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June 22, 2015

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

Re: ACS CAN Recommendations to the Senate Finance Committee's Chronic Care Working Group

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to provide recommendations to the Senate Finance Committee's chronic care working group on ways to improve Medicare for beneficiaries with chronic conditions. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN applauds the Senate Finance Committee, and the Chronic Care Working Group, for its efforts to craft policies that will transform the Medicare program to provide better care for individuals with chronic conditions, such as cancer.

According to the Centers for Medicare and Medicaid Services (CMS) more than two-thirds of Medicare beneficiaries have two or more chronic conditions. This number will continue to increase as the population ages. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care – utilizing more physician, hospital, post-acute, and home health services – than other beneficiaries. In 2010, beneficiaries with two or more chronic conditions accounted for nearly 98 percent of Medicare hospital readmissions.[1] This excess

[1] Centers for Medicare and Medicaid Services, Chronic Conditions Among Medicare Beneficiaries. Chartbook, 2012 Edition. Baltimore, MD. 2012.

utilization – and the associated increased costs to Medicare – could be reduced if the Medicare program changes the way it delivers and pays for services.

Medicare provides a critical source of health care coverage for millions of Americans but as it is currently structured the program does not encourage the kind of seamless care that beneficiaries with chronic conditions like cancer most need. There currently is little incentive for Medicare to foster integration across various sites of care or collaboration among providers. The program does not always utilize technology in ways that help to improve care. There are still gaps in coverage and Medicare is not yet a model of genuine patient-centered care.

The Centers for Medicare and Medicaid Innovations (CMMI) is currently testing a number of payment and delivery models that could help to improve Medicare. In addition, earlier this year the HHS Secretary announced the intent to move thirty percent of Medicare payments into alternative payment models. We applaud these efforts and believe that even more can be done to transform Medicare into a truly patient-centered program.

As the Working Group moves forward with its task to modernize Medicare, we encourage you to consider some guiding principles to help ensure that Medicare meets the needs of patients with chronic conditions:

- Medicare delivery models should guarantee that patients with chronic illness like cancer have access to the full range of providers, practitioners, items and services required to address their healthcare-related needs;

- Medicare should remain affordable and protect patients from catastrophic out-of-pocket financial costs;

- Medicare's payment should incentivize practitioners to provide high quality care, encourage care coordination, patient navigation, palliative care and appropriate care transitions;

- New Medicare payment and delivery models should reduce inequities and disparities in care;

- Medicare delivery models should incentivize a greater use of technology to ensure seamless care;

- Medicare beneficiaries with chronic conditions should receive care that is consistent with the latest practice guidelines or comparable clinical standards;

- Medicare should provide comprehensive coverage of all evidence-based preventive services with no cost-sharing to the patient;

- Medicare should ensure that throughout the continuum of care, the patient is a partner in decisions about their treatment options, including the settings of care; and

- Medicare should continue to systematically measure the success of new delivery and payment models and require high performance on both clinical quality and patient experience metrics that become more rigorous over time.

ACS CAN is pleased to offer specific recommendations for the Working Group and the Committee to consider.

Seamless Transitions of Care

The current fee-for-service Medicare program fails to address the needs of beneficiaries with chronic conditions. As a result, these vulnerable beneficiaries often "fall through the cracks". While some integrated health plans help beneficiaries move from one phase of care to another most Medicare beneficiaries are still left on their own to figure out the next steps in their care. This lack of care transition planning may result in beneficiaries not following through with necessary treatment or drug regimens. Further, a cancer patient's primary care physician may not even know that the patient has been to one or more specialists. Beneficiaries and their providers are left to cobble together care in an often haphazard fashion.

Fortunately, there is an opportunity for Medicare to provide more seamless transitions of care for patients with chronic conditions, like cancer, that would not only improve the delivery of care but also enable practitioners to treat the "the whole patient." There are specific tools that we believe would improve care transitions in the Medicare program. These include:

Care Coordination: Medicare beneficiaries with cancer often require a range of services – including oncology care, specialty care and primary care – and have to navigate between multiple providers in different care settings through the course of their treatment. This situation is not unique to cancer – patients with other chronic conditions face similar challenges.

