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BY ELECTRONIC FILING

Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1501-FC (Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates)

Dear Administrator McClellan:

On behalf of the Association of Community Cancer Centers (ACCC), I appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) final rule with comment period regarding revisions to the hospital outpatient prospective payment system (OPPS), published in the Federal Register on November 10, 2005 (the "Final Rule").[1] ACCC is a membership organization whose members include hospitals, physicians, nurses, social workers, and oncology team

members who care for millions of patients and families fighting cancer. ACCC's more than 700 member institutions and organizations treat 45% of all U.S. cancer patients. Combined with our physician membership, ACCC represents the facilities and providers responsible for treating over 60% of all U.S. cancer patients.

ACCC is committed to ensuring that cancer patients have access to the entire continuum of quality cancer care, including access to the most appropriate cancer therapies in the most appropriate settings. Hospital outpatient departments are a crucial part of the cancer care delivery system, providing a significant portion of this country's cancer care. Because advanced cancer treatments often are associated with considerable risk, several are available only through hospital-based oncologists, nurses, and pharmacists. Patients receiving these treatments must have substantial on-site clinical support in case of adverse reactions. ACCC members often serve patients who have numerous complications or histories of infusion reactions. Our members also play an important role in the health care safety net. In some cases, hospital outpatient departments are the only sites available for Medicare and uninsured patients who need cancer care. In addition, some treatments, such as those involving radiopharmaceuticals, are available only in hospitals because they require specialized equipment and handling that only is available in that setting. Finally, hospital outpatient departments play an important role in the early adoption of new technologies and frequently serve patients who have recently completed participation in clinical trials.

Adequate OPPS payment rates for cancer drugs[1] and the services required to prepare and administer them are critical to ensuring patient access to care. Since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Medicare payments for cancer drugs have been reduced significantly. The combined effects of these reductions seem to be slowly dismantling multi-disciplinary cancer care, which is certainly not CMS' intent. We believe that it is critical to establish payment rates that will ensure hospitals are reimbursed appropriately for the services they provide. For example, in Palm Springs, California, a leading medical clinic known for treating cancer patients, expects to close its doors at the end of January 2006 due to physician departures and losses caused by "reductions in Medicare reimbursements (that) cut into the clinic's operating margin.[2] We have also heard from several members that the continued "hits" to the entire service line may lead to hospitals choosing to close their infusion units entirely. Indeed in the Tidewater area of Virginia, three

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[1] We refer to drugs, biologicals, and radiopharmaceuticals collectively as "drugs" throughout our comments.

[2] Spillman, Benjamin. "Desert cancer clinic to close." The Desert Sun.com, December 2, 2005

outpatient infusion centers have closed, citing perceived reductions to reimbursement as a primary reason for their decision. At the same time, hospitals expect demand for care to increase at a rate of 35% to 40% each year as patients and therapies are shifted to outpatient departments. CMS must take care to ensure that Medicare beneficiaries are able to receive cancer care in the most appropriate settings.

ACCC is particularly troubled about the effect of CMS' decision not to make an additional payment for pharmacy handling costs. As we describe below, we are greatly concerned that this decision will threaten hospitals' ability to provide safe and effective cancer care and is inconsistent with CMS' goals of improving the quality of care provided to Medicare beneficiaries. We urge CMS to work with providers to ensure that hospitals are reimbursed appropriately for all of the costs of providing drugs and biologicals in 2006 and to develop a long-term methodology for measuring and reimbursing these costs.

We are also still concerned with the erratic changes in the price and availability of IVIG. We appreciate CMS's implementation of a $75 add-on payment for the pre-administration related services associated with infusion of IVIG, but we advise CMS to closely monitor the cost and availability of IVIG and respond accordingly to ensure appropriate compensation to hospitals and continued patient access. We also recommend that CMS revise its guidance regarding payment for hydration and non-chemotherapy drug infusion services during a single visit and allow separate payment for additional hours of infusion services. CMS also should allow hospitals a one-month grace period in which they can submit drug administration claims using the 2005 codes while updating their chargemasters. We are pleased that CMS decided not to implement its proposed reduction in payment for multiple diagnostic imaging procedures. We remain concerned about the dramatic reductions in payment for brachytherapy services, however. Finally, we recommend that CMS expand the oncology demonstration program to apply to care provided in hospital outpatient departments as well as in physician offices.

