December 21, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC  20201

Re: CMS-9937-P: Proposed Rule on Notice of Benefit and Payment Parameters for 2017

Dear Mr. Slavitt,

On behalf of the Cancer Support Community (CSC) and the patients we represent, we thank you for the opportunity to submit these comments in response to the recent Proposed Rule on Notice of Benefit and Payment Parameters for 2017, published in the Federal Register on December 2, 2015.

As the largest direct provider of social and emotional support services for people impacted by cancer, and the largest nonprofit employer of psychosocial oncology mental health professionals in the United States, CSC has a unique understanding of the cancer patient experience. Each year, CSC serves nearly one million people affected by cancer through its network of 44 licensed affiliates - more than 120 satellite locations, and a vibrant online community- and delivers more than $40 million in free, personalized services each year.

Additionally, CSC is home to the Research and Training Institute - the only entity of its kind focused solely on the cancer patient experience. The Research and Training Institute has contributed to the evidence base regarding the cancer patient experience through its Cancer Experience Registry®, various publications and peer-reviewed studies on distress screening, and the psychosocial impact of cancer and cancer survivorship, to name a few. This combination of direct services and research uniquely positions CSC to provide you and other policymakers with feedback based on evidence as well as real world impact.

CSC appreciates the actions that the Centers for Medicare & Medicaid Services (CMS) has outlined to protect consumers in the health insurance exchanges and to provide additional tools to assist them in choosing appropriate health insurance coverage and utilizing that coverage effectively for plan year 2017 and years after.

In particular, CSC commends CMS for its decision to establish some standards for network adequacy that would offer patients some protections in obtaining out-of-network care. The out-of-network access provisions of the ruling are of great importance to cancer patients, who often need timely specialty care that is not available in-network.
CSC is concerned about the criteria used for network adequacy standards. CSC believes that a strict and clear set of quantitative standards are necessary to assure a minimum threshold for network adequacy. Absent these requirements, health plans within a state or service area may have different interpretations of adequacy, resulting in significant variations in the strength and accuracy of plan networks.

The imposition of time and distance standards for the specialties with the highest utilization rates in a given state, represent one metric of network adequacy. It falls short of ensuring that patients with serious and life-threatening illnesses that do not meet the highest utilization rates in the state, have access to the specialized providers and services they need in order to ensure access to and continuity of care.

CSC applauds CMS for addressing the increasingly recognized problem of "surprise" medical bills and for implementing a process to provide timely exceptions to ensure that consumers who need care from out-of-network providers can receive it with reasonable cost-sharing, applying enrollee costs to the in-network out-of-pocket maximum, and protection from balance billing.

The cost-sharing protections in the proposed rule are essential to making care out-of-network a realistic possibility for cancer survivors, an important protection when out-of-network care may represent the best, or even the only, treatment option for certain cancer patients.

Regarding out-of-pocket expenditures, CSC is concerned about the provision of the proposed rule that would increase the maximum out-of-pocket limit (MOOP) for consumers who purchase 2017 health plans through the exchange.

The impact of the financial burden caused by out of pocket expenses cannot be overstated. Based on the findings of the Cancer Support Community’s study “Insight into Patient Access to Care in Cancer,” the high cost of cancer care is a troubling reality for those affected by cancer. In a survey of 480 adults ages 18-44 who are currently living with or have had cancer, 58.8 percent reported being seriously or very seriously concerned about bankrupting their families, and drug co-pays ranked among patients’ top three cost concerns.

Cancer places a financial burden on all patients, which is associated with their taking measures that may significantly impact quality of life and may negatively affect treatment outcomes. In an effort to cover costs, patients with cancer will use money originally set aside for another purpose. Our previous study, “Elevating the Patient Voice,” gave a dramatic picture of the choices patients and their families make in seeking to manage the cost of care: 37 percent cut their grocery expenses, 48 percent gave up vacations, celebrations and social events, and 24 percent borrowed against or used money from a retirement plan. We found that nearly one-half of respondents reported experiencing clinically high levels of stress-related anxiety about managing the financial cost of cancer.

Patients are making decisions, potentially detrimental ones, about their treatment based purely on financial considerations. Provisions like the one proposed are harmful to patients and the health care system because they impede patients’ ability to get the care they need, increasing the financial burden of the disease.

Finally, CSC urges CMS to consider including a provision to the proposed rule that would either release the patient from any co-pay associated with the addition of a care coordination management fee or that would limit the patient out-of-pocket cost to a nominal amount.
Health care that is planned according to the patient’s preferences and that coordinates active treatment and symptom management from the beginning of treatment holds the promise of boosting patient satisfaction with care, improving outcomes, and enhancing the appropriate utilization of resources. For this reason, we urge CMS to revise the Benefit and Payment Parameters for 2017 to ensure that all licensed mental health professionals are considered in the list of care providers who would be reimbursed for providing planning and care coordination services to cancer patients and others with serious chronic illnesses. This will support the transition to a new payment system that is in the best interest of its beneficiaries, caregivers, and providers and that is accountable for the quality of care.

In closing, I would like to thank you for the opportunity to comment on this proposed rule and share the voice of patients living with cancer. I would be happy to speak with you further about this issue and can be reached at 202-650-5382 or Linda@cancersupportcommunity.org.

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

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.”


