

The LUGPA Alternative Payment Model for Initial Therapy of Newly Diagnosed Patients With Organ-confined Prostate Cancer: Rationale and Development

Deepak A. Kapoor, MD,^{1,2} Neal D. Shore, MD,³ Gary M. Kirsh, MD,⁴ Jonathan Henderson, MD,⁵ Todd D. Cohen, MD,⁶ Kathleen Latino, MD¹

¹Integrated Medical Professionals, PLLC, Melville, NY; ²Icahn School of Medicine at Mount Sinai, New York, NY;

³Carolina Urologic Research Center, Myrtle Beach, SC; ⁴The Urology Group, Cincinnati, OH; ⁵Regional Urology, Shreveport, LA; ⁶Carolina Urology Partners, PLLC, Gastonia, NC

Over the past several decades, rapid expansion in healthcare expenditures has exposed the utilization incentives inherent in fee-for-service payment models. The passage of Medicare Access and CHIP Reauthorization Act of 2015 heralded a transition toward value-based care, creating incentives for practitioners to accept bidirectional risk linked to outcome and utilization metrics. At present, the limited availability of these vehicles excludes all but a handful of providers from participation in alternative payment models (APMs). The LUGPA APM supports the goals of the triple aim in improving the patient experience, enhancing population health and reducing expenditures. By requiring utilization of certified electronic health record technologies, tying payment to quality metrics, and requiring practices to bear more than nominal risk, the LUGPA APM qualifies as an advanced APM, thereby easing the reporting burden and creating opportunities for participating practices.

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KEY WORDS

Merit-based incentive payment system • Alternative payment model • Value-based care • Fee-for-service

The current desire to transition to value-based payment models is more easily understood when placed in context with national expenditures for health care. From 1980 to 1990, Medicare compensated physicians based on a system of usual, customary, and reasonable charges. This system implicitly increased expenditures by rewarding providers who were able to establish high billing profiles. In addition, this system created inequalities based on specialty and geographic location; in that decade, healthcare expenditures increased by a staggering 182.2%, from \$255.3 billion to \$721.4 billion.¹ This prompted the creation of a Physician Payment Review Commission, which, by Congressional mandate, researched alternatives to the then-existing model. The Commission ultimately endorsed the adoption of a standardized fee schedule based on the Resource-Based Relative Value Scale, which was codified in the

Omnibus Budget Reconciliation Act of 1990.^{2,3} Over the next decade, the growth rate in healthcare expenditures was cut by more than half, to an average of 8.9% annually. However, despite this decline, healthcare expenditures continued to be an expanding component of the national Gross Domestic Product (GDP); by the year 2016, healthcare expenditures accounted for 13.3% of GDP, increased from 12.1% and 8.9% in the years 1990 and 1980, respectively (Figure 1).

The growing share of GDP consumed by healthcare costs continued to concern federal lawmakers, and led to the adoption of the Sustainable Growth Rate (SGR) formula in the Balanced Budget Act of 1997.⁴ In essence, through a series of somewhat complex calculations that accounted for changes in price structure and the number of Medicare beneficiaries, the SGR formula linked physician reimbursement to changes in the GDP. This was not an issue during the

1990s, when GDP grew at an average of nearly 5.6%; however, in 2001, GDP growth fell to just over 50% of 2000 levels.⁵ This triggered SGR-mandated payment cuts to providers of 4.8% in 2002.

As can be seen in Figure 2, after 2000, annual percent change in GDP did not correlate with rising healthcare expenditures (Pearson's $r = 0.377$). Consequently, allowable expenditures under the SGR continued, to languish; from 2012 to 2015, Congress addressed pending physician cuts proscribed by the SGR formula through 17 separate temporary patches costing over \$150 billion, which did nothing to solve the fundamental flaws in the formula. Furthermore, because the payment cuts required by SGR were carried forward, this created a widening divergence between allowable and actual expenditures. This resulted in a payment cliff as each patch expired; by March 2015, reconciliation of the SGR formula with actual payment rates would

