

Federal Quality Reporting & the AUA Quality Registry (AQUA)

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Medicare Access and CHIP* Reauthorization Act (MACRA)

- March & April 2015, Bipartisan legislation
 - House 392 to 37; Senate 92 to 8
- April 2016, “Proposed Rule” announced
 - Clarifies implementation of MACRA
 - Comment period ended July 2016
- October 14, 2016, “Final Rule” published
- First reporting period starts January 2017[†]
([†]2017 is “transition” with phased engagement)



Medicare Payment Prior to MACRA

Fee-for-service (FFS) payment system, where clinicians are paid based on volume of services, not value.

The Sustainable Growth Rate (SGR)

- Established in 1997 to control the cost of Medicare payments to physicians

IF



**Overall
physician
costs**

>



**Target
Medicare
expenditures**



**Physician payments
cut across the board**



Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)



SGR



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2 Paths in new “Quality Payment Program” (QPP)

**Merit-based
Incentive
Payment
System (MIPS)**

or

**Advanced
Alternate
Payment Models
(A-APMs)**



Volume



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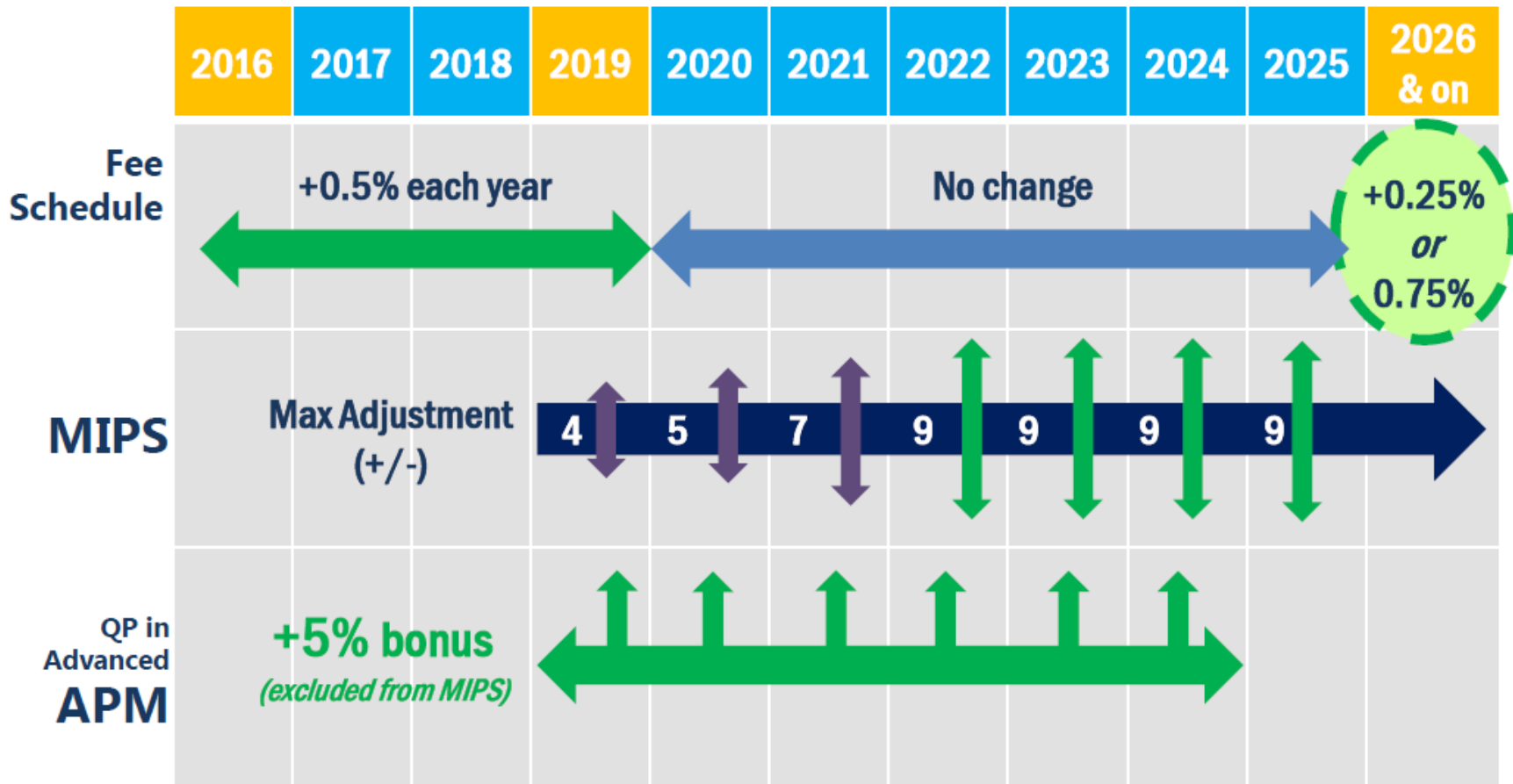
Value



