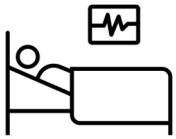
ACS CAN's Policy Recommendations for Improving Cancer Care in Rural America

May 13, 2026

People who live in rural and remote areas have specific challenges in accessing cancer treatments and preventive services. It is estimated that up to 20% of the U.S. population resides in rural areas, but only 3% of medical oncologists practice in rural communities and over 70% of counties do not have a medical oncologist.[1] Research shows there is a widening gap in cancer mortality between urban and rural areas.[2] Cancer patients and survivors who reside in rural areas are more likely to have limited incomes and face serious financial hardship.[3]

People who reside in rural areas face significant barriers to accessing care, limited primary care and public health capacity, limited access to clinical trials, cancer screening and prevention, higher rates of tobacco use, are more likely to face food insecurity and may lack patient support services. ACS CAN supports policy recommendations to improve cancer care in rural and remote areas.

Access to Care



People living in rural areas often have limited access to oncologists[4] and hospitals that provide comprehensive cancer services, especially at National Cancer Institute (NCI)-designated cancers and cancer centers that treat a large number of patients. Consequently, patients must travel long distances to access care or make changes to their treatment plans due to their location or access to treatment options – which can result in worse cancer outcomes.

Issue	ACS CAN Policy
Network Adequacy: Residents in rural and remote areas often have to travel great distances in order to access a clinician or facility (if one is even available within their plan's network).	ACS CAN supports strengthening network adequacy standards across all payers to improve access in rural and remote areas to oncology services, including but not limited to improving access to NCI-designated cancer centers, specialists and subspecialists, and pharmacies.
Access to Facilities: Hospitals, oncology practices, and other providers in rural areas depend on stability in patient coverage mix (i.e. whether and how their patients are insured) and payments for care in order to continue operating and providing access to care.	ACS CAN supports reimbursement adjustments to ensure rural hospitals and clinics remain a viable option for rural residents.

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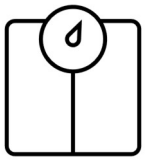
Barriers to Coverage and Enrollment: Major coverage programs like Medicaid, Marketplace plans, and Medicare often have barriers to enrollment such as (soon-to-be implemented) work requirements, few plan options, and lack of resources to help people enroll and navigate the program.	ACS CAN supports policies to strengthen patient protections to ensure that rural residents have access to high-quality, affordable coverage options as well as resources to help enrollees navigate these programs. *Medicaid*: ACS CAN supports eliminating federal Medicaid work requirements, more frequent eligibility checks, and funding losses to states caused by new limits on retroactive coverage and changes to Medicaid financing. *Marketplace and Medicare Advantage:* ACS CAN supports policies that ensure that residents of rural areas have access to a choice of affordable, comprehensive health care plan options.
Increasing access to telehealth: Telehealth can provide the opportunity for residents of rural areas to access specialized services and seek a second opinion on their health care treatment plan, which is critical in cancer care. Telemedicine and mobile clinics are one way to bring health education and services to rural communities.	ACS CAN supports expanded access to telehealth services where appropriate in cancer and cancer-related care, including primary care, preventive services and tobacco cessation services, palliative and supportive care services, and second opinion consultations that offer support to both providers (like Project Extension for Community Healthcare Outcomes (ECHO) programs) and patients. ACS CAN also supports expanding access to mobile health clinics, which can serve as a tool for expanding cancer screening and follow-up care at no cost to the patient in hard-to-reach rural communities.
Barriers to Transportation and Lodging: Travel to treatment and lodging while undergoing treatment are critical cost and logistical barriers to care for many cancer patients and their caregivers – and more so for patients who live in rural areas.	ACS CAN supports the development of models of care in federal programs that seek to address these barriers. We also advocate for Medicaid coverage of non-emergency medical transportation services and state appropriation of funds to offset the cost of lodging and transportation for those who lack access to these services near their homes.

Primary Care & Public Health Capacity



Limited primary care and public health capacity in rural communities impact access and delivery of all preventive services, including cancer screening and follow-up care.

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Clinician Shortages: Generally, rural areas have less access to primary care professionals than urban areas.	ACS CAN supports increasing and making permanent funding for Federally-qualified health centers (FQHCs), Health Resources and Services Administration (HRSA)-funded health centers, Tribal organizations and rural health clinics are an integral part of the health care safety net, providing access to primary care services.
Insufficient Primary Care Workforce: Rural areas increasingly rely on nurse practitioners and physicians' assistants to provide care.	ACS CAN supports expanding clinician and clinician-extender training for cancer prevention and early detection care and promoting retention of physicians and clinician-extenders in rural practice settings, for example, through the HRSA's Rural Primary Care Programs and Workforce.