I. Proposed Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

A. Payment for Pharmacy Handling Costs

In the Final Rule, CMS announced that it will reimburse separately payable drugs and biologicals administered in hospital outpatient departments at average sales price (ASP) plus 6%.[3] CMS asserts that this payment rate "will serve

[3] 70 Fed. Reg. at 68642.

as a proxy to make appropriate payment for both the acquisition cost and overhead cost of each of these products."[4] Based on an ACCC analysis that was recently shared with CMS staff, we estimate that this payment methodology will reduce hospital reimbursement for 115 drugs commonly used in cancer care by $200 million from 2005 to 2006. We are deeply sceptical that these rates will be sufficient to reimburse hospitals adequately for their pharmacy handling costs. ACCC urges CMS to reconsider this decision and provide an additional payment to reimburse hospitals for the substantial costs associated with safely handling and preparing drugs and biologicals. We are greatly concerned that patient safety and access to quality care will be put at risk if Medicare does not reimburse hospitals for all of the costs of providing care.

1. Pharmacy Services Are Critical to Protecting Patient Safety

Medication safety is a pressing concern in health care and is especially important in oncology due to the complexity of medication regimens and the inherent risks of preparing and administering cancer drugs. To ensure that each patient receives the correct dosage of each drug, in the correct sequence, and through the safest administration method, hospitals employ complex medication use processes in which physicians, nurses, and pharmacists review drug choices at each step of their prescribing, dispensing, and administration. Pharmacists make essential contributions to these processes by using a sequence of activities commonly referred to as "safety through redundancy." Registered pharmacists consult with physicians to determine drug interactions and contraindications, toxicity management and verification of therapy appropriateness, and dosing before and during administration of chemotherapy to a patient. Pharmacists also perform critical quality assurance tasks during the preparation of drug, such as labelling, recording, and tracking mixed drugs for safety purposes, sampling drugs at random to verify quality, and developing and reviewing protocols to flag potential interactions.

Thanks to such safety measures, cancer hospitals have been able to keep their pharmacy error rates relatively low and reduce harm to patients that would have been caused by those errors. A recent study of more than 10,000 medication orders at one cancer center found a medication error rate of 3%, lower than the overall error rates found in inpatient or primary care settings. Approximately two-thirds of the errors had the potential to cause harm, however.[5] Fortunately, none of

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[4] Id. at 68643.

[5] Tejal K. Gandhi et al, Medication Safety in the Ambulatory Chemotherapy Setting, 104 Cancer 2477-83, October 24, 2005.

the errors identified in this study actually caused harm to patients because the hospital used a rigorous chemotherapy order review process in which pharmacists and nurses assess and verify physicians' orders at each step of the medication use process.[6]

These safety protocols are necessary to prevent harm to patients, but they are costly to provide, and discussed in greater detail below.

2. Pharmacy Handling Costs Are Significant

In its June 2005 report to Congress, the Medicare Payment Advisory Commission (MedPAC) cited studies that found pharmacy service overhead costs make up 26% to 33% of pharmacy departments' direct costs, with the rest of the costs attributed to the acquisition cost of drugs.[7] Most of the overhead costs reflect ancillary supplies (gowns, booties, masks) and salaries and benefits of pharmacists and technicians. As described above, pharmacy professionals not only prepare drugs for administration, they also review the prescribed dosage and method of administration for potential errors and consult with physicians and nurses about recommended changes to drug selection, dosage, administration schedules, and route of administration. An ACCC member reported an average of 3.1 pharmacist interventions per hour over a 15 month period. Most interventions lasted 15 to 30 minutes, and the average pharmacist salary and benefits at that hospital was $56 per hour, producing a per-intervention cost of $14 to $28. These costs are in addition to the time needed to prepare a drug when no intervention is required. Nationwide, the median hourly wage for pharmacists is $54.14 ($41.78[8] plus benefit

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[6] Id. at 2482.

[7] MedPAC, Report to the Congress: Issues in a Modernized Medicare Program, June 2005, at 140.