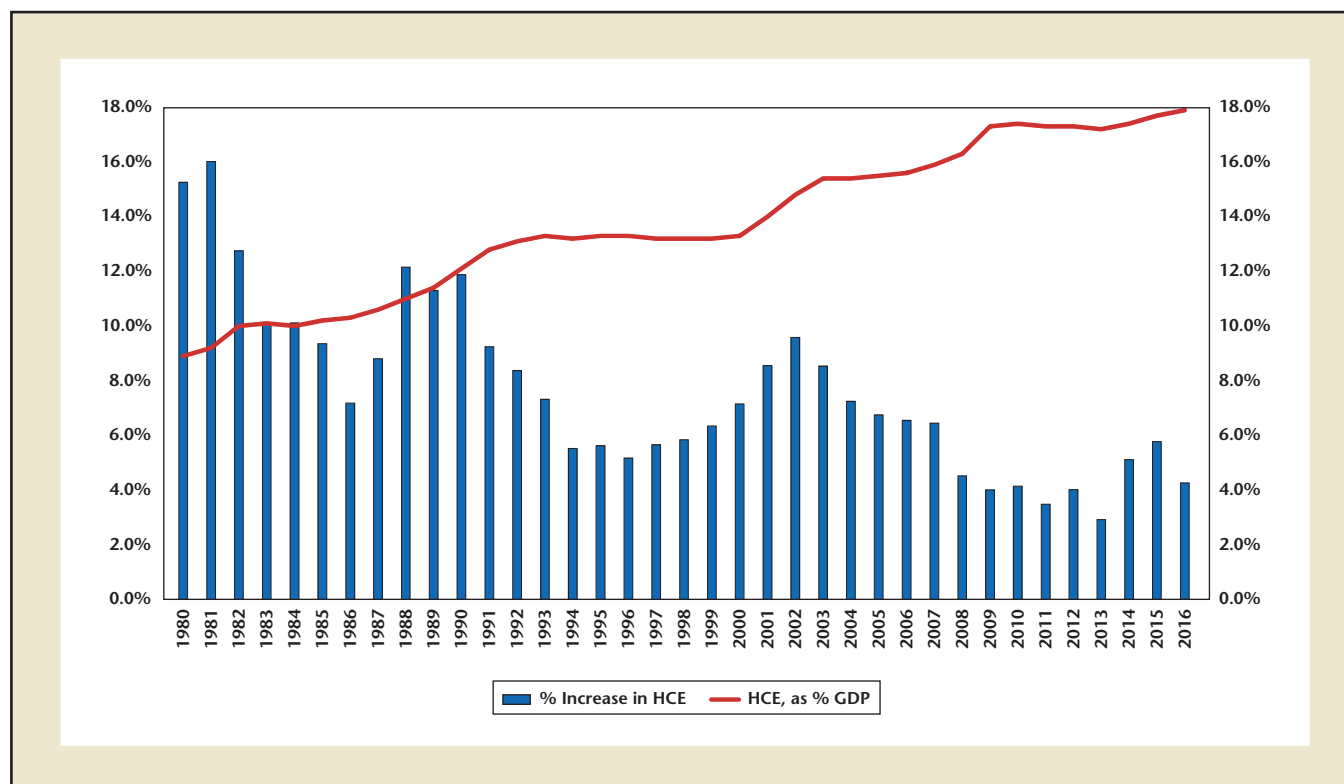


Figure 1. Healthcare expenditures, annual percentage change, and percentage of Gross Domestic Product (GDP).

