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Alternative Payment Models and Urology

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Abstract

Purpose of Review—The Medicare Access and CHIP Reauthorization Act (MACRA) is a historic bill that was recently passed that establishes how quality measurement and practice patterns will affect physician reimbursement. Alternative Payment Models (APMs) are an essential component of MACRA and Medicare’s vision of paying for high-value care. This review describes APMs in the context of MACRA and their impact on urology.

Recent findings—The majority of urologists will be affected by MACRA. Both APMs and bundled payments are considered APMs under MACRA. While most urologists do not currently participate in ACOs and Bundled Payments, both models are considered APMs under MACRA and are likely going to gain increasing attention in the coming years.

Summary—APMs will likely become more relevant to urologists’ practices in the future as both CMS and private payers are transitioning away from fee-for-service towards value-based payment.

Keywords

Bundled payments; accountable care organizations; alternative payment models; MACRA; urology

Introduction

In an attempt to transition from paying for health care quantity to paying for high value care, Medicare and other commercial payers are increasingly turning to alternative payment models (APMs). “Alternative payment model” is a broad term that defines several mechanisms by which payment moves away from the traditional fee-for-service structure, and links reimbursement more directly with quality and value in health care.

Medicare Access and CHIP Reauthorization Act of 2015

The Centers for Medicare and Medicaid Services (CMS) has a stated goal to have alternative payment models be responsible for 50% of payments by the end of 2018[1]. In an effort to achieve this goal, on October 14, 2016 CMS, released the final rule for the Medicare Access and CHIP Reauthorization Act (MACRA), a historic bill that permanently replaced the

Sustainable Growth Rate[2]. This legislation had great bipartisan support and may be one of the most important set of legislative changes with regards to direct impact on physician payments in recent history. MACRA establishes how quality measurement and practice patterns will affect physician reimbursement and APMs are an essential component of MACRA.

MACRA affects all physicians who bill Medicare more than \$30,000/year, provide care for greater than 100 Medicare beneficiaries per year, and who have participated in Medicare prior to 2017. The bill also impacts advanced practitioners (physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists). Measurement will start January 1, 2017, but bonuses and penalties will not be awarded until 2019.

To start, eligible professionals will choose to be a part of one of two separate pathways: the Merit-Based Incentive Payment System (MIPS) or APMs, between January 1, 2017 and Oct 2, 2017. Providers will collect data from Jan 1, 2017 to December 31, 2017. Bonuses and penalties will begin to be distributed January 1, 2019[3]. Figure 1 outlines the initial MACRA timeline.

Alternative Payment Models—Both MIPS and APMs are technically alternative payment models that attempt to drive quality and value into health care payment. In advanced (or qualified) alternative payment models, which are commonly referred to as APMs under MACRA, Medicare no longer reimburses providers based on the traditional fee-for-service structure. The term APM is vague and may apply to care provided for a specific population, episode of care, or clinical condition. However, under MACRA, Qualified APMs include: 1. A model established under the Centers for Medicare & Medicaid Innovation (CMMI), but not one that has received a Care Innovation Reward; 2. A Medicare Shared Savings Program Accountable Care Organization; 3. A Medicare Health Care Quality Demonstration Program; and 4. A demonstration program required by federal law. In addition, the model must fulfill 3 requirements: Certified EHR use; professional service payments based on MIPS-like quality measures; and be an entity that bears more than “nominal risk” or is an enhanced medical home[4]. Furthermore, physicians eligible to be in the Advanced APM track must have a certain percentage of payments or patients through an eligible APM; for 2017, this number is 25% of Medicare payments or 20% of Medicare patients. Current APMs (but not necessarily those considered an Eligible APM under MACRA) include: accountable care organizations (ACOs), patient centered medical homes, and bundled payments. A tentative list of Advanced APMs under MACRA, includes: Comprehensive ESRD Care – 2 sided risk, Comprehensive Primary Care Plus (CPC+), Next generation ACO model, Shared Savings Program (Track 2 & 3), Oncology Care Model, and Comprehensive Care for Joint Replacement (CJR).