Research has shown that effective care coordination at each phase along the continuum of cancer care is vitally important for patients.[2] Care coordination allows for deliberate organizing of patient care, ensuring that the patients' needs are communicated at the appropriate time

[2] Hewitt M, Greenfield S, Stovall, eds. Committee on Cancer Survivorship: Improving Care and Quality of Life, Institute of Medicine, National Research Council. *From Cancer Patient to Cancer Survivor: Lost in Translation.* Washington, DC: National Academies Press; 2006.

and to the appropriate person which in turn allows for safer and more effective care.[3] Conversely, a lack of care coordination for cancer patients has been shown to result in lower quality of care for cancer patients.[4]

Medicare should incentivize care coordination for all beneficiaries – regardless of whether they choose a Medicare Advantage plan, a new model like an Accountable Care Organization, or remain in traditional fee-for-service. For instance, an oncologist should be incentivized to maintain an ongoing dialogue with a cancer patient's primary care physician and other health care providers to ensure that the patient's non-cancer health care issues are addressed during her cancer treatments.

Palliative Care: Another vital tool for improved patient care in Medicare is palliative care. We urge the Working Group to provide greater access to palliative care services for beneficiaries with chronic care needs. Palliative care teams – including both physician and non-physician providers – work with patients to mitigate the burden of their disease and/or treatment regimens. Depending on the individual needs of the patient, palliative care teams provide help to more effectively manage the care of seriously ill patients throughout the care continuum starting at point of diagnosis including: education about pain management, facilitation of support systems for the patient and the family on-call physician, advance practice nurse symptom management consultations for home-bound patients, review of treatment protocols that are taking place (including reviewing medications, oxygen regimen, skin care, titration process, and other services), education of family members; and, if necessary, face-to-face evaluations for suggested hospice eligibility for patients with advanced disease.

Palliative care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. Evidence suggests that palliative care should be offered at the point of diagnosis.[5] Research also has demonstrated that the use of palliative care services improves the quality of care for individuals. For example, a 2010 study comparing individuals with metastatic non-small-cell lung cancer who received palliative care services early after diagnosis had a better quality of life compared to those who did not receive the service.[6] The

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[3] Care Coordination. May 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

[4] Bowles EJA, Tuzzio L, Wiese CJ, et al. Understanding High-Quality Cancer Care: A Summary of Expert Perspectives. *Cancer*, 2008; 112(4): 934-942.

[5] Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. J Clinical Oncol 2012; 30: 880-887.

[6] 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.

use of palliative care also has been shown to reduce health care costs. Individuals whose care is managed by palliative care professionals have reduced hospitalizations or re-hospitalizations.[7,8]

Unfortunately the existing fee-for-service Medicare program construct does not support expanded access to palliative care services. The existing Medicare codes fail to adequately support palliative care services. Few codes exist, and the existing codes contain limitations on the frequency of use. Non-physician members of the palliative care team are often prohibited from directly billing Medicare for their services. Currently, reimbursement levels are woefully inadequate to compensate all members of the inter-disciplinary palliative care team. We urge the Working Group to craft policies that support the interdisciplinary nature of the palliative care team, including payment for non-physician providers such as social workers who provide counseling services for patients and their families.

In addition, palliative care services are available in limited settings such as in-patient and hospice programs. We urge the Working Group to ensure that non-hospice beneficiaries who reside in the community setting have access to palliative care services.