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Payment Incentives



2 Paths in new “Quality Payment Program” (QPP)

**Merit-based
Incentive
Payment
System (MIPS)**

or

**Advanced
Alternate
Payment Models
(A-APMs)**



Existing Medicare Reporting Programs

**Physician
Quality
Reporting
Program (PQRS)**

**Value-Based
Payment
Modifier**

**EHR Incentive
Program
(Meaningful
Use)**



All rolled into MIPS



Quality



Cost



**Advancing Care
Information**



**Improvement
Activities**



4 Components to the MIPS Composite Performance Score (CPS)

- 1) Quality (current Physician Quality Reporting System / PQRS)
- 2) Cost (current Value-Based Modifier)
- 3) Advancing Care Information (current Meaningful Use)
- 4) Improvement Activities (New)

MIPS: Who is Included?

- All physicians (MD and DO), dentists, podiatrists, optometrists, PAs, NPs, CRNAs and clinical nurse specialists UNLESS they fall into 1 of 3 categories:
 - First year of Medicare Part B participation
 - Bill Medicare for less than \$30K annually AND see fewer than 100 Medicare Part B patients per year (this is about ~ 1/3 of Medicare providers but only 5% of Medicare payments)
 - Participate in an A-APM





Quality Payment Program

Check if you're included in MIPS

Now you can check if a clinician who bills to Medicare will need to submit data to MIPS. Just enter your National Provider Identifier (NPI) number into our tool.

[Check Now >](#)



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Am I included in MIPS?

To check if you need to submit data to MIPS, enter your 10-digit [National Provider Identifier \(NPI\)](#) number.

If you're exempt from MIPS with the first review, you won't need to do anything else for MIPS this year. If you are included with the second review of eligibility determinations at the end of 2017. [Learn more about MIPS eligibility.](#)

National Provider Identifier (NPI)

[Check Now](#)

Participating in an Alternative Payment Model (APM)? Talk to your Center for Medicare & Medicaid Innovation (CMMI) your participation. If you need help finding this information, please email us at qpp@cms.hhs.gov or call 1-866-288-8292



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Included in MIPS

J STUART WOLF, MD **must submit data to MIPS by March 2018.** This clinician will need to report as an individual or with a group.

Wha

Show Less

Clinician Summary

Clinician Name	NPI	Provider Type	Associated TINs	Enrolled in Medicare before
J STUART WOLF, MD	1023100492	Doctor of Medicine	1	Yes

Practice Details

Practice Name	Address	If clinician reports as individual	If clinician reports with group *
REGENTS OF THE UNIVERSITY OF MICHIGAN	475 MARKET PLACE BLDG ONE ANN ARBOR, MI 481091649	Included in MIPS. This clinician has billed Medicare for more than \$30,000 and has provided care for more than 100 patients at this practice.	Included in MIPS. This practice has more than \$30,000 and has provided care for more than 100 patients.

* If all clinicians in this group are excluded from MIPS because of provider type, the group does not need to report for 2017.



