June 27, 2016

Mr. Andrew Slavitt
Acting 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, DC 20201


Dear Acting Administrator 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 Final Rule for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) published in the Federal Register on April 27th, 2016.

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 more than one million people affected by cancer through its network of 170 locations, telephone helpline 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 focusing 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®, publications and peer-reviewed studies on distress screening, 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 commends CMS for the fundamental changes in physician payment policy arising with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The dismantling of the sustainable growth rate (SGR), establishment of alternative payment models, and creation of the merit based incentive payment system (MIPS) under MACRA provide opportunities for
CMS to implement significant positive changes to the Medicare program that will greatly benefit its beneficiaries.

We are particularly encouraged by CMS’s acknowledgement that resources are scarce for those health care professionals who perform extensive planning, psychosocial screening and critical thinking about the individual chronic-care needs of Medicare beneficiaries.

Psychosocial distress screening is vital to quality health care, yet rarely assessed systematically. Preliminary findings suggest that distress screening with appropriate follow-up care can lead to positive patient-centered outcomes, including improved access to community-based psychosocial services. According to the Institute of Medicine (IOM), there are more than 14 million cancer survivors in the US today, and at least 50% of those suffer from late treatment-related side effects, including physical, psychosocial, cognitive and sexual abnormalities, as well as concerns regarding recurrence and/or the development of new malignancies. Survivors also face issues involving lack of appropriate health maintenance counseling, increased unemployment rate and workplace discrimination. Studies show that the same effects of distress are observed in patients with other chronic illnesses such as diabetes, arthritis and heart conditions among others. Research shows that distress can negatively affect medical and psychological outcomes and obstruct advancement into long-term survivorship. Screening for psychosocial distress helps people identify their concerns and worries, and voice them with their health care team; it also provides personalized information and support to address each person’s specific concerns.

As a fundamental element of comprehensive, quality care, screening for psychosocial distress, referral and follow-up care should be a required component of routine care management as well as a reimbursed service. We at CSC are encouraged by the implementation of new reimbursement codes and payments for screening services for depression and follow-up plans. The optimization of current reimbursement opportunities is a key step to align Medicare reimbursement schedules with superior patient outcomes and high-quality cancer care delivery.

We commend the proposed rule for focusing on promoting connectivity between patients and providers through the use of health technology, and that it prioritizes the need to improve interoperability of Electronic Medical Records through the implementation of the Advancing Care Information initiative.

As the care for chronic conditions, including cancer, becomes more advanced, decisions faced by patients and families become more complex and often have significant trade-off considerations including efficacy, tolerability, cost and impact to overall quality of life, to name a few. We know from the Cancer Experience Registry, the only Registry of its kind to map the patient experience with cancer that patients often feel unprepared to make treatment decisions and are left to manage the long-term effects of their cancer experience. Taking steps to ensure that patients have access to information that would allow a meaningful discussion with their health care team is most certainly an important part of the overall care equation.

Specifically, by using and integrating creative tools for telemedicine into care plans and required elements for data collection, health care teams, patients and policymakers will have
the capability to understand the patient experience and develop a comprehensive assessment of providers’ performance while ensuring that patients receive appropriate clinical care.

The CSC urges the application of standards for interoperability that focus on adding meaningful value to patients and recommend the implementation of a validated telemedicine tool to routinely screen Medicare patients for psychosocial distress and link them with appropriate professional and community resources. The integration of telemedicine tools into measures and care plan tools may support provider adoption and promote collaboration among care teams across the continuum of care, supporting better more effective care coordination and a more patient-centered treatment approach.

Finally, we are concerned about the potential impact that the proposed rule will have on patients’ health outcomes and access to health care in some geographies, like rural and underserved areas. Small practices serving patients in these communities, may possibly lack the financial resources to meet reporting and technology requirements and may opt out of Medicare patients.

An emerging body of evidence continues to grow indicating that patient outcomes can be directly correlated with the areas in which they live. Dr. Otis Brawley recently presented a summary of work demonstrating the relationship between education levels, geographic origin and cancer incidence. Additionally, work published by Zeng et al. reported disparities in outcomes associated with patients living in rural vs. urban areas. CMS should work with stakeholders in diverse geographies and communities to ensure that patients who are already at risk are not placed in further jeopardy as a result of negative externalities originated by the implementation of the proposed rule.

In conclusion, CSC would like to thank CMS 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
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President
Cancer Support Community National Headquarters
i Institute of Medicine: Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs, 2008.

ii National Cancer Institute at the National Institutes of Health, http://www.cancer.gov/cancertopics/pdq/supportivecare/depression/HealthProfessional