Finally, while we support the inclusion of quality measures into the Medicare program, we note that currently there aren't any palliative related measures in the Medicare Advantage Five-Star Quality Rating System or the Medicare Shared Savings Program. While the Hospital Inpatient Quality Reporting Program includes patient experience from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), this survey does not capture patient experience from those who were too sick to participate in the survey or who died in the hospital. The National Quality Forum (NQF) Measures Application Partnership has repeatedly cited palliative care as a "high leverage" measure gap, and the Institute of Medicine's Report "Dying in America" also stressed measurement in this area. We urge the Working Group to work with CMS to ensure that palliative care quality measures are included in all of Medicare's quality-based performance programs.

Palliative Care Hospice Education and Training Act: ACS CAN also supports the Palliative Care Hospice Education and Training Act, which addresses three additional policy objectives that would help to ensure that more individuals have access to palliative care services by addressing the need to train more physicians, nurses, social workers, and other health professionals in the medical subspecialty of palliative care, the need to educate the public and providers about the availability of palliative care, and the need for a greater investment in evidence based research

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[7] Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, Tangeman T, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs* 30(3)454-463 (2011).

[8] Morrison RS, Penrod JD, Cassel JB, Caust-Ellenborgen M, Litke A, Spragens L, Meier DE. Cost savings associated with hospital palliative care consultation programs. *Arch Intern Med* 168(16)1783-1790 (2008).

specific to palliative care, and symptom management. The legislation was introduced in the 113th Congress and is expected to be re-introduced shortly. We recognize the legislation is outside the scope of the Senate Finance Committee, but its subject is germane to the scope of the Working Group as it works to ensure that Medicare beneficiaries are provided better quality of care through the use of palliative care services. We urge the Working Group to consider this legislation as you develop policy proposals to improve the Medicare program for beneficiaries with chronic care needs.

Patient Navigation: Another vital tool for eliminating fragmentation of care is patient navigation. When a Medicare beneficiary hears the devastating words "You have cancer" it is the beginning of a long and often complicated journey through the health care system. It is a journey best taken with an experienced navigator that can help the patient through each phase of treatment.

Patient navigation services are an effective means of integrating care for patients with chronic conditions and are particularly useful for beneficiaries with limited health literacy. These services provide an important channel for people to get more timely access to care including screenings that lead to earlier diagnosis and treatment. Navigators coordinate services, educate patients about care regimens and follow-up, improve communications between patients and practitioners, assist with informed patient decision making and play a critical role in guiding patients across disconnected systems of care. Patient navigators also help physician practices to run more efficiently by being the point of contact for patients with questions or for those who need extra time.

The National Patient Navigation Research Program, a trial of over 10,000 women and men with abnormal cancer screening and over 3,000 patients with diagnosed cancers and precancerous conditions, found that patient navigation had a positive effect on reducing delays in care and increased by 20 percent the proportion of patients completing diagnostic care.[9] Other research has shown that health systems that used patient navigators had better patient health outcomes and reduced health care expenditures through lower hospital readmissions or admissions, improved timely diagnostic resolution and prescription drug adherence.[10]

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[9] Freund K, Battaglia T, Calhoun E, et. al. Impact of patient navigation on timely cancer care: the patient navigation research program. *Journal of the National Cancer Institute* 2014 106(6) doi: 10.1093/jnci/dju115.

[10] Jandorf L, Stossel LM, Cooperman JL, GraffZivin J, Ladabaum U, Hall D, Thélémaque LD, Redd W, Itzkowitz SH. Cost analysis of a patient navigation system to increase screening colonoscopy adherence among urban minorities. *Cancer* 2013 Feb 1; 119(3):612-20; Donaldson EA, Holtgrave DR, Duffin RA, Feltner F, Funderburk W, Freeman HP. Patient navigation for breast and colorectal cancer in 3 community hospital settings: an economic evaluation. *Cancer* 2012 Oct 1;118(19):4851-9.

Currently Medicare does not pay for navigation services. The Oncology Bundled Payment Initiative recently released by the CMMI includes navigation as one of the services in the bundle but it leaves it up to individual physician practices to determine the level of service. We urge the Working Group to consider including Medicare coverage of navigation services – particularly in any new delivery or payment model. These services would include the delivery of current and customized diagnosis and treatment information that ensured patient understanding and informed decision making; the connection of patients to useful and available community services; consistent support and monitoring of care plans; and, an overall determination of the needed services to be used to remove barriers to care including transportation, lodging, health insurance, cultural, and language barriers. Further, we urge the Working Group to consider having Medicare measure the success of navigation services.