Clinical Trials and Research

The National Cancer Institute's (NCI's) National Cancer Plan has a goal that every person with cancer or at risk for cancer has an opportunity to participate in research or otherwise contribute to the collective knowledge base, and barriers to their participation are eliminated. Today opportunities to participate in research are starkly different in rural versus urban areas because of a lack of infrastructure and long distances. Policy changes can address some of those barriers.

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Outdated Rural Trial Infrastructure: The last major change to the NCI's clinical trial infrastructure occurred 15 years ago in response to a National Academies Report. Since that time, NCI's infrastructure has not changed, primarily serving urban areas. The broader clinical trials ecosystem, however, has continued to evolve, with the NCI system becoming outdated and the U.S. having lost ground relative to the rest of the world in cancer clinical trial volume.	ACS CAN supports extending the NCI Community Oncology Research Program (NCORP) and expanding the number of funded sites. ACS CAN also supports federal sponsorship of a National Academies consensus report to explore how to create an NCI community trial infrastructure that can spur regrowth of U.S. trial capacity. The report should outline how NCI investment can bring not only NCI-sponsored trial opportunities to community and rural settings, but also how that infrastructure can be developed in a way

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	to also catalyze capacity to expand non-federally funded clinical research.
Workforce: Limited staff skills and capacity are major impediments to conducting clinical trials. This is true regardless of geography, but rural areas are especially disadvantaged when competing for talent. NIH already helps fund the training of doctors and PhDs but is lacking a robust training program for frontline research staff like research coordinators and research nurses.	ACS CAN supports federal funding for NIH for programs that address clinical trial workforce barriers in rural areas.
Financial Support for Trial Expenses: Trial participation for rural patients (and care in general) often requires more travel and time off work than in an urban setting. As such, financial burdens of trial participation are high and can keep patients from taking part.	ACS CAN supports the enactment of the Clinical Trial Modernization Act (CTMA) (H.R. 3521) to address barriers that prevent patient enrollment in clinical trials. Even absent passage of CTMA, HHS has existing authority to enact some of the CTMA policies—namely creation of a trial participant financial support safe harbor from kickback laws – which would help support patients who want to enroll in clinical trials but have financial barriers to participation.
Fund Research to Address Disparities: Residents in rural areas have higher cancer mortality, particularly for historically marginalized communities.	ACS CAN supports increasing funding in areas where progress is lacking the most in order to better understand and address cancer health disparities.
Federal Research on Rural Impact: The Department of Health and Human Services (HHS) is statutorily required to analyze the possible effects of its programs and regulations, particularly those related to Medicare and Medicaid, on the quality and availability of health care for people living in rural communities. However, funding for this research is often insufficient.	ACS CAN supports resourcing HHS' Office of Rural Health Policy Development to develop specific policy proposals to improve access to care for rural residents who have serious and chronic illnesses.

Screening

People in rural communities are consistently less likely to receive recommended cancer screenings (breast, cervical, colorectal, lung, and prostate cancers) and follow-up care compared with urban residents.[5] People living in rural areas often have limited access to health care facilities, including screening facilities, oncologists and hospitals with all cancer services, which can result in worse cancer outcomes. Cancers are also more likely to be detected at later stages for rural populations than urban populations, especially for screenable cancers like

colorectal, cervical and lung cancer. Mortality from all cancers combined was 21% higher in non-metropolitan than in large metropolitan counties, with the largest differences for lung (45%) and cervical (36%) cancers – cancers that have effective prevention and early detection tools.[6]

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Self-collection: Scientific advancements have led to the creation of self-collection modalities (e.g. stool-based colorectal cancer screening, cervical cancer self-collection) that have the potential to increase access and uptake of cancer screening services and improve health outcomes. Patients can face barriers accessing these tests and consistent and appropriate follow-up care.	ACS CAN supports improving no-cost coverage for recommended self-collection modalities with follow-up care for cancer screening as an avenue to improve access and uptake for those facing access barriers, such as those living in rural communities.
Follow-on screening: Cancer screenings are a continuum and follow-up testing is necessary to resolve the question of whether an adult undergoing screening has cancer. Patients can face significant barriers, including cost, to accessing these services, which can result in delayed diagnosis and later stage cancers.	ACS CAN supports requiring all health care payers to cover follow-up testing necessary to determine whether an individual has cancer.
Cancer Prevention and Early Detection Programs: Programs like the National Breast and Cervical Cancer Early Detection Program increase screening rates for rural and other underserved communities. But the program funding levels fall short, limiting access to the program by those who are eligible.	ACS CAN supports maintaining and increasing funding for evidence-based prevention and early detection programs.

