January 5, 2015

Rep. Cathy McMorris Rodgers
Attn: Nick Magallanes
Health Policy Advisor
203 Cannon House Office Building
Washington, D.C. 20515

Comments Regarding: Cancer Care Payment Reform Act of 2015

Dear Representative Rodgers,

On behalf of the Cancer Support Community (CSC), I would like to thank you for leading the discussion on the important topic of cancer care payment reform.

CSC is a global network of over 170 service delivery locations with the only Research and Training Institute of its kind, delivering evidence-based social and emotional support to anyone impacted by cancer. CSC’s services are provided free of charge to patients, caregivers and health care professionals. Each year, CSC touches nearly 1 million patients through our direct services delivery arm and through our original research. Our frontline experience with the patient uniquely informs our policy positions and the following comments on The Cancer Care Payment Reform Act of 2015.

Diversity of Practices
CSC supports the effort to diversify practice participation in the proposed demonstration project. CSC recognizes that diversity is more than size of practice and geographic placement. Realizing that the proposed demonstration project is for the Medicare population, CSC suggests that you also include thresholds that would demonstrate that practices have additional measures of diversity including socio-economic status, race and ethnicity--to name a few.

Measures
CSC applauds you for ensuring that payment is related to practice performance and outcome measures. Rather than allowing practices to select 10 measures for evaluation, CSC recommends that there be a core set of mandatory performance
measures which have been proven to improve patient outcomes and reduce costs. One such requirement would be mandatory psychosocial distress screening and follow-up care for all patients within the first 30-45 days of first visiting the treating physician. A study by Barbara Andersen1 revealed a survival advantage of 1.3 years in women with breast cancer participating in a 26-session support group. Additionally, a meta-analysis by Linda Carlson2 noted two separate projects which demonstrated a decrease in the utilization of health care resources in patients with breast cancer and also prostate cancer who engaged in early psychosocial intervention. Additionally, the American College of Surgeons Commission on Cancer (CoC) has mandated distress screening and follow-up as a part of its accreditation requirements for cancer centers3. CSC believes CMS should follow the lead of the CoC on this important issue.

Patient Care Measures

1. CSC encourages an update in the proposed language to ensure consistency with professional guidelines and standards across patient care measures. Specifically, all patient care measures noted under e.2.A (beginning on page 6) should be compliant with published guidelines as noted in measure e.2.A.vii on page 8.

2. CSC encourages language be explicitly written to indicate that measures noted later in the draft as “Survivorship Measures” be included early in the planning of patient care vs. waiting until the patient completes active treatment. Specifically, psychosocial distress screening, care planning, nutritional support and conversations about advanced directives are an integral part of early patient care management.

Survivorship Measures

1. CSC recommends that the language noted on page 9, C.i – C.iii. include additional specificity about survival rates (e.g., overall survival, progression free survival, etc) and that the patient goal of therapy is a part of the defined survival measures.

2. CSC recommends that the order of notation for C.iv. and C.v. be reversed such that psychosocial distress screening becomes a tool used to identify items that should be a mandatory inclusion in the survivorship care plan.

3. Survivorship Care Plan – as noted earlier, CSC recommends that the care plan be established within 45 days of consult with the treating physician vs. waiting until after the completion of chemotherapy.

4. Psychosocial Distress Screening – as noted earlier, CSC recommends that screening for psychosocial distress be required within 30-45 days of consult with the treating physician. CSC also recommends the language be updated to emphasize the importance of screening, referral to follow-up care and rescreening within 60 days.

Modification or Addition of Measures – Appropriate Stakeholders

CSC applauds the inclusion of flexibility to modify measures as appropriate. With regard to the defined stakeholders able to inform modifications, CSC encourages the addition of patient advocacy organizations who perform IRB reviewed and approved research and who present at or publish in peer-reviewed meetings and journals.
Care Coordination Management Fee
CSC recommends the inclusion of specific language that would either release the patient from any co-pay associated with the addition of a care coordination management fee or language that would limit the patient out-of-pocket cost to a nominal amount.

In conclusion, CSC sincerely thanks you for the opportunity to comment on the discussion draft. We are eager to sit down with you in person to review our suggestions and be of assistance in any way we can.

If you would like to discuss our comments further or schedule a visit, please do not hesitate to contact me at Linda@cancersupportcommunity.org or 202-650-5382.

Sincerely,

[signature]

Linda House, MSM, BSN, RN
President
Cancer Support Community

References
American College of Surgeons Commission on Cancer 2012 Patient-Centered Standards – Standard 3.2 “The Cancer Committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.”