American Cancer Society
Cancer Action Network
555 11th Street, NW
Suite 300
Washington, DC 20004
202.661.5700
www.fightcancer.org

December 18, 2019

The Honorable Alex Azar
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Division of TennCare; TennCare II Demonstration; Amendment 42 Draft – Modified Block Grant and Accountability

Dear Secretary Azar:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Tennessee's Medicaid Section 1115 demonstration amendment and extension application. 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 nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN appreciates Tennessee's goal of promoting the health of low-income Tennesseans, but we oppose any proposal to block grant the Medicaid program and have serious concerns about the requested "flexibilities" for running the program. Over 37,350 Tennesseans are expected to be diagnosed with cancer in 2019[1] and there are nearly 326,530 cancer survivors in the state[2] – many of whom are receiving health care coverage through the TennCare program. ACS CAN wants to ensure that cancer patients and survivors in Tennessee will have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer.

The proposed block grant and operational flexibilities could seriously limit eligibility and access to care for some of the most vulnerable Tennesseans, including those with cancer, cancer survivors, and those who will be diagnosed with the disease. We strongly urge the Centers for Medicare and Medicaid Services (CMS or the "Department") to consider stakeholder comments and reject Tennessee's block grant waiver.

Following are our specific recommendations for the TennCare waiver application:

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[1] American Cancer Society. *Cancer Facts & Figures 2019*. Atlanta, GA: American Cancer Society; 2019.
[2] American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2019-2021*. Atlanta, GA: American Cancer Society; 2019.

Proposed Financing Model

Block Grant Structure

ACS CAN strongly opposes Tennessee's proposal to change the Medicaid financing structure to a block grant. This proposal would fundamentally alter the Medicaid program in Tennessee, shifting the funding from a percentage match, whereby the program's funding adjusts automatically to account for the number of enrollees and rising health care costs, to one where annual funding for the program would be capped. We understand that the state is asking for additional block grant funding from the federal government on a per capita basis if enrollment increases past the baseline calculation, but we believe this will still not meet the needs of low-income Tennesseans. A block grant could significantly reduce low-income cancer patients', survivors', and their families' access to affordable, comprehensive health care in the state.

Block Grants Unable to Respond to Unexpected Medical Cost Growth

Tennessee's block grant would be based on *historical* (pre-TennCare) spending per enrollee category and inflated annually using a pre-determined growth rate (Tennessee has chosen an inflation factor based on the Congressional Budget Office's (CBO) projections for growth in Medicaid spending). Health care costs are often greater than projected, as increases in medical expenses and health coverage needs are difficult to predict in advance. For example, a new breakthrough cancer treatment or an unexpected health care emergency could cause health care costs to increase significantly. If projected costs are more than estimated in the base period enrollment the state would be left paying a greater portion of the costs than they would under a federal match, putting significant pressure on the state's budget. In 2017, the non-partisan CBO estimated that applying a block grant would significantly reduce federal Medicaid revenue to states and lead to an estimated three quarters of program enrollees becoming uninsured from 2019 to 2026.[3] The likelihood of more Tennesseans becoming uninsured should concern the Department, as this would be counter to the objective of the Medicaid program, which is to improve the health and wellness needs of vulnerable and low-income individuals and families.[4]

Additionally, economic downturns or a major state disaster could create greater need for Medicaid coverage among state residents. Even if CMS were to approve the block grant increase with enrollment increases in the state, the state could still be responsible for costs above those garnered through enrollment increases. Currently, when these unexpected incidents occur the federal match automatically adjusts to cover additional state spending needs. If CMS approves the block grant, but not the state's requested enrollment increases from the cap, Tennessee could face even greater financial strain due to a significant decrease of federal Medicaid funds. If the federal funds are exhausted, the state may have no choice due to funding constraints other than to simply stop providing or limit coverage and/or services until the next year's block grant becomes available, leaving many beneficiaries – including those with cancer – without access to lifesaving medical care and cancer treatment, decreasing their health outcomes (which would be contrary to the stated goal of the state's waiver application and to CMS' objectives for the Medicaid program).