Commercial Tobacco Control

People living in rural areas in the United States have significantly higher commercial tobacco use prevalence than those in urban areas and face greater barriers to quitting, resulting in persistent disparities in preventable cancer outcomes. They are also more likely to experience exposure to secondhand smoke due to fewer smoke-free protections and experience high exposure to tobacco products and tobacco industry marketing, including targeted advertising, price discounts and greater access to tobacco retailers[7]. Youth in rural communities report higher use rates of tobacco products than their urban peers.[8] An NCI-funded study further showed that rural patients in the Midwest were three times less likely to receive cessation treatment compared with those in urban clinics. Many of the states with the greatest proportion of smoking-related cancer deaths – accounting for 1/3 of all cancer deaths caused by smoking – are also

some of the most rural.[9] These disparities highlight the urgent need to expand[10] prevention and cessation support in rural health care and community settings.

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Tobacco Cessation: Individuals have limited access to primary care providers in rural areas who can provide cessation treatment. Research[11] suggests pharmacists can successfully deliver cessation treatment, particularly if reimbursement mechanisms are established.	ACS CAN supports the expansion of cessation services in FQHCs, via telehealth, and through pharmacists, and requiring a comprehensive, barrier-free, evidence-based tobacco cessation benefit for Medicaid recipients.
Tobacco Control Program Funding: Evidence-based tobacco control programs are proven to reduce tobacco use by implementing multicomponent interventions designed to help people live tobacco-free lives. Despite higher tobacco use rates in rural areas, tobacco control programs are underfunded, and quitlines remain underutilized in rural communities.	ACS CAN supports increased and sustained funding for fact-based interventions to address tobacco use and the resulting health outcomes.

Nutrition

Research has found that food insecurity can be associated with poor diet quality, obesity and reduced fruit and vegetable intake – all risk factors for cancer.[12]Additionally, the number of cancer patients who experience food insecurity is estimated to range between 17% and 55%.[13] Supplemental Nutrition Assistance Program (SNAP) provides a greater economic return in rural communities compared to urban communities. A 2014 study found that SNAP benefit spending increased rural economic output by 1.25% and rural employment by 1.18%, compared to 0.53% and 0.50% for urban communities, respectively.[14]

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SNAP: In order to qualify for SNAP benefits, recipients must satisfy various administrative burdens, including expanded time limits and work requirements. In addition, states, many of which are already in a budget crisis, must now cover a higher percentage of the costs of the program.	ACS CAN supports increased funding for SNAP and the elimination of administrative burdens to recipients' access to these benefits. We also support a repeal of reductions of federal funds for the program.

Patient Supportive Care

Patient navigation has become increasingly recognized for improving patient outcomes, reducing unnecessary treatment costs and increasing patient satisfaction. However, patient navigation is still absent or limited in many cancer prevention and care programs and hospital settings due to cost concerns and a lack of long-term funding to pay for these services. Instead, patient navigation programs are often financed via short-term funding like private or governmental grants. These limitations could adversely impact rural healthcare settings that may be less able to sustain these services.

Issue	ACS CAN Policy
Patient Navigation Services: Rural communities lack access to the patient navigation services needed to ensure better patient experience and outcome due to a cancer diagnosis.	ACS CAN supports requiring health care payers (including health plans and federal programs such as Medicare and Medicaid) to support robust patient navigation services.
Educational materials: Patient education empowers patients and improves outcomes. However, these materials are often not designed with the unique challenges faced by rural residents in mind, nor are rural residents often made aware of the existence of these resources.	ACS CAN supports requiring health care payers (including private health plans and federal programs such as Medicare and Medicaid) to develop and disseminate evidence-based patient educational materials to educate rural residents about prevention and early detection of cancer and cancer care.
"Food is Medicine" (FIM): The inability to maintain a healthy diet because of cancer symptoms and treatment-related side effects is common and can negatively impact overall clinical outcomes. FIM interventions offer an opportunity to improve survivorship for people with cancer. 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, like cancer, and often address food and nutrition insecurity – problems that can be magnified when an individual also lives in a rural area.	ACS CAN supports policies and funding that increase access to FIM initiatives and interventions intended to prevent, treat, or manage chronic diseases, like cancer, and often address food and nutrition insecurity.

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