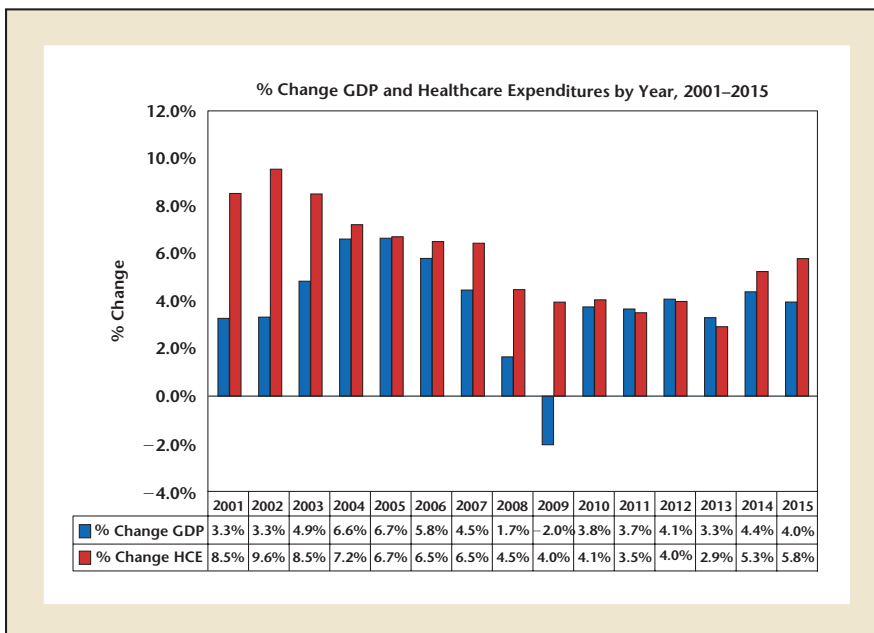


Figure 2. Percentage change in health care expenditures (HCE) and Gross Domestic Product (GDP) by year, 2001–2015. The correlation between percent change in GDP and HCE was determined using the Pearson product-moment correlation coefficient.

have necessitated a fee schedule reduction of 21.2%. It was clear that legislative action was necessary to resolve this issue, but there was concern about both the utilization incentives inherent in fee-for-service models and the disconnect between payments and outcomes; as such, there was little desire to simply return to an unfettered fee-for-service model.

Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as a solution to permanently repeal and replace the flawed SGR formula.⁶ This

which would redistribute revenues from within the provider community based on a normative-based scoring system. To facilitate the shift from fee-for-service to value-based care, MACRA also encouraged the development of alternative payment models (APMs) as an additional payment structure either in conjunction with, or in lieu of, the more traditional model offered under the MIPS. Physicians who participated in varieties of APMs would either be totally exempted from participation in the MIPS, or be subject to more lenient scoring in

urologists nationwide were qualified APM participants in 2017.⁷ This discussion explores the necessity for a specialty-specific urology APM, the requirements for a successful APM, the rationale for newly diagnosed prostate cancer as an APM model, and an overview of the LUGPA APM for initial therapy of newly diagnosed patients with organ-confined prostate cancer.

Issues Related to the MIPS

The MIPS provides physicians with a methodology to continue in a fee-for-service payment model while simultaneously creating incentives to enhance quality and control costs. Under the MIPS, four quality and resource use metrics are combined to form a single score; three of these metrics are adaptations of previously existing programs, and a new fourth program was added. The scores for these four programs are combined into a single aggregate score, after which the Secretary of Health and Human Services will determine the threshold percentiles for bonus and penalties. The various components of MIPS received variable weighting over 3 years, with progressively greater emphasis on resource use during this period. An overview of the historic programs and corresponding MIPS components, with the originally proposed relative weights, is presented in Table 1.

Of the four components of the MIPS, only the resource use component is calculated from claims data; the remaining three require submission by practices on either the basis of National Provider Identification (NPI) number or Taxpayer Identification Number (TIN), depending on the number of providers in the group. To measure resource use, CMS attributes patients to a reporting entity on a retrospective basis using a two-step

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legislation had broad bicameral, bipartisan support and attempted to curtail increased healthcare spending and better align payment with technologic and clinical best practices. By default, providers would be placed in a modified fee-for-service model known as the Merit-based Incentive Payment System (MIPS),

the MIPS program. Unfortunately, although APMs offer many financial advantages over MIPS for qualified practices, urologists are largely excluded from eligibility from participation in APMs; based on historic metrics, the Centers for Medicare and Medicaid Services (CMS) estimated that a mere 88

TABLE 1**MIPS Categories and Scoring Weights, Final Rules vs Initial Proposal (initial proposal in parentheses)**