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[3] Congressional Budget Office. *Impose caps on federal spending for Medicaid. Budget Options*. Published December 8, 2016. Accessed December 2019. https://www.cbo.gov/budget-options/2016/52229.

[4] Medicaid.gov. About section 1115 demonstrations. Accessed December 2019. https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

Tennessee's application requests that CMS allow the state to exclude certain expenses from the block grant calculation and continue to be financed through the federal match structure, including: (1) services that are currently carved out of the state's 1115 demonstration waiver; (2) outpatient prescription drugs; (3) certain payments made directly to hospitals; (4) payments made on behalf of individuals who are dually eligible for the Medicare and Medicaid programs; and (5) administrative expenses. This is a clear acknowledgement from the state that a block grant financing structure does not protect the state nor its Medicaid beneficiaries, including cancer patients and survivors, from financial risk from medical or other unexpected events. These requested exceptions are not sufficient to protect the state if healthcare costs grow above the block grant amount. Therefore, CMS should consider the negative and detrimental impact a block grant could have on Tennessee's budget, which would harm state residents, local hospitals, and health care systems.

Block Grants Mean Reduced Federal Funds for Hospitals, Providers, and Health Centers

We are concerned the state may choose to cut payments to providers to help keep spending under the new block grant amount so that they can "share" the resulting savings with the federal government.[5] These cuts could make it harder for patients with serious and chronic health conditions – who rely on prompt access to primary care providers as well as specialists – to access providers who can help them find the best treatments and manage their conditions. If the state reduced provider payments, it is very likely that fewer providers would participate in the program or they would stop taking new Medicaid patients, seriously limiting enrollees' access to care. Providers operating in low-income and rural areas in Tennessee, which traditionally have a high number of Medicaid enrollees and uninsured individuals, would likely be impacted the most. Reduced provider payments could also contribute to more hospital closures in the state and have a deleterious impact on access for Medicaid enrollees.

In addition, reduced federal financial support through a block grant could result in a shift of additional costs to Tennessee hospitals, health systems, providers, and enrollees through increased uncompensated care. Many public hospitals, children's hospitals, rural providers, and federally qualified health centers (FQHCs) make up the safety net for low-income individuals and families, including those battling cancer. These health systems greatly rely on Medicaid revenue to provide services. There are 29 community health center organizations in Tennessee[6] that serve nine percent of Medicaid beneficiaries in the state and 22 percent of the state's uninsured.[7] Without current federal and state funding levels, hospital systems, community health centers, and providers may have to limit the number of Medicaid or uninsured patients they treat due to lower reimbursement rates and higher uncompensated care costs. Not only would this mean reduced access for Medicaid beneficiaries and the uninsured, but it could also hinder efforts to improve health outcomes in the state – which would be antithetical to the state's goal to continue to improve the health of its residents through the waiver. Again, CMS should consider the

[5] The state proposes that in any year in which the state underspends its block grant, the state and the federal government share 50/50 in the resulting savings. This proposal is discussed more below under "Other Proposals of Concern."

[6] National Association of Community Health Centers. Community Health Center Chartbook. Published January 2019. Accessed December 2019. http://www.nachc.org/wp-content/uploads/2019/01/Community-Health-Center-Chartbook-FINAL-1.28.19.pdf.

[7] Ibid.

impact a block grant structure would have on Tennessee residents, Medicaid beneficiaries, and health care systems in the state.

State Flexibilities

Tennessee is requesting unprecedented flexibilities without the need for federal approval as part of its block grant model. The state is also requesting these flexibilities apply to those exempt populations for which the state would continue to receive regular FMAP. The state notes that "it is not the intention of the state to enumerate in detail in this document every innovation, reform, or policy change that might take place over the life of the demonstration, since the purpose of the block grant is precisely to give the state a range of autonomy within which it can make decisions about its Medicaid program."[8] At the same time, the state waiver application states that these flexibilities will only be used when adding services or benefits. While we appreciate the clarification, ACS CAN fears that by providing unlimited flexibility – without seemingly any CMS oversight – there is little preventing the state at some point in the future from imposing additional barriers to important services in order to save state dollars, making it more difficult for patients to access the care they need.

