MUC2024-049 Breast Cancer Screening Episode-Based Cost Measure

American Academy of Family Physicians (AAFP) comments

Recommendation: Do not support

While we recognize the importance of working to improve affordability and efficiency, as well as the statutory requirement for cost measurement, the proposed cost measures for the MIPS program continue to concern the AAFP as they are currently designed. Before this or any other cost measure is implemented, we believe they should go through a rigorous endorsement process and further testing and refinement. Given the continuous and comprehensive nature of care delivered by family physicians, the AAFP does not believe that episode-based measurement adds value or improves patient outcomes in a primary care context.

We continue to reiterate concerns previously communicated to CMS by the AAFP, as well as many other physician specialty societies. Those include but are not limited to the following:

- The current and proposed episode-based cost measures make the unfounded assumption that lower cost is commensurate with higher quality. While in some cases that may be true, the support for this argument is superficial and among other things, does not account for patient preferences, case mix, and other significant factors that are beyond the measured clinician's control.
- They lack transparency. The inability of clinicians to improve their performance on cost-related measures because of the lack of visibility into the cost of care outside their direct care setting, as well as many cost-related factors fall outside their sphere of control.
    - The lack of interoperability and transparency across care settings makes these measures difficult for clinicians to impact. Eligible clinicians have no way of knowing how they are performing throughout the performance period, and that hinders their ability to maximize their performance.
    - Therefore, these measures do not lend themselves to improvement.
- Risk adjustment methodologies that do not fully recognize the social and economic context of the patient are insufficient to reflect the variance in cost that can result.
- Evidence-based cost measures (EBCMs) are likely to consider the impact of specific condition-related costs at least twice (and sometimes more) in multiple EBCMs. We are concerned this may have a bigger impact on primary care. Given the breadth of care provided by primary care physicians, they are likely to be attributed multiple episode-based cost measures.

Concerns specific to this proposed measure include but are not limited to the following:

- We support the intent of incentivizing early detection. But of all of the cost drivers in US healthcare, we do not think breast cancer screening is the thing to go after.
- Cost measures should not target preventive care and screenings. Based on the information provided, it sounds like this measure could penalize primary care physicians for increasing breast cancer screenings.
- In the Preliminary Assessment, there was no clear explanation of whether primary care physicians will be held accountable for this measure (in addition to radiologists).

Additionally, we urge the developers to explain how a radiologist and/or other attributed physician can control costs for radiology procedures and/or cancer treatments.

- It does not appear there are any exclusions and/or adjustments of/for patients with high-risk status (family history, dense breasts, patients needing MRI, etc.) Additionally, it does not appear there is risk adjustment for anything directly or indirectly related to social needs.
- The Preliminary Assessment states that, "for this continuous variable measure, a lower score indicates better quality of care." We highly disagree with this. A lower score simply indicates lower costs. Lower costs may actually be associated with lower quality of care. Higher costs are sometimes correlated with higher quality of care. The two are not the same.
    - Improved performance (i.e. lower costs) does not equal better patient outcomes in many cases. We are concerned that efforts to reduce costs could lead to poorer outcomes for patients.
- Threats to validity: Clinicians who care for patients with barriers to breast cancer screening and going to follow up appointments could be negatively impacted. If a patient is late to screening, they could have a more advanced presentation upon actually getting the screening done. Then if they have barriers to getting diagnostic imaging and/or biopsies done (i.e. takes longer than 8 months which is very much a reality for some patients who face difficulty navigating the health system, transportation barriers, homelessness, lost to follow up, drug use impacting the ability to use anesthesia), then the disease is likely to be more advanced at presentation.

One possible solution could be a slow, phased implementation of this cost measure. This could entail pay-for-reporting at the outset (or perhaps a zero percent weight) for a few years until the measure has been more thoroughly tested, the specifications have been further refined, and the measure as gained endorsement from a CBE.