Historic Programs	MIPS Category	Year of Program (Performance Year)		
		2017 (%)	2018 (%)	2019 (%)
PQRS	Quality	60 (50)	50 (40)	30
Meaningful Use	Advancing care information	25 (25)	25 (25)	25
Value-based Modifier	Resource use	0 (10)	10 (20)	30
N/A	Clinical practice improvement activities	15 (15)	15 (15)	15

The final CMS MACRA Implementation Rule (published 11/4/16) increased the 2017 weighting for Quality from 50% to 60% and reduced Resource Use weighting from 10% to 0%. The Final Rule for CY 2018 Updates to QPP (published 11/02/17), reduces keeping the Quality weight to 50% but increases the weight of Resources Use to 10%, as opposed to 0% in the Proposed Rule. The program weights for 2019 are specified by statute. CMS, Centers for Medicare and Medicaid Services; CY, calendar year; MACRA, Medicare Access and CHIP Reauthorization Act of 2015; MIPS, Merit-based Incentive Payment System; PQRS, Physician Quality Reporting System; QPP, Medicare Quality Payment Program.

system. If a primary care physician performed an evaluation and management service, the patient is attributed to that physician. If not, the patient is assigned to the specialty physician who has the plurality of evaluation and management codes. This is challenging for specialists, as they have no control or knowledge of which patients are going to be attributed to them for the purpose of resource use calculation. The physician to whom the patient is attributed is assigned all costs for inpatient, outpatient, ancillary services, and Part B drugs for that patient, regardless of who provides the service. The MIPS was designed to function as a deficit-neutral program, with penalties from lower-scoring providers used to fund bonuses for higher-scoring providers; in addition, a separate bonus pool of \$500 million was created for “exceptional” performers. However, concerns regarding the stringency of the program led CMS, through the rulemaking process, to make the initial performance year (2017) of the program transitional; eligibility requirements were altered so that 40.8% of providers were exempted from MIPS reporting.⁸ For providers

not exempted from MIPS reporting, three options were provided: (1) report a minimum amount of data and be exempt from both penalties and bonuses; (2) report a partial year of data and be eligible for limited bonuses; or (3) report a full year of data and be eligible for larger bonuses. Providers eligible for MIPS that did not meet the minimum reporting would be subject to a 4% negative payment adjustment in 2019. In addition, CMS recognized concerns regarding the weighting of the various MIPS components and reassigned the resource use component to 0% for the first year; to

modification of the program in the 2018 Proposed Rule with Comment Period. Of particular note is that CMS greatly expanded the number of physicians exempt from MIPS reporting from 40.8% to 63.7%—an increase of 56.1%. Unfortunately, this expansion is not evenly distributed across specialties. Over 97% of providers for which CMS provided MIPS eligibility data in the 2018 Final Rule can be directly or indirectly cross-walked to the 2017 MACRA Final Rule. Table 2 illustrates the 10 specialties with the highest and lowest MIPS reporting obligations. Only an

Only an additional 2.8% of urologists are proposed to be exempted from MIPS reporting in performance period 2018 versus 2017; as such, urology is behind only critical care medicine in the percentage of physicians who are compelled to participate in the MIPS.

compensate for this change, they increased the weight of the quality component to 60% for the 2017 performance period.

CMS reports that it “engaged more than 100 stakeholder organizations and over 47,000 people since January 1, 2017, to raise awareness, solicit feedback, and help clinicians prepare to participate in MIPS”⁹; this resulted in continued

additional 2.8% of urologists are exempted from MIPS reporting in performance period 2018 versus 2017; as such, urology is behind only critical care medicine in the percentage of physicians who are compelled to participate in the MIPS in performance year 2018.¹⁰ Beyond the unequal allocation of MIPS exemptions among different specialties, the attempt by CMS to

