

119TH CONGRESS
2D SESSION

H. R. 10087

To amend title XVIII of the Social Security Act to provide for coverage of cancer care planning and coordination under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

AUGUST 13, 2026

Mr. DESAULNIER introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to provide for coverage of cancer care planning and coordination under the Medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Cancer Care Planning and Communications Act”.

6 (b) **FINDINGS.**—Congress makes the following find-
7 ings:

1 (1) Cancer care in the United States is often
2 described as the best in the world because patients
3 have access to many treatment options, including
4 cutting-edge therapies that save lives and improve
5 the quality of life.

6 (2) Access to the best treatment options is not
7 equal across all populations and in all communities.
8 The 1999 Institute of Medicine report entitled “The
9 Unequal Burden of Cancer” found that low-income
10 people often lack access to adequate cancer care and
11 that ethnic minorities have not benefitted fully from
12 cancer treatment advances.

13 (3) In addition, despite access to high-quality
14 treatment options for many, individuals with cancer
15 often do not have access to a cancer care system
16 that incorporates shared decision making and the co-
17 ordination of all elements of care.

18 (4) Cancer survivors often experience the
19 under-diagnosis and under-treatment of the symp-
20 toms of cancer and side effects of cancer treatment,
21 a problem that begins at the time of diagnosis and
22 may become more severe with disease progression
23 and at the end of life. The failure to treat the symp-
24 toms, side effects, and late effects of cancer and can-
25 cer treatment may have a serious adverse impact on

1 the health, survival, well-being, and quality of life of
2 cancer survivors.

3 (5) Individuals with cancer often do not partici-
4 pate in a shared decision-making process that con-
5 siders all treatment options and do not benefit from
6 coordination of all elements of active treatment and
7 palliative care.

8 (6) Quality cancer care should incorporate ac-
9 cess to psychosocial services and management of the
10 symptoms of cancer and the symptoms of cancer
11 treatment, including pain, nausea, vomiting, fatigue,
12 and depression.

13 (7) Quality cancer care should include a means
14 for engaging cancer survivors in a shared decision-
15 making process that produces a comprehensive care
16 summary and a plan for follow-up care after primary
17 treatment to ensure that cancer survivors have ac-
18 cess to follow-up monitoring and treatment of pos-
19 sible late effects of cancer and cancer treatment, in-
20 cluding appropriate psychosocial services.

21 (8) The Institute of Medicine report entitled
22 “Ensuring Quality Cancer Care” described the ele-
23 ments of quality care for an individual with cancer
24 to include—

1 (A) the development of initial treatment
2 recommendations by an experienced health care
3 provider;

4 (B) the development of a plan for the
5 course of treatment of the individual and com-
6 munication of the plan to the individual;

7 (C) access to the resources necessary to
8 implement the course of treatment;

9 (D) access to high-quality clinical trials;

10 (E) a mechanism to coordinate services for
11 the treatment of the individual; and

12 (F) psychosocial support services and com-
13 passionate care for the individual.

14 (9) In its report “From Cancer Patient to Can-
15 cer Survivor: Lost in Transition”, the Institute of
16 Medicine recommended that individuals with cancer
17 completing primary treatment be provided a com-
18 prehensive summary of their care along with a fol-
19 low-up survivorship plan of treatment.

20 (10) In “Cancer Care for the Whole Patient”,
21 the Institute of Medicine stated that the develop-
22 ment of a plan that includes biomedical and psycho-
23 social care should be a standard for quality cancer
24 care in any quality measurement system.

1 (11) The Commission on Cancer has encour-
2 aged survivorship care planning by making the de-
3 velopment of such plans for patients one of the
4 standards of accreditation for cancer care providers,
5 but cancer care professionals report difficulties com-
6 pleting the plans.

7 (12) Because more than half of all cancer diag-
8 noses occur among elderly Medicare beneficiaries,
9 addressing cancer care inadequacies through Medi-
10 care reforms will provide benefits to millions of
11 Americans. Providing Medicare beneficiaries more
12 routine access to cancer care plans and survivorship
13 care plans is a key to shared decision making and
14 better coordination of care.

