

[11] Loucks TL, Tyson C, Dorr D, Garovic VD, Hill J, McSwain SD, Radovick S, Sonnenberg FA, Weis JA, Brady KT. Clinical research during the COVID-19 pandemic: The role of virtual visits and digital approaches. J Clin Transl Sci. 2021 Mar 8;5(1):e102. doi: 10.1017/cts.2021.19.

stakeholder comment on whether a different payment structure might be more appropriate and what steps could further simplify the code set and its associated requirements.

ACS CAN appreciates CMS' awareness of the importance of care management, and we have long been supportive of CMS' efforts to develop this code family. Many cancer patients require complex care from many different providers, and would and do benefit from efforts to manage this care. While we understand that CMS has limited ability to change patient cost-sharing requirements for these services, we encourage the agency to work with Congress to potentially remove cost-sharing for services in this area, as this cost-sharing is likely a major factor in the underutilization of these codes.

Evidence is clear that cost-sharing disincentivizes Medicare enrollees from seeking care,[12] particularly among the chronically ill[13] and lower-income populations.[14] Challenges paying cost-sharing can be particularly hard for people with a history of cancer – who experience higher incidence of financial hardship than people without a history of cancer.[15] Charging cost-sharing on this set of codes is particularly challenging as it is for care that does not necessarily occur when the patient is present, and providers may be hesitant to use the code so as not to cause confusion or hardship for their patients. We support efforts from the agency and Congress to remove patient cost-sharing for care coordination codes.

4. Payment Implications of Technology Enablement of Primary Care

CMS would like to better understand how technology is being used throughout primary care, in ways that are changing and increasingly innovative. The agency seeks comment on how it should develop a comprehensive and consistent approach to payment for technology-enabled care given "likely lower cost-to-serve but potentially higher quality of care delivered." They seek information on how to best structure payment for these technologies in a way that aligns with the agency's mission to increase quality, improve health, reduce costs, and strengthen the healthcare system.

ACS CAN appreciates CMS' attention to these important questions, as the presence of technology-enabled care increases in patients' lives and as part of their care, including cancer care. This includes most prominently artificial intelligence (AI) technology. ACS CAN addressed the applications of AI in cancer care in our response to CMS' Request for Information on Accelerating the Adoption and Use

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[12] Madden JM, Bayapureddy S, Briesacher BA, Zhang F, Ross-Degnan D, Soumerai SB, Gurwitz JH, Galbraith AA. Affordability of Medical Care Among Medicare Enrollees. JAMA Health Forum. 2021 Dec 10;2(12):e214104. doi: 10.1001/jamahealthforum.2021.4104.

[13] Wong MD, Andersen R, Sherbourne CD, Hays RD, Shapiro MF. Effects of cost sharing on care seeking and health status: results from the Medical Outcomes Study. Am J Public Health. 2001 Nov;91(11):1889-94. doi: 10.2105/ajph.91.11.1889.

[14] Roberts E, Glynn A, Donohue J, Michael McWilliams J, Gellad W, Cornelio N, Sabik L. Consequences of Health Insurance Cost Sharing Among Low-Income Medicare Beneficiaries: Evidence from Benefit Cliffs in Medicaid and Medicare's Prescription Drug Subsidy Program. Health Serv Res. 2020 Aug;55(Suppl 1):98–9. doi: 10.1111/1475-6773.13470.

[15] National Center for Health Statistics: National Health Interview Survey, 2019-2020. Public-use data file and documentation. Retrieved from: https://www.cdc.gov/nchs/nhis/2020nhis.htm. July 2022.

of Artificial Intelligence as Part of Clinical Care, and we refer the agency to our previous comments.[16]

We urge CMS and the larger Department of Health and Human Services (HHS) to develop and implement oversight mechanisms throughout HHS agencies that require evidence of efficacy and patient safety prior to deployment, utilize appropriate validation studies of the intended use patient populations, ensure that when appropriate, use of AI tools is meaningfully disclosed to patients, specify the extent of qualified human engagement and review while implemented, and require creation and use of effective adverse event reporting and post-approval monitoring systems across the programs and regulatory responsibilities the Department oversees. HHS should also promulgate regulations that provide clear standards as to the entity (or entities) to be held accountable in cases where AI applications result in patient harm. Any regulatory framework should prioritize patient safety and protection of patient health information.

G. Supporting Beneficiaries Planning for Future Medical Decisions

2. Request for Information (RFI) on Community-Based Palliative Care

CMS requests information on appropriate requirements the agency should consider for the administration of community-based palliative care. Community-based palliative care services are delivered outside the hospital and across a variety of care settings including outpatient facilities, physician offices, at home care, and others. CMS asks a number of specific questions in its RFI regarding palliative care, including whether eligibility for any future supportive or palliative care service for Medicare beneficiaries should be restricted to certification of a likely life expectancy duration.

ACS CAN appreciates CMS' awareness of the importance of palliative care for many patients living with serious illnesses, including many people with cancer. Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of a serious illness. Palliative care is appropriate at any age and any stage in a serious illness (ideally made available to patients with serious illnesses upon diagnosis) and can be provided along with curative treatment. The goal is to improve quality of life for both the patient and the family.