TABLE 2**Specialties With Highest and Lowest % MIPS Reporting Obligations**

Provider Type, Specialty	Total Providers	2017 MIPS Eligible	2017 MIPS Eligible (%)	2017 Rank	2018 MIPS Eligible	2018 MIPS Eligible (%)	2018 Rank	% Change, 2017-2018 MIPS Eligible
Critical Care	3466	2625	75.7%	16	2790	80.5%	1	6.3%
Urology	11,606	9222	79.5%	9	8964	77.2%	2	-2.8%
Dermatology	12,821	10,480	81.7%	3	9755	76.1%	3	-6.9%
Gastroenterology	15,352	12,773	83.2%	1	11,298	73.6%	4	-11.5%
Colon/Rectal Surgery	1502	1236	82.3%	2	1071	71.3%	5	-13.3%
Orthopedic Surgery	25,998	20,129	77.4%	14	18,236	70.1%	6	-9.4%
Neurology	17,378	13,049	75.1%	18	12,056	69.4%	7	-7.6%
Thoracic/Cardiac Surgery	4486	3387	75.5%	17	3099	69.1%	8	-8.5%
Pulmonary Disease	13,221	10,542	79.7%	8	9126	69.0%	9	-13.4%
Vascular Surgery	4174	3209	76.9%	15	2846	68.2%	10	-11.3%
...
CRNA	58,974	23,897	40.5%	41	21,582	36.6%	38	-9.7%
Pediatrics	12,116	4577	37.8%	43	4303	35.5%	39	-6.0%
Anesthesiology	50,488	29,902	59.2%	34	17,105	33.9%	40	-42.8%
Psychiatry	33,632	14,199	42.2%	39	11,325	33.7%	41	-20.2%
General Practice	6454	2475	38.3%	42	2155	33.4%	42	-12.9%
Clinical Nurse Specialists	3140	1292	41.1%	40	1000	31.8%	43	-22.6%
Geriatrics	4548	3222	70.8%	24	1434	31.5%	44	-55.5%
Optometry	36,385	12,133	33.3%	44	4793	13.2%	45	-60.5%
Dentist	3180	448	14.1%	46	281	8.8%	46	-37.3%
Chiropractor	45,763	4487	9.8%	47	632	1.4%	47	-85.9%

MIPS, merit-based Incentive Payment System.

ease the regulatory burden on the medical community has created another unintended consequence. Rather than have risk spread over a large pool of providers, a smaller number of what were likely more compliant physicians will now be competing against each other for what will be limited performance bonuses.

There is broad concern about the burden and relevancy of the MIPS program. A recent survey of 750 group practices by the Medical Group Management Association identified the Medicare Quality

Payment Program (QPP) as their single greatest regulatory burden, with 82% of respondents rating the QPP as “very burdensome” or “extremely burdensome.”¹¹ With respect to the MIPS, in particular, 71% of survey respondents said that they are “very concerned” or “extremely concerned” with overall implementation costs, and an even greater percentage—78% of all respondents—said that they are very or extremely concerned with the relevance of MIPS to specialty care. Perhaps most troubling is the fact that nearly three of every four

respondents view the MIPS “[a]s a government program that does not support our practice’s clinical quality priorities.” At the October 5, 2017, Medicare Payment Advisory Commission (MedPAC) meeting, concerns regarding the utility of the MIPS as a mechanism to reward quality prompted nearly unanimous consensus among MedPAC commissioners that MIPS should be “repealed” and “replaced.”¹²

APM Development

Being subject to MIPS reporting, with its associated potential penalties,

Cost of Prostate Cancer Therapy

Just as existing episode-based APMs such as the Comprehensive

not receive active intervention (AI) during the first 12 months after prostate biopsy were considered to have been managed with active

diagnosis; given the percentage of patients newly diagnosed with relatively lower-risk disease, it appears that only nearly half of appropriate AS candidates are actually receiving immediate AI.

Part of this issue may be that the current fee-for-service payment system has not kept pace with existing consensus guidelines¹⁹; consequently, providers are reimbursed nearly 2.7 times more in the first year of diagnosis for AI than for AS. Although AS requires adherence to a rigorous regimen of follow-up, there is no mechanism in place to compensate providers for the resources needed to properly track and counsel newly diagnosed patients with prostate cancer. This counseling is important, as patients with substantial emotional distress are more likely to choose AI over AS at the time of diagnosis.²⁰ Conversely, once on a surveillance protocol, patients on AS may tend to experience more distress than those who initially chose AI.²¹ The lack of resources currently available to providers may account for recent reports of high attrition rates for patients on AS²²; particularly troubling is data suggesting that attrition rates for AS are higher in underserved communities.²³

Regional Variability in Prostate Cancer Therapy

A surprising degree of regional variability exists in the management of

In 2015, there were approximately 79,000 Medicare fee-for-service beneficiaries diagnosed with prostate cancer...