The waiver application goes on to say that the Department "will work with CMS to determine what reporting processes (*if any*) [emphasis added] are necessary in order to keep CMS adequately apprised on the progress of the state's demonstration; however, consistent with the conceptual framework of the block grant, routine programmatic changes will not require CMS approval."[9] ACS CAN is extremely concerned with the state's request to not need CMS approval for reporting or programmatic changes to the demonstration. These requirements, which are included in statute and not waivable under the 1115 waiver process, are necessary to ensure the public and stakeholders can weigh in on any proposed changes made by the state, whether it be an addition or subtraction of benefits or services. The requirements also provide a check and balance on the states' demonstration to ensure that the demonstration is improving the health outcomes of Tennessee residents, as the state hypothesizes it will, rather than harming enrollees. We are also concerned that the waiver does not enumerate the criteria under which it would consider a policy change to be a "programmatic change" that would not warrant additional CMS review. Therefore, we urge CMS to reject the state's request for these unprecedented flexibilities from federal requirements that are meant to protect beneficiaries from harmful proposals.

Block Grants Could Restrict Eligibility, Enrollment, or Benefits Guaranteed by Medicaid

The state suggests that block grants provide the state with greater flexibility in administering the Medicaid program in a way that is more relevant to its residents, but that "it is not its intent under this proposal to reduce benefits for members below their current levels."[10] Because the state may see a significant reduction in overall federal funding under a block grant, the state may be forced to use other cost-saving measures that are otherwise prohibited by the current Medicaid program, particularly if CMS does not approve the enrollment funding increase, including enrollment freezes, waiting lists, and increased cost sharing for impacted beneficiaries. This is antithetical to the purpose of the Medicaid program, which is to provide comprehensive health coverage to low-income individuals that need it.

[8] Waiver application at 13.
[9] Ibid.
[10] Waiver application at 17.

Multiple studies have shown that individuals are less likely to seek health services, including life-saving preventive screenings (e.g., mammograms and colonoscopies), when they must pay for those services out-of-pocket.[11,12,13] Deterring a low-income person from care could result in higher costs later, which the state may have to bear and which could negatively impact the federal government in the long term.

For a person with cancer, enrollment freezes, waiting lists, and out-of-pocket cost sharing could mean a later-stage diagnosis when treatment costs are higher, and survival is less likely. Ultimately, block granting Medicaid raises serious issues about the program's ability to offer low-income Tennesseans quality, affordable, and comprehensive health care coverage, particularly for those suffering from cancer. Therefore, we strongly urge the Department to consider the impact this proposal could have on low-income cancer patients and survivors who need health care coverage to fight and hopefully survive their disease and to deny the state from moving forward with this harmful proposal.

Freedom to Use the Same Tools as Medicare and Commercial Payers to Lower Drug Costs
Closed formulary: Citing the need for "basic formulary management commonly used by other payers to manage prescription drug spending", Tennessee proposes to adopt a "commercial-style" closed formulary with at least one drug available per therapeutic class.

ACS CAN opposes the proposal to adopt a closed drug formulary for TennCare. There is no single oncology drug that is medically appropriate to treat all cancers. Cancer is not just one disease, but hundreds of diseases. Cancer tumors respond different depending on the type of cancer, stage of diagnosis, and other factors. As such, oncology drugs often have different indications, different mechanisms of action, and different side effects – all of which need to be managed to fit the medical needs of an individual. Oncologists take into consideration multiple factors related to expected clinical benefit and risks of oncology therapies and the patient's clinical profile when making treatment decisions. For example, one fourth of cancer patients have a diagnosis of clinical depression,[14] which may be managed with pharmaceutical interventions that may limit cancer treatment options because of drug interactions or side effects. As such, when enrollees are in active cancer treatment, it can be particularly challenging to manage co-morbid conditions.