[8] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment and Wages, November 2004, Pharmacists, available at http://www.bls.gov/oes/current/oes291051.htm.

costs of 29.6%[9]), while the wage for pharmacy technicians is $15.66 ($12.09[10] plus benefit costs of 29.6%[11]).

Pharmacy service costs also include contract negotiations, building and information systems maintenance and upgrades, transportation of drugs within the hospital, and disposal of unused products (that typically involve the housekeeping department) to comply with Environmental Protection Agency (EPA) and National Institute for Occupational Safety and Health (NIOSH) regulations. Accordingly, costs for these items and services are affected by regulatory and accreditation standards and can increase dramatically when these standards change. For example, many hospitals currently bear the costs of renovating their facilities to comply with the new sterile compounding standards of the United States Pharmacopeia Chapter 797. A 2005 study commissioned by the National Patient Advocate Foundation found that the average cost per dose of chemotherapy administration, including all of the costs listed above, is $36.03.[12] This is in addition to the acquisition cost of the drug.

3. Medicare's Payments for Drugs Do Not Compensate Hospitals for Their Pharmacy Handling Costs

Historically, Medicare' OPPS rates were intended to cover pharmacy handling costs in addition to drugs' acquisition costs. In 2006, the MMA requires Medicare to begin reimbursing separately payable drugs administered in hospital outpatient departments at acquisition cost.[13] When Congress created this change in the law, it recognized that rates based on acquisition cost would not compensate hospitals for handling costs. To determine whether OPPS rates should be adjusted

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[9] U.S. Department of Labor, Bureau of Labor Statistics, Private Industry, Health Care and Social Assistance Workers, by Industry and Occupational Group, September 2005, Hospitals: Management, Professional, and Related, available at http://www.bls.gov/news.release/ecec.t14.htm.

[10] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment and Wages, November 2004, Pharmacy Technicians, available at http://www.bls.gov/oes/current/oes292052.htm.

[11] U.S. Department of Labor, Bureau of Labor Statistics, Private Industry, Health Care and Social Assistance Workers, by Industry and Occupational Group, September 2005, Hospitals: Management, Professional, and Related, available at http://www.bls.gov/news.release/ecec.t14.htm.

[12] Gary Oderda, Documentation of Pharmacy Cost in the Preparation of Chemotherapy Infusions in Academic and Community-Based Oncology Practices, available at http://www.npaf.org/pdf/gap/utah.pdf.

[13] MMA, Pub. L. No. 108-173, § 621(a)(1), 117 Stat. 2066, 2307 (2003), amending Social Security Act § 1833(t)(14)(A)(iii), 42 U.S.C. § 1395l(t)(14)(A)(iii).

to reflect these costs, Congress instructed MedPAC to study pharmacy service and handling costs.[14] MedPAC's report, described above, concluded that these costs are significant and that an adjustment is warranted.

In the OPPS proposed rule for 2006, CMS announced its plans to pay an additional 2% of ASP for separately payable drugs, on top of an estimated acquisition cost of ASP plus 6%, to reimburse hospitals for pharmacy handling costs.[15] Although many stakeholders, including ACCC, and the Advisory Panel on Ambulatory Payment Classification Groups (the APC Panel) supported an additional payment, these groups also were concerned that 2% of ASP would not be adequate reimbursement for hospitals' significant pharmacy handling costs. The APC Panel recommended that CMS carefully consider this proposal to ensure that it was in line with hospital costs.[16] ACCC supported this recommendation and suggested that CMS increase the add-on payment to 8% of ASP.

Against the advice of hospitals, provider groups, and its own advisory panels, including MedPAC and the APC Panel, CMS abandoned this proposal in the Final Rule. Instead, CMS concluded that reimbursement for all separately payable drugs at ASP plus 6% would be an appropriate payment for both the acquisition and overhead costs of these drugs.[17] We are concerned that the methodology CMS used to reach this conclusion is flawed, and hospitals may not be able to continue to provide safe and effective cancer care as a result.