Care for Joint Replacement Model (CJR) reconcile costs on an annual basis,¹⁵ the LUGPA APM development team tabulated the Medicare-allowed amount for all Part A and B claims associated with prostate cancer over a 12-month period, commencing with the prostate

surveillance (AS). The results of the cost analysis are presented in Table 4. Based on this analysis, Medicare expenditures for prostate cancer therapy exceed \$1.7 billion in the first year after diagnosis alone. The substantial nature of this cost is reflected by the fact that,

... Medicare expenditures for prostate cancer therapy exceed \$1.7 billion in the first year after diagnosis alone.

biopsy used to establish the cancer diagnosis. The historic cohort was developed using the Medicare 5% Limited Data Set (LDS) Claims Files for 2011 to 2015 for Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, Ninth Revision (ICD-9), or Medicare Severity-Diagnosis Related Group (MS-DRG) codes referable to International Classification of Disease Codes Version 9 and 10 diagnosis codes referable to prostate cancer.¹⁶ Intervention was defined as any patient undergoing hormonal therapy, surgery, or radiotherapy during the initial 12 months after prostate biopsy. Patients who did

for 2015, Medicare reports that the total outlay for all non-Part B-related urology professional services for all diagnoses was approximately \$1.1 billion.¹⁷

Evolving Clinical Paradigm in Prostate Cancer

Evolving scientific knowledge regarding the natural history of prostate cancer suggests that 43% of newly diagnosed prostate cancer cases had a Gleason score ≤ 6 and would likely be able to defer AI at the time of diagnosis,¹⁸ and instead be closely monitored via AS. Analysis of the Medicare claims data suggests that 23% of newly diagnosed patients with prostate cancer do not have some form of intervention in the first year after

TABLE 4

Annual Episodes and Treatment Cost

Proposed Episode Categories and Subcategories	Annual Episodes (n)	Annual Episodes (%)	Average Episode Cost (\$)
Active Surveillance	14,283	22.8	12,658
Active Intervention	48,356	77.2	32,788
Total	62,640	100.0	28,199

prostate cancer²⁴; limiting variability in disease management through integrated delivery systems has been shown to reduce healthcare expenditures.²⁴ Existing APMs such as the Oncology Care Model and CJR measure costs against benchmarks in regions determined by the United States Census Bureau (Figure 3). To determine if regional variability exists in prostate cancer therapy, the LUGPA APM development team stratified utilization data from the Medicare 5% LDS by Metropolitan Statistical Area (MSA) and then aggregated MSAs into their respective US Census divisions. As shown in Table 5, the results of this analysis revealed a remarkable degree of variation in the management of newly diagnosed patients with prostate cancer, particularly with respect to

utilization of AS versus AI. Use of AS varied from a low of 19.6% to a high of 29.2% in the West South Central and New England census divisions, respectively—a difference of 49.7%. Variation in choice of AI was much less dramatic, with use of radical prostatectomy alone varying between 12.4% and 14.1% in the New England and both East and West South Central divisions, respectively. This regional variation of 13.7% was similar to that seen for radiotherapy alone, which varied 13.9% between the 20.1% and 22.9% utilization observed in New England and West South Central divisions, respectively. Given the differential in cost between AS and AI, reducing the treatment variability between these options should provide an opportunity to reduce treatment costs.