Greater Use of Health Information Technology: Health information technology (HIT), while still evolving, can help to foster better care coordination and support patient navigation services for Transitions of Care. Cancer patients often receive fragmented and uncoordinated care because of the multiple clinicians and other medical professionals involved in their care. Therefore, care that is coordinated requires access to all of a patient's data by all of her providers, an essential function that electronic health records (EHRs) can provide. Stage 3 Meaningful Use measures have taken steps forward to achieving this goal, such as requiring providers to incorporate a Summary of Care (SoC) into a patient's EHR following referrals. To further build on these measures, we recommend the survivorship plan also be included in the SoC following the patient transition from the oncologist to the primary care physician. SoCs that include a survivorship plan and are incorporated within the EHR can prompt the primary care physician when follow up care is needed before, during, or after a patient visit. This can ensure the patient receives the appropriate care and reduce physician burden by engaging relevant care team members at the prescribed moment without having to manually search the survivorship plan.

Despite any recommendations, the current lack of interoperability and information blocking across providers and health systems must be addressed to achieve the potential benefits of HIT. ACS CAN urges the Working Group to work with the Office of the National Coordinator to ensure that all consumers have the ability to access lab results, care summaries and plans, as well as the ability to view upcoming appointments and other functionalities made available by EHRs.

Survivorship or Post Treatment Planning: For patients with chronic illness transitioning from specialty care back to primary care there is a critical need for chronic disease self-management care planning. In the case of cancer patients, this kind of post treatment planning is commonly referred to as a survivorship plan. For cancer patients who have successfully completed treatment, survivorship care planning will entail scheduling required screening tests, physical therapy if necessary, oncology nutrition services, access to and an understanding of maintenance drugs, and a plan for health promotion (diet, exercise, weight management) to reduce risk of late effects of cancer (e.g., Endocrine problems). Successful models of survivorship planning are cropping up at some hospitals. An excellent example is the survivorship planning program at Paoli Hospital in Pennsylvania. Oncologists refer their post-treatment patients for care planning and the results have been impressive – greater adherence to post-treatment plans, an opportunity for patients to engage with the nurse when questions arise, and greater patient involvement in their care.

Beginning January 1, 2015, Medicare began to pay for non-face-to-face care management services furnished to Medicare beneficiaries with multiple chronic conditions. While it is too soon to evaluate the effectiveness of the program, we urge the Working Group to consider Medicare payment for in-person care planning visits.

Transition into the Medicare program: Care coordination also is vitally important as beneficiaries transition into Medicare or in instances where beneficiaries may experience a change in supplemental coverage. There are limits on when beneficiaries can enroll in the Medicare program. Unfortunately these "special enrollment periods" have not always been updated to reflect the existing health care landscape. For example, an individual otherwise entitled to enroll in Medicare who elects COBRA coverage is not granted a special enrollment into the Medicare program once her COBRA coverage expires. In addition, there exist some outstanding questions regarding the transition from coverage through Marketplace qualified health plans and Medicare. We urge the Working Group to examine these transitions and provide greater beneficiary protections.

Eliminating Barriers to Prevention and Health Promotion

A large number of chronic conditions can be prevented through lifestyle choices and screening tests. Preventive services are an important component to prevent cancer, can prevent the recurrence of cancer, and can help to reduce costs system wide. According to the American Cancer Society, avoiding the use of tobacco products, maintaining a healthy weight, staying physically active, eating a healthy diet, and using recommended screening tests can reduce an individual's risk of developing and dying from cancer.[11] Unfortunately, there are barriers that impede individuals' access to screenings and other preventive services.