Allowing for the use of a closed formulary would severely restrict a physician's ability to prescribe the medically appropriate treatment for an individual without going through a lengthy appeals process. Denying enrollees access to medically appropriate therapies can result in negative health outcomes, which can increase Medicaid costs in the form of higher physician and/or hospital services to address the negative health outcomes.

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[11] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost sharing on the use of preventive services. *Health Services Research.* 2000; 34: 1331-50.
[12] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care.* 2011; 49: 865-71.
[13] Trivedi AN, Rakowsi W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med.* 2008; 358: 375-83.
[14] American Cancer Society, *Coping with Cancer: Anxiety, Fear, and Depression*. Available at https://www.cancer.org/treatment/treatments-and-side-effects/emotional-side-effects/anxiety-feardepression.html.

Impact on tobacco cessation: ACS CAN is also concerned about the implications a closed formulary will have on individuals' access to smoking cessation products. Currently, there are seven Food and Drug Administration (FDA)-approved tobacco cessation medications available to help people quit. Multiple options are necessary because different treatments work for different people. Tobacco users are disproportionately low-income[15] and have a higher risk for chronic diseases associated with tobacco addiction, including lung cancer.[16] Limiting access to a panoply of tobacco cessation products will hinder individuals' ability to break their dependence on tobacco.

Tennessee's request to duplicate FDA process: In addition, the waiver proposes to have the flexibility to exclude new drugs from its formulary "until market prices are consistent with prudent fiscal administration or the state determines that sufficient data exist regarding the cost effectiveness of the drug."[17] We are concerned that this policy would hinder cancer patients' access to innovative cancer therapies. Additionally, "until market prices are consistent with prudent fiscal administration" is a completely arbitrary designation and would allow the state to essentially make up their own definition of what they consider to be a "prudent fiscal administration."

The FDA is the world standard for drug approval. The agency employs physicians, statisticians, chemists, pharmacologists, and other scientists to ensure that drugs that are approved can clinically demonstrate safety and effectiveness.[18] The agency also invests significant resources in research, development, and technology to aid in this evaluation and review process. The waiver appears to seek to allow the state to supplant the FDA's federal role in drug safety and effectiveness. This creates an unnecessary administrative burden as the state would attempt to duplicate existing federal responsibilities. The state lacks the resources necessary to duplicate those already conducted by the FDA.

Furthermore, we are concerned that even if the state were to conduct its own determination as to the effectiveness of a new drug, the waiver provides no information regarding what process the state will use to make that determination and how timely such a determination would be made. Requiring a state to undergo a duplicative approval process to the FDA's process will result in delayed access to innovative treatments. In addition, allowing the state to make its own determination regarding the efficacy of a drug takes the clinical care decision away from the physician-patient relationship and places it on the state.

Future inclusion of prescription drugs in block grant financing: We are also concerned that the waiver appears to seek to incorporate the prescription drug benefit into the block grant financing system in the future. Including the prescription drug benefit into the block grant would further limit federal funding to

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[15] Jamal A, Phillips E, Gentzke AS, et al. Current Cigarette Smoking Among Adults — United States, 2016. *MMWR Morb Mortal Wkly Rep.* 2018;67:53–59. DOI: http://dx.doi.org/10.15585/mmwr.mm6702a1

[16] U.S. Department of Health and Human Services. *The Health Consequences of Smoking – 50 Years of Process: A Report of the Surgeon General*, 2014. Available at https://www.surgeongeneral.gov/library/reports/50-years-of-progress/.

[17] Waiver application at 15.

[18] Food and Drug Administration. *Drug Development and Approval Process*. Updated June 13, 2018. Accessed December 2019. https://www.fda.gov/drugs/development-approval-process-drugs.

the state and, with the request to limit oversight of this demonstration, could allow the state to make draconian cuts to the Medicaid program.