Outcome and Quality Metrics

At present, there is one proposed and three existing quality measures that are specific to prostate cancer: (1) avoidance of overuse of bone scan for staging low-risk prostate cancer patients (National Quality Forum [NQF] 0389); (2) adjuvant hormonal therapy for high-risk or very high-risk prostate cancer (NQF 0390); (3) radical prostatectomy pathology reporting (NQF 1853); and (4) the proposed bone density evaluation for patients with prostate cancer who are receiving androgen deprivation therapy. In addition, practitioners may report on follow-up after biopsy (MIPS/Physician Quality Reporting System), which is not specific to prostate cancer. Not only are there no quality metrics with respect to AS for prostate cancer, but the



Figure 3. US census regions and divisions. Reprinted from www.census.gov.

TABLE 5**Treatment for Newly Diagnosed Patients With Prostate Cancer, by US Census Division**

Treatment Type	New England	Middle Atlantic	East North Central	West North Central	South Atlantic	East South Central	West South Central	Mountain	Pacific
Active surveillance, %	29.2	20.2	21.5	23.0	23.5	19.7	19.6	24.5	27.2
Active intervention, %									
Prostatectomy only, %	12.4	14.0	13.8	13.5	13.4	14.1	14.1	13.2	12.8
Radiation therapy only, %	20.1	22.7	22.3	21.9	21.7	22.8	22.9	21.5	20.7
Hormone therapy only, %	7.7	8.7	8.6	8.4	8.3	8.8	8.8	8.2	7.9
Cryoablation only, %	1.9	2.2	2.1	2.1	2.1	2.2	2.2	2.1	2.0
Prostatectomy and radiation therapy, %	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.9
Prostatectomy and hormone therapy, %	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.9
Hormone and radiation therapy, %	21.7	24.5	24.1	23.6	23.4	24.6	24.7	23.1	22.3
Prostatectomy, hormone, and radiation therapy, %	0.9	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.9
Other, %	4.1	4.7	4.6	4.5	4.5	4.7	4.7	4.4	4.3

only method to determine if a patient is on AS is by excluding all other therapeutic interventions.

clinically appropriate patients, allowing them to avoid potentially unnecessary services. The LUGPA APM,

if total episode spending is less than that established at the benchmark date.

The LUGPA APM is an episode-based model currently under development that aligns incentives for physicians to recommend active surveillance in clinically appropriate patients, allowing patients to avoid potentially unnecessary interventions.

Longitudinal measurements of prostate cancer treatment patterns would benefit greatly if direct measurements of AS existed.

The LUGPA APM for Initial Therapy of Newly Diagnosed Patients With Organ-confined Prostate Cancer

The LUGPA APM is an episode-based model that aligns incentives for physicians to recommend AS in

development of which was supported in part by Myriad Genetics (Salt Lake City, UT) and Integra Connect (West Palm Beach FL), will compensate physicians for the management time required to responsibly continue newly diagnosed patients on AS, while simultaneously creating benchmarks defined based on a practice's historic clinical decision making, considering prior use of AS versus AI. Practices are eligible for a performance-based payment if they meet certain quality thresholds and

Specifically, the LUGPA APM consists of two phases: an initial 12-month total cost of care episode that commences at the initial diagnosis of organ-confined prostate cancer diagnosis, with subsequent episodes of care for qualified beneficiaries who remain on AS after the initial 12-month period. The model includes both a \$75 monthly care management fee for AS episodes and a retrospective performance-based payment for enhancing the utilization of AS over baseline levels. The performance-based bonus payments would only apply to the initial 12-month period, while the monthly care management fee would continue for as long as the patient remained on AS. The

monthly management fee would be used for (1) tracking AS beneficiaries to ensure compliance throughout episodes; (2) tracking laboratory results longitudinally in a consistent format for optimal PSA testing; (3) continually educating beneficiaries about disease progression; (4) social services and care coordination across practitioners; and (5) reviewing/revising the care plan.

The performance payment would consist of a retrospective comparison of actual initial episode spending for newly diagnosed patients against a practice-specific target price. This target price would blend practice-specific and regional prevalence of AS. However, to enhance inclusivity, target prices for low-volume practices would be regional. The target price would utilize 3 years of historic data on utilization of different treatment modalities for prostate cancer (with an update for later performance years) and include trending methodology to account for unit cost changes. The APM would use CMS payment standardization methodology for all calculations with a back-end geographic adjustment to the performance-based payment.