Under the Affordable Care Act, Medicare waives cost-sharing for covered United States Preventive Services Task Force (USPSTF) recommendations that receive an "A" or "B" rating. While this removed a major barrier for beneficiaries' access to these services, gaps still exist in coverage, access, and cost. It is important that Medicare provides all beneficiaries with consistent and comprehensive coverage for all the required preventive services that receive and A or B rating from the USPSTF[12] – particularly as they relate to cancer screenings (including lung cancer, cervical cancer, colorectal cancer, and breast cancer), tobacco cessation, and obesity screening and behavioral interventions, all of which are key components of cancer prevention. We urge the Working Group to require Medicare cover all USPSTF "A" and "B" recommended services with no cost-sharing and ensure coverage determinations are clear, consistent and comprehensive for the program, providers, and patients. This clarity will benefit not only the Medicare population, but also qualified health plans which are likewise required to provide coverage for USPSTF recommendations.

Tobacco cessation: The use of tobacco is the number one cause of preventable death in the United States, killing more than 480,000 Americans each year. At least 30 percent of the 589,430 cancer deaths expected to occur this year will be caused by tobacco use.[13] People who quit using tobacco, regardless of their age, can be expected to live a longer and healthier life than individuals who continue to use tobacco products.[14] Individuals often need different tools to help them to be successful in their tobacco cessation goals. Research shows that use of both

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[11] American Cancer Society, Cancer Prevention & Early Detection: Facts & Figures 2015-2016, available at http://www.cancer.org/acs/groups/content/@research/documents/webcontent/acspc-045101.pdf.
[12] United States Preventive Services Task Force, USPSTF A and B Recommendations by Date, http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/.
[13] American Cancer Society, Cancer Facts & Figures 2015, available at http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-044552.pdf.
[14] U.S. Department of Health and Human Services. *The Health Benefits of Smoking Cessation: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1990.

counseling and pharmacotherapy in combination is more effective than either on its own.[15] Medicare provides coverage of tobacco cessation drugs and counseling limited to eight face-to-face sessions a year. We are concerned the current coverage requirements are insufficient. We urge the Working Group to remove barriers to accessing all tobacco cessation options, including extending coverage to telephone counseling and self-help materials and remove all limits on treatment sessions. Medicare must provide coverage for multiple provider-individual discussions as may be necessary. It often takes an individual several attempts before she quits tobacco use completely.[16] Ongoing access to recommended pharmacotherapy and counseling support increases the likelihood that a quit attempt will be successful which, in turn, could not only improve an individual's health but help to lower costs in the system.

Weight management and physical activity: For the majority of Americans who do not use tobacco products, weight management, good nutrition, and physical activity are the greatest modifiable determinations of cancer risk.[17] Approximately one fourth to one third of cancer cases and one third of cancer deaths are due to overweight and obesity, poor nutrition, and physical inactivity.[18] Individuals who are overweight or obese have an increased risk of cancer incidence and recurrence, as well as a decreased risk of survival of cancer.[19]

While Medicare covers intensive behavioral therapy for obesity, the current coverage guidelines provide insufficient access to evidence-based interventions by the full range of qualified treatment providers and in all settings where intensive behavioral interventions for weight management and improved diet are likely to be offered. We urge the Working Group to expand Medicare coverage of evidence-based behavioral interventions for weight management to include additional treatment providers – including registered dietitians – and settings in which the behavioral interventions could take place, including independent and community-based facilities, outpatient hospital settings, skilled nursing facilities, and inpatient rehabilitation facilities.

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[15] U.S. Department of Health and Human Services. Public Health Service. *Treating Tobacco Use and Dependence: 2008 Update.* May 2008. Available at http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/treating_tobacco_use08.pdf.

[16] Centers for Disease Control and Prevention. Quitting Smoking Among Adults—United States, 2001–2010. Morbidity and Mortality Weekly Report 2011;60(44):1513–19.