In reaching its decision to reimburse separately payable drugs at ASP plus 6%, CMS used an analysis of mean unit cost from hospitals' claims and relied on a MedPAC survey that found that hospitals generally set charges high enough to reflect handling costs as well as acquisition costs.[18] MedPAC also reported that hospitals do not have precise information about the magnitude of their pharmacy expenses, however, and that drugs administered in outpatient departments generally require more preparation time than drugs administered to inpatients.[19]

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[14] Social Security Act § 1833(t)(14)(E)(i), 42 U.S.C. § 1395l(t)(14)(E)(i).

[15] 70 Fed. Reg. 42673, 42730 (July 25, 2005).

[16] Panel's Recommendations, APC Panel Biannual Meeting – August 2005, at 2, available at http://www.cms.hhs.gov/FACA/Downloads/0817_192005mtg.zip.

[17] 70 Fed. Reg. at 68642-43.

[18] Id. at 68642.

[19] MedPAC, Report to the Congress: Issues in a Modernized Medicare Program, June 2005, at 140.

We are concerned that CMS' reliance on hospital charges converted to costs fails to capture hospitals' true costs of providing care. We urge CMS to work with providers to determine whether all of the pharmacy costs described above are represented accurately in CMS data.

Unless hospitals are reimbursed adequately for the substantial costs of safely handling advanced cancer therapies, they will not be able to continue to provide quality care. Although Medicare payments historically have been sufficient to cover both handling and acquisition costs,[20] we expect that many hospitals will struggle to provide critical pharmacy services under the reduced rates for 2006. In the past, hospitals were able to support their pharmacy safety protocols using their margins on drug reimbursement. This margin will be eliminated in 2006 as Medicare reimbursement for 115 separately payable drugs used in cancer care is reduced by $200 million. Indeed, several ACCC members anticipate losses as high as $1 million next year because of the payment changes and elimination of the pharmacy add-on adjustment. Faced with dramatic reductions in reimbursement, hospitals may have to reduce expenditures through lay offs of essential pharmacy, nursing, and social work staff who are critical to the preparation and delivery of medicine and associated support services, but whose services are not separately reimbursed by Medicare. This clearly is contrary to CMS' goals of improving patient care and enhancing quality.

CMS and providers must work together to develop a short-term transitional payment adjustment and develop a long-term payment methodology to ensure that hospitals are reimbursed appropriately for pharmacy handling costs. Because even low error rates present an unacceptable risk of serious harm to patients, Medicare must support hospitals' efforts to improve their error reduction programs through adequate reimbursement. We thank CMS for taking the time to discuss these concerns with us, and we look forward to working with the agency to develop a solution to this problem.

B. Payment for IVIG

ACCC thanks CMS for responding to hospitals' concerns about ensuring access to IVIG. IVIG is an important therapy for many cancer patients, including those who have had bone marrow transplants and certain kinds of leukemia. When Medicare began to reimburse IVIG in other settings at ASP plus 6%, many hospitals experienced significant increases in demand for this critical therapy but have not been able to obtain sufficient quantities of it for their patients. Hospitals' efforts to

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[20] Id. at 139, 140.

acquire enough IVIG are complicated by the fact that IVIG products are not interchangeable. Each brand of IVIG is particularly suited for specific conditions, and patients who respond well to one brand may experience adverse effects if switched to another brand. We are pleased that CMS recognizes these concerns, and we support the add-on payment of $75 for the pre-administration-related services associated with infusion of IVIG.[21]

Notwithstanding the above, we remain concerned with the erratic prices confronting hospitals when they purchase IVIG. An ACCC member estimates the cost of its monthly IVIG allotment has risen 30 percent with an additional 20 percent charge if the allotment is exceeded and additional supply is needed. This issue is compounded by the fact that the hospital has been notified by several private practices in the area that they can no longer obtain IVIG and will be sending patients needing IVIG treatment to the member hospital for treatment.

Such dramatic changes in the demand and costs of IVIG may require more frequent updates to IVIG reimbursement rates to reflect rapidly changing prices. Alternative solutions include possibly considering a "pass-thru" payment or increasing the amount of the $75 add-on.

To ensure that this payment is sufficient to protect beneficiary access to IVIG, we recommend that CMS work with providers to determine whether the payment fully compensates hospitals for the costs of providing this critical therapy.

