



Maine Coalition To Fight Prostate Cancer

Terrence M. Kungel
Chairman & C.E.O.
(855) 552-7200 Ext. 800
TKungel@MCFPC.org
www.MCFPC.org

20 November 2015

Patrick Conway, MD
Deputy Administrator for Innovation & Quality
Centers for Medicare & Medicaid Services
Chief Medical Officer
7500 Security Boulevard
Baltimore, MD 21244

Kate Goodrich, MD
Director Quality Measurement and Value-Based Incentives Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Subject: Non-Recommended PSA-Based Screening 20 November 2015

Dear Drs. Conway and Goodrich,

The Maine Coalition to Fight Prostate Cancer “MCFPC” welcomes the opportunity to submit comments in response to the draft clinical quality measure developed by Mathematica Policy Research on “unnecessary screening for prostate cancer using prostate-specific antigen (PSA).” The Maine Coalition to Fight Prostate is highly concerned that the measure, as proposed, will incentivize doctors to curtail patient discussions about PSA screening, thereby obviating their right to information about risks and benefits, and completely preventing any attempt at shared decision making. As you know, discussion about the risks and benefits of PSA screening in targeted populations is advocated by many leading societies, including the American College of Physicians, the American Society of Clinical Oncology, the National Comprehensive Cancer Network and the AUA. The American College of Physicians recommends discussion about risks and benefits of PSA screening in men between the age of 50 and 69 years. The American Society of Clinical Oncology recommends discussion about risks and benefits of PSA screening in men with a life expectancy > 10 years. The National Comprehensive Cancer Network recommends discussion about risks and benefits of PSA screening in men over the age of 45 years. Finally, the AUA recommends discussion about risks and benefits of PSA screening in men between the age of 55 and 69 years, and in men 40 to 54 years who are African-American or have family history of prostate cancer. Clearly there is substantial disagreement about the role of PSA-screening. At the very least, a national clinical quality measure should not be deeply divisive and controversial, as this PSA screening measure would be. The measure, as currently drafted, recognizes the shortcomings of routine PSA screening without consideration of age/comorbidities, individualized risk for prostate cancer and patient preferences. Additionally, it is based on the current recommendation of the United States Preventive Services Task Force (USPSTF) and a HEDIS measure that only focuses on PSA based screening in men 70 years and older. As you know, the USPSTF is now in the process of updating this specific recommendation (currently in the phase of public comment about research methodology). Therefore, the MCFPC urges CMS to delay further development of this measure until the task force has reviewed the literature, analyzed the evidence, and completed its update process. The proposed measure does not provide exclusions for men at high risk, including African Americans and those with a family history. This is a critical patient population which many medical societies specifically state should be considered distinct from the broader population.

The USPSTF’s D Recommendation ignored compelling data from European studies about the benefits of prostate cancer screening. The USPSTF heavily relied on the badly flawed PLCO study. Current estimates suggest over 1,000+ more men are now dying as a result of the USPSTF flawed position. The number of unnecessary deaths, and wrongful death lawsuits, will only increase if even more doctors abandon routine PSA testing. MCFPC urges CMS to reconsider this measure before holding doctors accountable for



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offering this test to their patients. With such a controversial issue, the importance of shared decision making and the physician and patient relationship cannot be minimized.

The MCFPC appreciates the opportunity to offer comments.

Sincerely,

Terry Kungel

Terrence M. Kungel