Studies show that palliative care interventions are associated with improvements in patient quality of life and symptom burden.[17] Without palliative care, patients with serious illnesses and their families are at risk of poor-quality medical care that is characterized by inadequately treated symptoms, fragmented care, poor communication with healthcare providers, and enormous strains

[16] ACS CAN. Letter re: Request for Information: Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care. 90 Fed. Reg. 60108 (December 23, 2025). February 17, 2026. https://www.fightcancer.org/sites/default/files/acs_can_ai_rfi_response_final_0.pdf.

[17] Kavalieratos D, Corbelli J, Zhang D, Dionne-Odom JN, Ernecoff NC, Hanmer J, Hoydich ZP, Ikejiani DZ, Klein-Fedyshin M, Zimmermann C, Morton SC, Arnold RM, Heller L, Schenker Y. Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis. JAMA. 2016 Nov 22;316(20):2104-2114. doi: 10.1001/jama.2016.16840.

on family members or other caregivers.[18,19]

Because of cancer's high symptom burden and other factors, much of the evidence base for palliative care was built from experiences caring for people with cancer. In one study, patients with metastatic non-small-cell lung cancer who received palliative care services shortly after diagnosis even lived longer than those who did not receive palliative care.[20] Another study found that the receipt of a palliative care consultation within two days of admission was associated with 22% lower costs for patients with certain comorbid conditions, saving an average of $3,200 on every admission, with savings climbing to $4,200 for patients with cancer.[21]

Despite the clear benefits of palliative care to many cancer patients, access to this crucial care remains a challenge. A recent study of the Medicare enrollees with cancer found that despite considerable growth in early palliative care receipt, utilization remained low in 2019 – only 10.64% of enrollees with advanced cancer in this study received this care.[22] Another recent study found that higher geographic accessibility to palliative care physicians was associated with a greater likelihood of palliative care receipt among patients diagnosed with advanced cancer – suggesting the importance of increasing the number of palliative care physicians, especially in rural and socioeconomically deprived areas, to enhance the accessibility of guideline-recommended palliative care.[23] Improving reimbursement opportunities for this care is one important way to accomplish this goal.

Given the importance of palliative care to the treatment experience of so many people with cancer, and the continuing challenges some patients face in accessing these services, ACS CAN is encouraged by CMS' attention to this issue. If the agency moves forward with additional policy change in this area, we urge them to avoid overly burdensome requirements that would complicate care delivery or reduce access to palliative care for people with cancer and other serious illnesses.

ACS CAN urges CMS not to restrict palliative care services based on life expectancy duration. Some people with cancer who benefit from palliative care services do enter remission and are considered

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[18] Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. JAMA. 2004 Jan 7; 291(1):88-93. https://pubmed.ncbi.nlm.nih.gov/14709580/.

[19] Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. The Milbank Quarterly. 2011;89(3):343-380. doi:10.1111/j.1468-0009.2011.00632.x.

[20] Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363:733-742. https://pubmed.ncbi.nlm.nih.gov/20818875/.

[21] May P, et al. Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities. Health Affairs. January 2016. https://pubmed.ncbi.nlm.nih.gov/26733700/.

[22] Xin Hu et al. Early palliative care among patients diagnosed with advanced cancers in the US (2010-2019): Trends and contribution of provider variation.. *J Clin Oncol* **42**, 11017-11017(2024). DOI:10.1200/JCO.2024.42.16_suppl.11017.

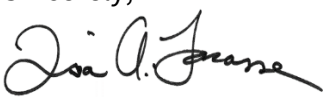
[23] Qinjin Fan et al. Geographic accessibility to palliative care physicians and early receipt of palliative care among individuals diagnosed with stage IV cancer in the US.. JCO Oncol Pract 19, 89-89(2023). DOI:10.1200/OP.2023.19.11_suppl.89.

recovered from their cancer. Others may not enter remission but are able to use curative therapies to keep their tumors or cancers at a certain status that allows them to manage their condition as a chronic illness. Many people with cancer benefit when they receive palliative care in conjunction with curative treatment, and we want to reemphasize that it is beneficial at any age and any stage of cancer. Studies also show that patients benefit more when they receive this care as soon as possible after their diagnosis: early palliative care can lead to improved symptom control, reduced distress throughout the disease-directed therapy, and care delivery that matches the patients' preferences.[24] Despite these benefits, use of "early" palliative care remains low,[25] and we urge CMS not to limit access to palliative care based on an arbitrary prognosis timeline, which might prevent some cancer patients from receiving palliative care services at diagnosis. Determinations of which patients may benefit from palliative care are best made by the treating physician.

CONCLUSION

Thank you for the opportunity to comment on the CY2027 Medicare Physician Fee Schedule proposed rule. If you have any questions, please feel free to contact me or have your staff contact Jennifer Hoque, Associate Principal for Access to Care, at Jennifer.Hoque@cancer.org.

Sincerely,



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

[24] Howie L, Peppercorn J. Early palliative care in cancer treatment: rationale, evidence and clinical implications. Ther Adv Med Oncol. 2013 Nov;5(6):318-23. doi: 10.1177/1758834013500375.

[25] Xin Hu et al. Early palliative care among patients diagnosed with advanced cancers in the US (2010-2019): Trends and contribution of provider variation.. *J Clin Oncol* **42**, 11017-11017(2024). DOI:10.1200/JCO.2024.42.16_suppl.11017.