II. Drug Administration

ACCC supports CMS' decision to begin using 20 of the 33 new drug administration Current Procedural Terminology® (CPT) codes in the OPPS in 2006 and to create 6 new C-codes instead of using the 13 new codes that require determinations of initial, sequential, and concurrent infusions or intravenous pushes.[22] We greatly appreciate that the agency addressed our concerns about the 13 CPT codes and believe the new codes, describing drug administration services in greater detail than the old codes, will help CMS collect the data it needs to set more appropriate payment rates in the future. We also appreciate CMS' recent transmittal clarifying how the new codes should be used.[23] According to this

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[21] 70 Fed. Reg. at 68648.

[22] Id. at 68880.

[23] January 2006 Update of the Hospital OPPS Manual Instruction: Changes to Coding and Payment for Drug Administration, Transmittal 785, Change Request 4258, December 16, 2005.

guidance, hospitals may report a first hour for each different type of infusion provided when the infusions can be reported using different codes and they meet the requirements for billing an hour of each type of infusion.[24] This instruction permits hospitals to report and be paid for providing a hydration service and a chemotherapy service to a patient during a single visit.

We are concerned, however, that because CMS issued its guidance on the new drug administration codes in the middle of December, many hospitals have not been able to update their chargemasters before January 1. They also have not had sufficient time to educate their staff about the new codes. As a result, some hospitals have held their charges for both drug administration services and drugs until the chargemasters have been revised and the staff are fully trained. One ACCC member estimated the value of their delayed billings to be in the hundreds of thousands of dollars. Many hospitals simply cannot afford the costs of providing care if they do not receive timely reimbursement from Medicare.

We recommend that CMS allow hospitals a one-month grace period during which they can be reimbursed for using the 2005 drug administration codes if they desire. When CMS eliminated the 90-day grace period for discontinued codes effective January 1, 2005, it stated that information about new, revised, and discontinued CPT and Healthcare Common Procedure Coding System (HCPCS) codes is available in October of each year, giving providers time to implement any changes to their billing systems.[25] This year, however, CMS issued the new drug administration codes in November and did not release guidance on their use until December 16. Due to the late issuance of guidance on the new codes, we believe a brief extension is necessary to allow hospitals to be reimbursed in a timely manner while they update their systems.

Additionally, we urge CMS to make separate payment additional hours of infusion services. Under the Final Rule, payment for additional hours of infusion services is packaged into the rate for the first hour. Hospital outpatient departments frequently treat patients who require infusions administered over several hours. For example, one ACCC member indicated that in June of this year, her hospital treated 177 patients who required multiple hours of chemotherapy infusions. Due to the differences in reimbursement for drug administration services in the hospital outpatient department compared to physician offices, the hospital was reimbursed almost $35,000, or $200 per patient, less than a physician office

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[24] Id. (revising Medicare Claims Processing Manual (CMS Pub. 100-4), ch. 4, § 230.2).

[25] CMS Transmittal 89, Change Request 3093, February 6, 2004, revising Medicare Claims Processing Manual (CMS Pub. 100-04), ch. 4, § 20.1.1.

would have been paid for treating the same patients. This payment inequity will continue in 2006 as hospitals will be paid $87, or 31%, less than a physician's office for infusions lasting 4 hours.

As noted, these losses are not insignificant. Another member, for example, indicated that her hospital has been treating a patient who failed first line treatment for acute promyelocytic leukemia and now is undergoing second line treatment. An orphan drug is the best hope for patients with this rare form of leukemia who have not responded to other treatment. Because this drug must be administered seven days a week for six months, most patients with this condition must seek treatment in hospitals. Under the OPPS, however, hospitals would be reimbursed for only half the time involved in administering the drug, resulting in payment for the course of treatment that is $2000 less than what a physician office would receive for the same regimen. If inadequate Medicare reimbursement leaves hospitals unable to provide these services, some patients may have nowhere else to go for care. Patients who require infusions administered over periods of 8 hours, seven days a week, or in other situations that are outside normal physician office hours depend on hospital outpatient departments to provide their critical cancer treatments.

