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# Incentivizing the Lower-Cost Decision: LUGPA Believes It Knows How

Ariela Katz | November 19, 2017



Deepak A. Kapoor, MD

A newly proposed urology-specific alternative payment model (APM) could save up to 37% on costs of care, partly by giving physicians incentives to pursue active surveillance (AS) rather than active intervention (AI), according to the Large Urology Group Practice Association (LUGPA).<sup>1</sup>

The model is predicated on the belief that a subgroup of patients who typically receive AI could benefit from deferred AI, “thus avoiding overutilization of services while reducing morbidity and cost,” LUGPA said in a statement.<sup>2</sup>

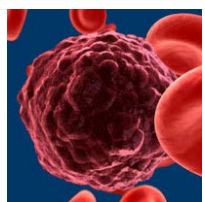
LUGPA estimates that in 2015, 79,000 Medicare fee-for-service beneficiaries were newly diagnosed with prostate cancer, and 79% of those cases were localized to the prostate. Of those diagnosed with localized disease, 77% received AI. LUGPA believes that a subgroup of this population can safely defer AI and thereby avoid overutilization of services while reducing morbidity and costs. LUGPA said that, based on an analysis, an average AI episode of care costs Medicare over 2.5 times more than an AS episode, a difference of over \$20,000.<sup>1</sup>

LUGPA’s model would use a specialized payment model to give physicians more of an incentive to choose AS in cases where it is medically appropriate. The model, which has been submitted to HHS for consideration, would provide fees during AS for care management of beneficiaries diagnosed with localized prostate cancer. Also, physicians would receive performance-based

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proposal to be submitted and is one of only a handful of submitted proposals across all of healthcare,” said Deepak A. Kapoor, MD, chairman of LUGPA’s health policy committee.<sup>2</sup>

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The LUGPA APM has been submitted to the HHS’ Physician-Focused Payment Model Technical Advisory Committee for review. The public comments period has ended, and the payment model now will be considered by a review team that will assess the proposal, additional information, and public comments. After formulation of recommendations, the APM proposal will be brought to a full advisory committee for deliberation and a public vote. Finally, the application will be sent with a recommendation for consideration by the Secretary.<sup>3</sup>

The proposed APM is designed for both independent and hospital-based urologists and is specifically for initial therapy of patients with newly diagnosed organ-confined prostate cancer.<sup>1</sup> In the APM, episodes of care are divided into 12-month blocks. LUGPA proposes that for patients who are receiving AS or AI, the initial episodes of care should begin with a prostate biopsy and a diagnosis of prostate cancer. For patients who remain on an AS program, it is advised that they continue with additional 12-month episodes of care.

A number of quality measures would be used to evaluate results in the model, including efficiency and cost reduction, communication and coordination of care, clinical outcomes, and patient-reported outcomes. LUGPA is predicting that the proposed APM could save \$138 million in healthcare costs over 5 years, with Medicare’s share of that savings being approximately \$51 million.<sup>1</sup>

“We believe our proposed APM achieves the Triple Aim of improving both patient care and societal health outcomes, while also reducing total expenditures,” stated Neal D. Shore, MD, president of LUGPA, in a press release.<sup>2</sup> “If approved by CMS, this APM should positively affect US urologic care.”

The APM proposal comes at a time when costs related to prostate care may be on the rise. Various groups—such the American Urological Association, the American Society for Radiation Oncology, and the Society of Urologic Oncology—have issued guidelines for increased screening for clinically localized prostate cancer, potentially spawning a rise in prostate biopsies. These guidelines state that patients who elect AS should receive a systematic biopsy with ultrasound or MRI-guided imaging as part of disease staging and should be encouraged to have a confirmatory biopsy within the initial 2 years and surveillance biopsies thereafter.<sup>4</sup>

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