Exceptions process: While we appreciate the state clarified in its waiver to CMS that the state will maintain an exceptions process to cover drugs not on the formulary when medically necessary, we request greater clarification of how long the exceptions process will take before a drug can be approved to be covered. Cancer patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the prescription drugs that are most medically appropriate for their condition. Disruptions in cancer treatment or adjuvant therapy, such as hormone therapy, can result in negative health outcome. Additionally, switching patients' medication mid-treatment can provoke undue anxiety and uncertainty for patients and can negatively impact their chance of survival.

Therefore, we strongly urge CMS to deny the state's request to impose a closed formulary with only one drug per therapeutic class, as it would severely impact cancer patients' access to medically appropriate treatments needed to fight their cancer diagnosis.

Improving Administrative Efficiencies
Tennessee is asking to be exempt from federal standards and requirements for its managed care program, including the Managed Care Rule. This important safeguard ensures Medicaid Managed Care Organizations (MCOs) must meet certain requirements related to patient care. For example, the managed care rule sets standards related to adequate networks, so patients have access to the appropriate providers and receive the care they need. The managed care rule requires MCOs to comply with standards of time and distance to measure this network adequacy, helping patients access both primary care providers and specialists they need. For an individual undergoing cancer treatment, timely and uninterrupted access to services is critical.

When cancer treatment is delayed or disrupted, the effectiveness of the treatment could be jeopardized, and the individual's chance of survival can be significantly reduced. Failure to consider the care delivery and/or treatment regimen of patients, especially those managing a complex, chronic condition like cancer, could have devastating effects on patients, their families, and providers. Therefore, we urge the Department to consider the impact that flexibilities in the state's managed care programs could have on cancer patients, survivors, and those who will be diagnosed with the disease. We urge CMS to deny the state's request to be exempt from federal network adequacy standards.

Streamlining Unnecessary Approvals
The Department seeks to have the flexibility to make changes – "including the additions of optional benefits and increases in the amount, duration, and scope of covered benefits, without the need for CMS approval."[19] We appreciate the state clarifying in its waiver to CMS that it is only requesting these flexibilities when there are *increases* to the amount, duration, and scope of covered benefits. However, we strongly urge CMS to not give the state blanket waiver authority for coverage of benefits without seeking out stakeholder input first. It is critically important that our organization and other stakeholders have an opportunity to review and provide public comment on any changes to the amount, duration, and scope of benefits provided by state Medicaid programs, whether positive or negative.

[19] Waiver application at 21.

Pathway to Permanency
The state requests to make this demonstration permanent and no longer need approval from CMS to make changes to benefits and services in the future, either through the State Plan Amendment or demonstration amendment process. We have serious concerns with this request, as it would remove important opportunities for the public to review and provide feedback on the program changes and the impact that these policies are having on enrollees and stakeholders. It is especially important that enrollees and stakeholders impacted by the demonstration waiver have the ability to provide feedback to the state and CMS before any additional policies are continued or newly implemented. TennCare is a joint venture between Tennessee and CMS, the individuals, families, providers and communities served by the program should have a voice in how the program is administered. We strongly urge the Department deny Tennessee's pathway to permanency request and retain the important function for stakeholder comment on any changes that would impact covered benefits and services.

Appropriately Penalizing Member Fraud
The state seeks to suspend or terminate the eligibility of individuals who have been determined to be guilty of fraud and to prevent them from re-enrolling for up to 12 months. The state also seeks the flexibility to make a case-by-case determination of the appropriate punishment for a determination of fraud, but no details are provided on if an appeals process will be offered and how robust that appeals process will be.

ACS CAN supports state efforts to reduce or eliminate fraud from health care programs. However, we are concerned that suspending or terminating the eligibility of individuals without a robust appeal process in place could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals in active cancer treatment. During the proposed suspension or termination period, low-income cancer patients will likely have no access to health care coverage, making it difficult or impossible to continue treatment until they meet the state's "appropriate punishment." For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team could have a significant impact on an individual's cancer prognosis and the financial toll that the lock-out would have on individuals and their families could be devastating. Therefore, we urge CMS to ensure the state has a swift appeal process in place before allowing the states request to suspend or terminate the eligibility of individuals who have been determined to be guilty of fraud.