Under MACRA, if physicians participate in APMs, they do not receive MIPS payment adjustments. Instead, they have the opportunity to earn a MIPS incentive bonus, which is 5% of a physician’s prior year’s total annual expenditures awarded in 2019, for participation in 2017.

MIPS—In contrast to APMs, MIPS adjusts fee-for-service payments in an attempt to modify payments for increasing value. MIPS assigns physicians with a Composite Performance Score, which is calculated based on quality, clinical practice improvement activities, Meaningful Use of Certified Electronic Health Record technology, and resource use measures. The measure is a culmination of measures from the Value based Payment modifier, Physician Quality Reporting System, and the Medicare Electronic Health Record (HER) for eligible professionals (EPs), and now replaces these individual measures. Physicians will receive payment adjustments based on the Composite Performance Score. This score does not pertain to hospitals or facilities.

If participating in MIPS, providers will report performance data by March 31, 2018 and Medicare will provide performance feedback in 2018. Bonuses and penalties will begin to be distributed January 1, 2019.

MACRA and Urology—How MACRA will affect urologists' remains unclear. What is clear is that the majority of urologists will be affected, with the potential for monetary gains or losses. Table 1 provides a summary of alternative payment models and potential roles for Urologists. During the transition year, it is estimated that roughly 79.5% of providers will be covered under MIPS, with exclusions occurring for low volume (16.2%), newly enrolled in Medicare (3.6%) and qualifying APM participants (QPs, 0.8%). It is estimated that in 2019, under the standard scoring model, urologists will receive \$11 million dollars for bonus payments, including exceptional performance outliers and will be responsible for \$4 million dollars in penalties because of failing to participate, all together totaling 0.6% of allowed charges[5].

Currently, APMs do not play a major role in urologists practices. However, many hypothesize an increasing trend away from fee-for-service payment and towards APMs. In order to be successful under MACRA, better integration will be critical, with some theorizing that groups that are currently more integrated, such as those affiliated with the Large Urology Group Practice Association (LUGPA), will be better able to respond to MACRA than academic groups. However, others hypothesize that academic and larger private practices will respond similarly to the shift towards value and integration, making the practice structures more analogous.[6] Furthermore, across specialty partnerships will be essential, and urologists will need to examine the full spectrum of health outcomes that may result from a surgical episode. [7] Moreover, practices will have to track quality metrics and be able to respond to the results accordingly. Some Urology practices are already developing protocols and surveying their own quality metrics, which may make for an easier transition to MACRA [6].

Accountable Care Organizations (ACOs) as Alternative Payment Models

“Accountable care organization” is a general term that describes a payment model that attempts to tie payments to quality and value [8]. It is usually a provider-led organization; often with a primary care focus, but including specialists; and covers a population of people. The ACO is responsible for cost and quality improvements for an established population of patients [9].

ACOs are one of the fastest growing alternative payment model entities. As of the end of January 2016, ACOs demonstrated a 12.6% growth over the previous year, with 838 ACOs in all 50 states and the District of Columbia. ACOs cover 28.3 million lives, and 22% of Medicare beneficiaries in 477 Medicare ACOs. However, ACOs include both public (Medicare and Medicaid) and commercial contracts, with a greater share of commercial contracts than government contracts (17.2 for commercial payers vs. 8.3 for Medicare +2.9 for Medicaid ACO lives per payer in millions)[10].

Potential unintended consequences for accountable care organizations—

Although initial results demonstrated improved quality and cost savings with ACOs [11], recent analyses suggest that Medicare ACOs may not actually reduce cost and yield significant improvements in quality [12, 13]. Without a significant shared savings, physicians may feel as though the practice changes required by their ACO may not be worth the trouble. In addition, most ACOs are large organizations and physician participants may feel disconnected from the decisions that are made by their ACO leadership. Physician engagement will be essential for the success of ACOs.

ACOs and MACRA—Under MACRA, ACOs that meet the previously described APM criteria, will be considered “Advanced” or “Qualified” APMs and will be eligible for the resultant gains (or losses). Those ACOs that do not meet the required criteria will be subject to MIPS.