Apart from the novel payment structure that incentivizes use of AS, the LUGPA APM incorporates quality measures in the domains of efficiency and cost reduction, communication and care coordination, clinical outcomes, and process to ensure that appropriate patients are being selected for therapy. In addition to reporting domains on avoidance of overuse of bone scan as well as reporting prostate biopsy results, two additional domains will be utilized. The first is a modification of NQF 2962, which would create a patient-reported outcome measure regarding prostate cancer shared decision making that would apply to all beneficiaries in the initial episode of the APM. The second is a completely new measure that would measure time on AS. Specifically, there would be three nonpayable G-Codes used to describe reasons beneficiaries left AS: (1) beneficiary choice; (2) lack of compliance with AS protocol; and (3) disease progression. The calculation of the measure would be straightforward, with the denominator being the number of beneficiaries in initial or subsequent AS episodes

and the numerator being the sum of number of months beneficiaries in the denominator were on AS. There is not a current mechanism to track the duration of AS, and this measure would fill that void while allowing APM entities to better track beneficiaries on AS. Moreover, nonparticipating urologists can also use the G-Codes, allowing for national tracking of both the utilization and duration of AS.

Although the focus of any APM should be on ensuring that patient outcomes and satisfaction are enhanced, it is also important that these vehicles do so in an economically responsible fashion. In addition to enhancing shared decision making, improving compliance with recommended clinical pathways, and reducing morbidity associated with AI, the LUGPA APM has the potential to substantially reduce Medicare expenditures. The differential between expenditures for AS and AI is approximately \$20,000 in the first year after diagnosis; a 10% increase in utilization of AS would mean savings to the Medicare program in excess of \$125 million annually.

MAIN POINTS

- Over the past several decades, rapid expansion in healthcare expenditures has exposed the utilization incentives inherent in fee-for-service payment models.
- The passage of the Medicare Access and CHIP Reauthorization Act of 2015 heralded a transition toward value-based care, creating incentives for practitioners to accept bidirectional risk linked to outcome and utilization metrics.
- At present, there are no urology-specific alternative payment models available; as such, most urologists are compelled to participate in the Merit-based Incentive Payment System.
- The LUGPA alternative payment model (APM) is an episode-based model currently under development that aligns incentives for physicians to recommend active surveillance in clinically appropriate patients, allowing patients to avoid potentially unnecessary interventions.
- The LUGPA APM supports the goals of the triple aim in improving the patient experience, enhancing population health and reducing expenditures. The LUGPA APM is designed to have broad appeal to urologists, including those in large and small practices, whether independent or hospital owned, with or without ownership of ancillary services.

Conclusions

Over the past several decades, rapid expansion in healthcare expenditures has exposed the utilization incentives inherent in fee-for-service payment models. The passage of MACRA heralded a transition toward value-based care, creating incentives for practitioners to accept bidirectional risk linked to outcome and utilization metrics. At present, the limited availability of these vehicles excludes all but a handful of providers from participation in APMs. At present, there are no urology-specific APMs available; as such, most urologists are compelled to participate in the MIPS. Although CMS has eased the regulatory burden on the medical community as a whole, the distribution of MIPS exemptions is disproportionate, creating additional management issues for urology practices.

The LUGPA APM supports the goals of the triple aim in improving the patient experience, enhancing population health and reducing expenditures. By requiring utilization of certified electronic health record technologies, tying payment to quality metrics, and requiring practices to bear more than nominal risk, the LUGPA APM qualifies as an advanced APM, thereby easing the reporting burden and creating opportunities for participating practices. The LUGPA APM is designed to have broad appeal to urologists, including those in large and small practices, whether independent or hospital-owned, with or without ownership of ancillary services. Endorsed by both the American Urological Association and the

American Association of Clinical Urologists, the LUGPA APM creates a substantial value proposition for CMS and APM participants by utilizing AS when appropriate. Given the unmet need filled by this proposal for urology participation in APMs, the opportunity to reduce medical expenditures, and most importantly, the opportunity to enhance outcomes and beneficiary experience, the LUGPA APM could be the foundation for value-based care models in urology. ■

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