Other Proposals of Concern
The state does not provide any estimates on the number of people impacted or any fiscal analysis of the proposals. Overall, it appears that the state is requesting flexibilities to not have to provide its share of funding towards the TennCare program, but rather places the greatest amount of funding on the federal government. The block grant and its flexibilities are all presented under the guise that this model allows the state to "maximize program efficiency while also implementing reforms to better meet member needs."[20] Additionally, if the state underspends the block grant, it gets to "share" the savings, 50/50, with the federal government, even though the state may not have spent any monies of its own towards the program. This essentially incentivizes the state to cut/reduce its Medicaid spending or place arbitrary limits on TennCare enrollees' benefits and services.

[20] Waiver application at 21.

Tennessee states that any savings achieved under the block grant will be reinvested in the TennCare program, but initially requested to invest those funds on "items and services not otherwise covered under TennCare, or not otherwise eligible for federal match, if the state determines that such expenditures will benefit the health of members or are *likely* to result in improved health outcomes [emphasis added]."[21] The state also indicates these savings could be used for public health initiatives that **are not** specifically targeted at the TennCare population. While we appreciate Tennessee including priorities for program innovation in the CMS waiver application and support the state wanting to improve the lives of rural Tennesseans through a rural health initiative, we do not believe federal funds meant for Medicaid enrollees' health care services should be spent on programs that do not directly impact Medicaid beneficiaries. There are other federal programs and grants[22] that could help the state achieve greater rural community health and address state-specific health crises, like the opioid epidemic, rather than using funds that should be spent on the health of TennCare enrollees. Therefore, we urge CMS to ensure federal dollars are spent on health care services for Medicaid enrollees and not on other public health initiatives that do not directly support Medicaid beneficiaries.

Finally, the Secretary of Health and Human Services is not permitted to waive Sections 1903 and 1905 through the 1115 waiver process, where the financing structure of the Medicaid program is located, as multiple experts have noted.[23,24] Such a change would require congressional authority, yet Congress has repeatedly declined to pass legislation on this issue, most recently during the debate over repealing and replacing the Affordable Care Act in 2017. In addition, out of the approximately 1,800 comments Tennessee received regarding the waiver, comments were overwhelmingly **against** the waiver application – an important point that CMS should take into consideration when reviewing the waiver application.

Conclusion

We appreciate the opportunity to provide comments on Tennessee's 1115 waiver application. The preservation of eligibility and coverage through the TennCare program remains critically important for many low-income Tennesseans who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We ask CMS to weigh the potential impact a block grant structure could have on low-income Tennesseans' access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime. We urge CMS to deny Tennessee's request, and any state request, to change the financial structure of the Medicaid program to a block grant or capped funding structure.

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[21] State-level waiver application at 14.

[22] Please see rural health funding opportunities here: https://www.hrsa.gov/ruralhealth/programopportunities/fundingopportunities/default.aspx and https://www.ruralhealthinfo.org/funding.

[23] Alker J. *Pending CMS Guidance on Medicaid Block Grants: Executive Overreach Strikes Again*. Georgetown University Center for Children and Families. Published June 27, 2019. Accessed December 2019. https://ccf.georgetown.edu/2019/06/27/pending-cms-guidance-on-medicaid-block-grants-executive-overreach-strikes-again/.

[24] Bagley N. *Tennessee wants to block grant Medicaid. Is that legal?* Published September 17, 2019. Accessed December 2019. https://theincidentaleconomist.com/wordpress/tennessee-wants-to-block-grant-medicaid-is-that-legal/.

Our comments include numerous citations to supporting research, including direct links to the research for the benefit of CMS in reviewing our comments. We direct CMS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with CMS to ensure that all people are positioned to win the fight against cancer. If you have any questions, please feel free to contact me or have your staff contact Michelle DelFavero of our policy team at Michelle.DelFavero@cancer.org or 202-585-3266.

Sincerely,

Lisa A. Lacasse, MBA
President