ACOs and Urology—Only 10% of urologists (1118) are MSSP ACO participants[14]. However, 50% of the original MSSP ACOs had at least one urologist participating its organization (and up to 55). Groups that included urology providers had more total number of providers and covered a larger number of beneficiaries compared to those that did not include an urologist[14]. While most APMs are currently primary care focused, CMS’ goal is to have more models applicable to specialty groups in the future[7]. As a part of this goal, MACRA created a Physician – Focused Payment Model Technical Advisory Committee, which is a board comprised of 11 physicians, who are tasked with the goal of reviewing submissions for new APMs and submitting recommendations to the HHS Secretary.

In the future, in order for urologists to realize gains under MACRA, costs, savings and quality measures will be increasingly measured and it will be important for urologists to analyze high cost events and if care could be improved in a more cost-efficient manner. Furthermore, urologists will likely see more care transition to clinics, rather than ER visits; outpatient procedures will more likely be done in clinic settings, and procedures will be more likely to be performed in outpatient centers, rather than as inpatients, if appropriate. It will also be necessary to avoid great variability in treatment and costs and it will be critical to participate in more care coordination with PCPs and other specialists[9].

Episode-based bundled payments

Bundled payments are another potential mechanism by which a provider can realize gains from APM participation under MACRA. Bundled payments occur when a single entity is held financially responsible for all services in a given period of time. In a traditional sense, a

bundled payment is a lump sum payment for hospitalization costs, physician costs, and post acute care costs; but in reality, it is usually done through retrospective reconciliation and may or may not include all of the costs in the acute and post-acute phase of the health care service.

Bundled payments started in 1983, with the kidney transplant bundle at UCLA. [15] Medicare entered the bundle payment market in 1991, where 4 hospitals participated in the “Medicare Participating Heart Bypass Center Demonstration.” During this demonstration project, Medicare paid one fee for the inpatient hospital fee, physician services, and any readmissions related to the surgery. This demonstration expanded to 7 hospitals and continued until 1996.

Current demonstration programs—Currently, the Centers for Medicare and Medicaid Innovation (CMMI) is piloting four models of care, under its Bundled Payment for Care Improvement (BPCI) Initiative [16]. Model 1 is a single payment for a hospital admission, which does not include physician services. All MS-DRGs are included in the bundle. Model 2 is a retrospective payment where participants choose from 48 clinical care episodes. The bundle is based on inpatient and post-acute care and related services for 90 days. Actual expenditures are compared to target prices and gains or losses are realized. Model 3 is similar to model 2, but only includes post-inpatient care at a skilled nursing facility or using home health care. Model 4 is a single bundled payment, including physician services, for an entire hospital stay. In this model, participants also choose from 48 clinical care episodes.

The Oncology Care model is another bundled payment, where participants receive regular Medicare FFS payments plus an additional 2 part payment system: a per-beneficiary Monthly Enhanced Oncology Services (MEOS) payment for care coordination and a performance based payment for each care episode, which is calculated retrospectively on a semi-annual basis. The bundle is loosely defined and includes both Medicare and commercial payers.

Mandatory Bundled Payments—In addition to these demonstration programs, Medicare currently has several mandatory programs. These include the Comprehensive Care for Joint Replacement (CJR) model and the Bundled Payment Model for Cardiac Care.

CJR was initially started April 1, 2016. After January 1, 2019, practices participating in CJR will assume downside risk for care episodes. Practices can choose to accept downside risk as early as January 1, 2018, so that they can be Advanced APM participants under MACRA.

Payment includes all charges for an episode of care for diagnosis codes MS-DRG 469 or 470. The payment begins with the inpatient surgery and ends 90 days after discharge and includes all services covered under Medicare Parts A and B. Each year, Medicare will release benchmark prices for each MS-DRG. Hospitals will be paid on a fee-for-service basis prospectively, but actual spending will be compared to Medicare’s target, and bonuses will be rewarded or repayments made based on cost and quality and the benchmark price. Participation is mandatory for and limited to hospitals located in 67 geographic areas

(Metropolitan Statistical Areas). Initially, this bundle only included total hip and knee replacements, but it now includes surgeries to repair hip and femur fractures[17].