We understand that CMS is collecting charge and cost data for all the CPT codes to determine appropriate payment rates for all drug administration services, including those that currently are packaged. It appears that the earliest CMS would implement separate payments for these services would be January 2007, however. Our review of 2004 OPPS claims data identified 4,069 claims for 90781 *IV infusion, add'l hour* and 719 claims for 96412 *Chemotherapy infusion, add'l hour* even though these codes are not recognized for payment. The average costs for the two services were $70.28 and $77.71, respectively. In addition to this data, there is partial year data from 2005 available to CMS for use in calculating payment rates for these packaged codes. We ask CMS to use this data to establish separate payments so that more equitable payments for prolonged drug administration services can be established immediately.

III. Multiple Diagnostic Imaging Procedures

ACCC is very pleased that CMS has not implemented its proposal to reduce payment by 50% for second and subsequent imaging procedures within the same family when performed in the same session.[26] We agree that further analysis is necessary before any payment reduction should be implemented. Imaging

[26] 70 Fed. Reg. at 68708.

services are critical to cancer care, both for the initial diagnosis and for assessing the effectiveness of treatment. ACCC is greatly concerned that a dramatic payment cut would harm patient access to these important services and could discourage hospitals from investing in new technologies. It also could incentivize hospitals to schedule imaging services over several days, increasing the patient's inconvenience and potential exposure to contrast media. Reduced payment also could lead to increased use of invasive diagnostic techniques that put the patient at greater risk for complications and ultimately may cost the patient and Medicare more. We appreciate CMS' willingness to explore these issues further before implementing reductions for critical imaging services.

IV. Brachytherapy

ACCC is dismayed that CMS finalized its proposal to reduce payments for brachytherapy APC 651. Payment for this code will drop from $1248.93 in 2005 to $666.21 in 2006, a reduction of 46%. This drastic reduction could jeopardize hospitals' ability to offer brachytherapy as a treatment option. We urge CMS to reconsider this decision and apply a dampening adjustment to stabilize payment for brachytherapy services.

V. Oncology Demonstration Program

In 2006, CMS will implement an oncology demonstration program to gather information on the quality of care provided to Medicare beneficiaries with cancer. Participating physicians will report the primary focus of the evaluation and management service provided to the patient, the patient's current disease state, and whether current management adheres to clinical guidelines.[27] We believe this program would be equally beneficial for evaluating the quality of care provided in hospital outpatient departments, too, and we strongly urge that CMS expand it to apply to in this setting. Indeed, MedPAC has urged Medicare to "pay the same amount for identical services regardless of the setting in which they are furnished.[28]" To date, ACCC has not been provided a plausible explanation why physicians who treat patients in a hospital setting are denied equal consideration. Allowing hospital-based oncologists to participate also would improve the equality of Medicare's payments to physicians across treatment settings.

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[27] 70 Fed. Reg. 70115, 70272 (November 21, 2005).

[28] MedPAC, Report to the Congress: Medicare Payment Policy, March 1999, at p. 6.

VI. Conclusion

ACCC urges CMS to protect cancer patients' access to quality care in the most appropriate setting by providing appropriate reimbursement for cancer treatments under the OPPS. Toward this end, we believe it is imperative for CMS to make an add-on payment for pharmacy handling costs. In addition, it is critical that CMS revise the coding and payment policies for drug administration services to make separate payment for additional hours of infusion services and to allow hospitals to be paid separately for administration of hydration and non-chemotherapy infusions in a single day. We recommend CMS work with providers to ensure proper compensation to hospitals for providing IVIG treatments and advise the agency to closely follow and appropriately respond to rapidly changing prices and availability of IVIG. We suggest that CMS permit hospitals to submit claims using the 2005 drug administration codes for one month while hospitals update their chargemasters and train their staff on the new codes. We also recommend that CMS apply a dampening mechanism to stabilize payments for brachytherapy APC 651 and protect beneficiary access to this treatment option. Finally, we suggest that CMS expand the oncology demonstration program to measure the quality of care provided in hospital outpatient departments as well as in physician offices.

ACCC appreciates the opportunity to offer these comments. We look forward to continuing to work with CMS to address these critical issues in the future. Please feel free to contact our staff person, Deborah Walter, at (301) 984-5067, if you have any questions or if ACCC can be of further assistance. Thank you for your attention to this very important matter.

Respectfully submitted,

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President, Association of Community Cancer Centers