[17] Kushi LH, Doyle C, McCullough M, et al. and the American Cancer Society 2010 Nutrition and Physical Activity Guidelines Advisory Committee. American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention. *CA Cancer J Clin* 2012;62:30-67.

[18] American Cancer Society, Cancer Facts & Figures 2014.

[19] Kuski, et al.

Cancer screening continuum: In addition to lifestyle changes, a key component to preventive care is access to cancer screenings that help detect a cancer before it has the opportunity to grow and spread; and, in the case of cervical and colorectal cancer screening, prevent cancer altogether by removing precancerous lesions. Unfortunately there exists a lack of clarity regarding coverage of multiple cancer screenings. Where a cancer screening can be conducted through multiple tests (for example, colorectal cancer screening which be conducted through a fecal occult blood test (FOBT), flexible sigmoidoscopy, double contrast barium enema, colonoscopy, or CT colonography) it is unclear the extent to which multiple forms of screening are covered or how CMS defines the screening continuum. We urge the Working Group to require that all cancer screening tests (including multiple types of test, where medically appropriate) be covered without cost-sharing obligations to the beneficiary. Given the importance of cancer screenings, this policy should extend to individuals in non-Medicare covered plans as well.

Medicare coverage of colorectal cancer screenings: Colorectal cancer is one of the most preventable forms of cancer. Unfortunately colorectal cancer also is the second leading cause of cancer death among both men and women in the United States. In 2015, more than 130,000 new cases will be diagnosed and about 50,000 deaths will be caused by colon cancer. Yet many Americans do not receive colorectal screenings as recommended, and one in three adults between the ages of 50 to 75 are not up-to-date with screening recommendations.[20] Affordability is the number one reason cited by unscreened individuals for not getting screened for colorectal cancer.[21]

Currently Medicare covers screening colonoscopies with no cost-sharing to the beneficiary. However, there are two major barriers still faced by beneficiaries seeking colorectal cancer screening in Medicare. First, beneficiaries who receive a screening colonoscopy that involves the removal of one or more precancerous polyps will be assessed a copayment because under Medicare rules the removal of the polyp is a diagnostic – not screening – procedure. While this loophole has been fixed for individuals enrolled in qualified health plans, Congressional action is required to ensure that this barrier to colonoscopies is removed for Medicare beneficiaries as well. We urge the Working Group to include the bipartisan Removing Barriers to Colorectal Cancer Screening Act (S. 624) in its final recommendations.

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[20] CDC. Prevalence of colorectal cancer screening among adults—Behavioral Risk Factor Surveillance System, United States, 2012. MMWR 2013; Vol. 62.

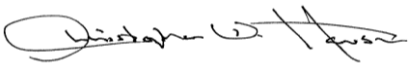
[21] 2014 American Cancer Society Market Research: http://nccrt.org/wp-content/uploads/CRC-Communications-Guidebook-final-v4-02232015.pdf (accessed May 14, 2015)

Similarly, when a patient chooses a stool test first and the test comes back positive, cost-sharing applies to the follow up colonoscopy required to complete the screening process even if nothing is found. About five to ten percent of high sensitivity stool tests are positive and must be followed with a colonoscopy screening.[22] This scenario has the potential to drive cost-sensitive patients to choose the more expensive colonoscopy as a first line screening exam, or it may lead them to forego colorectal cancer screening altogether. It also makes it hard for public health advocates to recommend high sensitivity stool testing to cost-sensitive Medicare beneficiaries, knowing that if the patient starts with stool testing, cost may prohibit them from getting the needed follow up exam. We therefore urge the Working Group to work closely with CMS to address this issue.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to provide comments to the Senate Finance Committee's Chronic Care Working Group. If you have any questions, please feel free to contact me or have your staff contact Keysha Brooks-Coley, Director of Federal Relations at Keysha.Brooks-Coley@cancer.org or 202-661-5720.

Sincerely,



Christopher W. Hansen
President
American Cancer Society Cancer Action Network

[22] Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. An Intern Med 2008;149:627-37.