The Bundled Payment Model for Cardiac Care includes the Acute Myocardial Infarction (AMI) model and the Coronary Artery Bypass Graft (CABG) bundle. These are retrospective, 90 day bundles, where the fee-for-service payment is set against a benchmark. The bundles will begin July 1, 2017 and are expected to run through December 31, 2021. Downside risk will begin performance year (PY) 3. There will be additional incentives for patients to receive cardiac rehab services after hospital discharge. CMS will initially randomly select hospitals for mandatory participation. These models will also qualify as Advanced Alternative Payment Models under MACRA.

Potential unintended consequences for bundled payments—Physicians have several concerns about bundled payments. First, since current bundled payment programs do not incorporate robust risk-adjustment, physicians that treat medically complex patients may be unfairly penalized[18]. Second, the implementation of bundled payments may lead to an undue administrative burden for practices. For example, it will be difficult for a practice to understand how to do well in a bundled payment program without sophisticated analytics. Finally, physicians may feel a loss of autonomy in their ability to order tests that may be expensive, but clinically necessary [19].

Bundled payments and Urology—There are currently no urology-specific bundled payments, but many theorize that they are likely to be initiated in the future. Both the American Urologic Association (AUA) and LUGPA are currently working on creating episodes of care. In fact, the AUA has an alternative payment model workgroup, which is working with the American College of Surgeons (ACS) on creating APMs for prostatectomy and nephrectomy.[20] LUGPA has partnered with Integra Connect to create urology specific APMs [21].

The future of alternative payment models

At the time of writing this manuscript, the fate of the Affordable Care Act (ACA) has yet to be determined. Principles such as paying for increased value, health care transparency, and patient access to data are long-standing and held true prior to the inception of the ACA. [22] Although the current administration promised to eliminate the ACA during the presidential campaign, MACRA embodies many of these values and was passed with great bi-partisan support, so may be unlikely to change. However, CMMI was created as a part of the ACA and has been responsible for devising and evaluating Medicare's APMs. Since the values on which CMMI is based have bi-partisan support, and the goal of CMMI is decreased domestic spending, it is also less likely that it will be discontinued [22]. Furthermore, the move away from traditional FFS towards value is occurring outside of the ACA and government programs and thus the trend, regardless of what happens with the ACA, will likely continue.

In contrast, changes may be realized with the mandatory nature of bundled payment, as the Health and Human Services (HHS) secretary, Tom Price, was leading the effort to eliminate

mandatory bundled payments prior to his confirmation. However, only time will tell what changes will truly come with the new administration.

Conclusion

APMs are playing a critical role in the United States transformation of paying for health care quantity to a system paying for increased value. MACRA is accelerating the role of APMs in the health care system, but growth in APMs is occurring outside of MACRA as well and is also being driven by commercial payers. It will be important for urologists to track and respond to quality measures and increase care coordination, both goals of APMs, in order to succeed under MACRA.

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- Medicare Access and CHIP Reauthorization Act (MACRA) establishes how quality measurement and practice patterns will affect physician reimbursement and APMs are an essential component of MACRA.
- Alternative payment models (APMs) include Accountable Care Organizations (ACOs) and bundled payments.
- While APMs do not currently play a large role in urologists' practices, they will likely become more relevant in the future as both CMS and private payers are transitioning away from fee-for-service towards value-based payment

Figure 1.

Initial Medicare Access and CHIP Reauthorization Act of 2015 Image based on figure created by CMS [3].

Table 1

Alternative payment models (APMs) and urologists' potential role

Alternative Payment Model	Urologists' Potential Role
MACRA	In 2017, about 80% of providers will be covered under MIPS and 0.8% as qualified APM participants
Accountable Care Organizations (ACO)	Currently primary care focused, but CMS' goal is to have more models apply to specialty groups in the future
Bundled Payments	Currently no urology-specific bundles; AUA working on prostatectomy and nephrectomy bundle; LUGPA working on urology specific APM