15 (13) Important payment and delivery reforms
16 that incorporate cancer care planning and coordina-
17 tion are already being tested in the Medicare pro-
18 gram; the Oncology Care Model has been imple-
19 mented in a number of oncology practices, and addi-
20 tional models that will include care planning have
21 been proposed.

22 (14) The alternative payment models, including
23 the Oncology Care Model, provide access to cancer
24 care planning for Medicare beneficiaries who receive
25 their cancer care in practices that are part of the

1 Oncology Care Model. Other Medicare beneficiaries
2 who are not enrolled in these delivery demonstra-
3 tions may not have access to a cancer care plan or
4 appropriate care coordination.

5 (15) The failure to provide a cancer care plan
6 to patients in many care settings relates in part to
7 inadequate Medicare payment for such planning and
8 coordination services.

9 (16) Changes in Medicare payment for cancer
10 care planning and coordination will support shared
11 decision making that reviews all treatment options
12 and will contribute to improved care for individuals
13 with cancer from the time of diagnosis through the
14 end of the life. Medicare payment for cancer care
15 planning may begin a reform process that helps us
16 realize the well-planned and well-coordinated cancer
17 care that has been recommended by the Institute of
18 Medicine/National Academy of Medicine and that is
19 preferred by cancer patients across the Nation.

20 **SEC. 2. COVERAGE OF CANCER CARE PLANNING AND CO-**
21 **ORDINATION SERVICES.**

22 (a) IN GENERAL.—Section 1861 of the Social Secu-
23 rity Act (42 U.S.C. 1395x) is amended—

24 (1) in subsection (s)(2)—

1 (A) in subparagraph (JJ), by striking
2 “and” at the end;

3 (B) in subparagraph (KK), by adding
4 “and” at the end; and

5 (C) by adding at the end the following new
6 subparagraph:

7 “(LL) cancer care planning and coordination
8 services (as defined in subsection (ooo));”; and

9 (2) by adding at the end the following new sub-
10 section:

11 “Cancer Care Planning and Coordination Services

12 “(ooo)(1) The term ‘cancer care planning and coordi-
13 nation services’ means, with respect to an individual who
14 is diagnosed with cancer, the development of a treatment
15 plan by a physician, physician assistant, or nurse practi-
16 tioner that—

17 “(A) includes each component of the Institute
18 of Medicine Care Management Plan (as described in
19 the article entitled ‘Delivering High-Quality Cancer
20 Care: Charting a New Course for a System in Crisis’
21 published by the Institute of Medicine);

22 “(B) is furnished in written form or electroni-
23 cally, at the visit of such individual with such physi-
24 cian, physician assistant, or nurse practitioner, or as
25 soon after the date of the visit as practicable; and

1 “(C) is furnished, to the greatest extent prac-
 2 ticable, in an appropriate form that appropriately
 3 takes into account cultural and linguistic needs of
 4 the individual in order to make the plan accessible
 5 to the individual.

6 “(2) The Secretary shall establish frequencies at
 7 which services described in paragraph (1) may be fur-
 8 nished, provided that such services may be furnished with
 9 respect to an individual—

10 “(A) at the time such individual is diagnosed
 11 with cancer for purposes of planning treatment;

12 “(B) if there is a change in the condition of
 13 such individual or such individual’s treatment pref-
 14 erences;

15 “(C) at the end of active treatment and begin-
 16 ning of survivorship care; and

17 “(D) if there is a recurrence of such cancer.”.

18 (b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—

19 (1) IN GENERAL.—Section 1848(j)(3) of the
 20 Social Security Act (42 U.S.C. 1395w–4(j)(3)) is
 21 amended by inserting “(2)(LL),” after “health risk
 22 assessment),”.

23 (2) INITIAL RATES.—Unless the Secretary oth-
 24 erwise provides, the payment rate specified under
 25 the physician fee schedule under the amendment

1 made by paragraph (1) for cancer care planning and
2 coordination services shall be the same payment rate
3 as provided for transitional care management serv-
4 ices (as defined in CPT code 99496).

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to services furnished on or after
7 the first day of the first calendar year that begins after
8 the date of the enactment of this Act.

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