EDITORIAL

Punishing Physicians for PSA Screening

In the world of Medicare, failures to e-prescribe or comply with meaningful use can result in decreased payments to physicians. Medicare's intentions, which are admirable, are to improve quality and contain costs and perhaps less admirably, through monetizing physician behavior. Physicians are now faced with a new 2015 Medicare proposal, designed by CMS contractor Mathematica Policy Research, which would financially punish providers who order a PSA screening test to detect prostate cancer. The so called "Non-Recommended PSA-Based Screening" measure is designed to discourage PSA screening in all men over age 18, without regard to age or risk factors.[1] If implemented the measure might find its way into Medicare's clinical quality reporting programs that will involve 50% of physician reimbursements in 2018.

Who developed this proposal? According to their web site "Mathematica provides comprehensive research and data collection services informed by our understanding of policies and programs, experience designing evaluations, and technical knowledge of methods for collecting information and analyzing it."[2] Ironically this group also worked with the state of Massachusetts in 2013 to increase awareness about prostate cancer screening and equip "patients of color" to speak to their providers about PSA screening.[3] What is also concerning about this new CMS proposal is Mathematica's disclaimer that "…these performance measures are not clinical guidelines and do not establish a standard of care….". Can you really say that? Once doctors stop ordering PSA it will clearly impact standard of care. Will CMS protect providers from litigation for failure to diagnose prostate cancer? CMS and their contractor have embarked on a very slippery slope, recently referred to as a "war against men's health".[4] Mathematica's proposal is based upon the 2012 U.S. Preventive Services Task Force (USPSTF) that recommended against PSA-based screening for prostate cancer with a grade "D" recommendation.[5] The impact of the USPSTF action is already being felt. The incidence of screening has decreased by up to 30% with the impact of delayed diagnosis of advanced prostate cancer unclear at this time.

It is well documented that the USPSTF recommendations were considered flawed by many cancer experts and professional groups. It relied heavily on complications and gave little consideration to the increase in active surveillance for low risk disease. The panel embraced a major negative US study that was compromised due to off protocol screening contamination and minimized the 20% mortality reduction of a European screening trial. The USPSTF downplayed the morbidity of untreated metastatic prostate cancer and focused on diagnosis and treatment related side effects, a concept parroted by Mathematica as a reason to decrease PSA testing. Further, concerns raised by the USPSTF policies of excluding specialists who actually treat the disease led to congressional proposals to revamp their evaluation processes. Even in the fine print, the USPSTF responsibly states that patients requesting PSA screening should be provided with the opportunity to make informed choices to be screened that reflect their values about specific benefits and harms.[5] This "Non-Recommended PSA-Based Screening" measure contradicts that USPSTF recommendation.

SEER data has shown that the incidence of metastatic prostate cancer declined dramatically with the advent of PSA screening in the early 1990's. The challenge today is not over diagnosis but the over treatment of low risk nonlife threatening prostate cancer. If CMS is concerned about prostate cancer quality and costs they might be wise to consider starting with rewarding documented value improvements in prostate cancer care. These include: limiting extensive staging studies for low risk disease, not screening asymptomatic men with co-morbidities or limited life expectancies and rewarding appropriate use of active surveillance.

To mandate not doing PSA screening as a quality metric for payments to providers is misguided. To quote Dr. Benjamin Davies, University of Pittsburgh Urologist and contributor to Forbes: "Let's monetize appropriate care, not monetize the wholesale disruption of PSA screening. To do so — as is being proposed — is a war on men's lives to the benefit of nobody". By punishing physicians for ordering PSA screening this is also a war against physicians who might actually help many men through the early detection of prostate cancer.

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