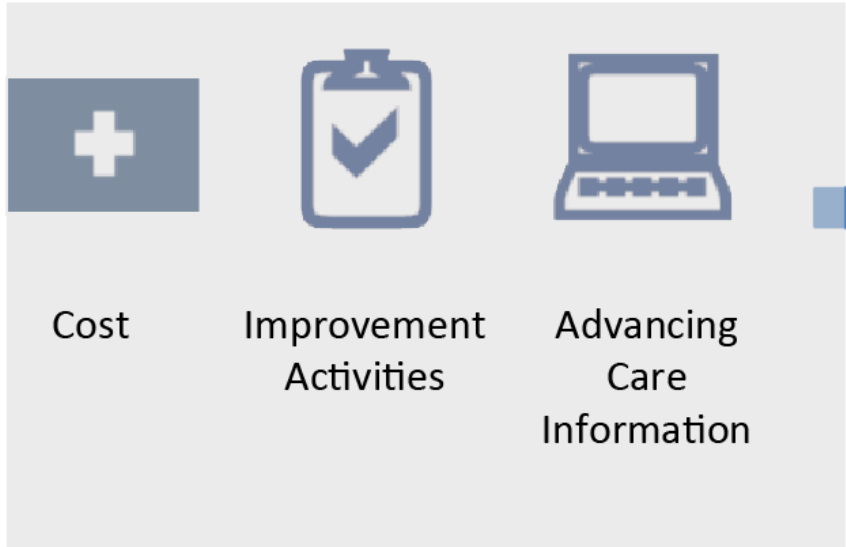
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Quality



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Quality

- 271 measures to choose from, need to report on 6 (down from 9 in PQRS)
- Must include 1 outcome measure or other high-priority measure
- Urology specialty measure set
- Report on 80% of your Medicare patients



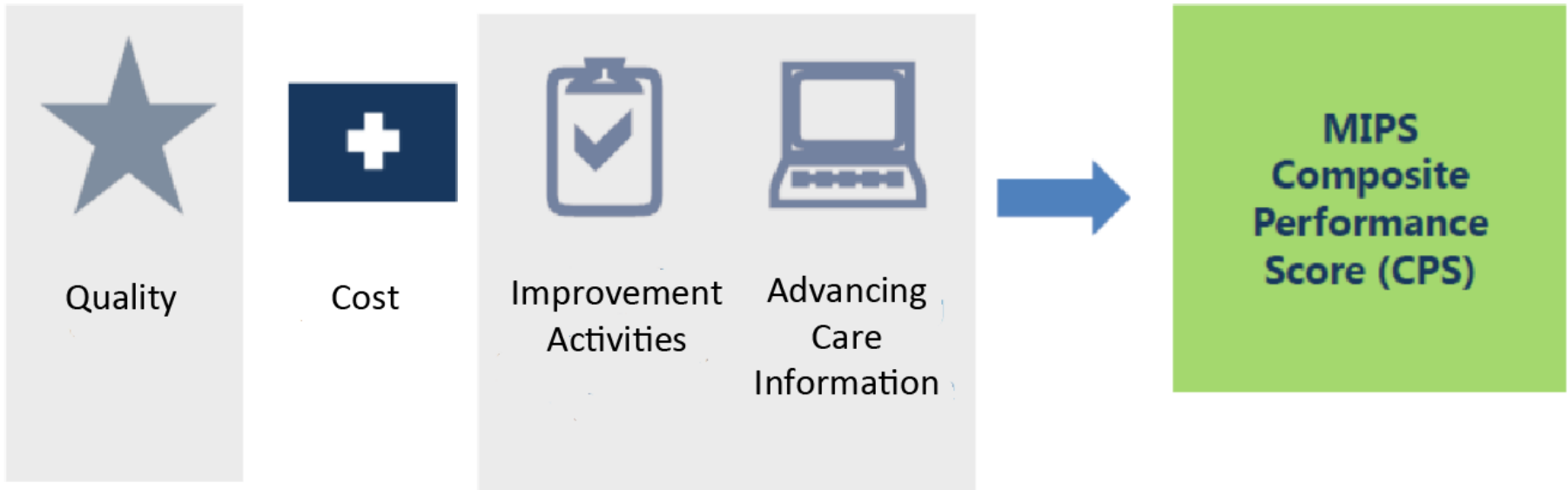
Urology Specialty Measure Set

1. Assess urinary incontinence, women > 65 yo
2. Plan of care for #1
3. No bone scan in low risk CaP
4. ADT in high risk CaP managed with XRT
5. Reporting Bx result to PCP/Ref MD and patient
6. Assess personalized risk of surgery
7. Receipt of specialist report



Urology Specialty Measure Set

8. Screen for and counsel about tobacco use
9. Screen for and counsel about tobacco use, adolescent
10. Screen for HTN and document follow-up
11. Documentation of medications
12. Medication reconciliation post-discharge
13. Advance care plan

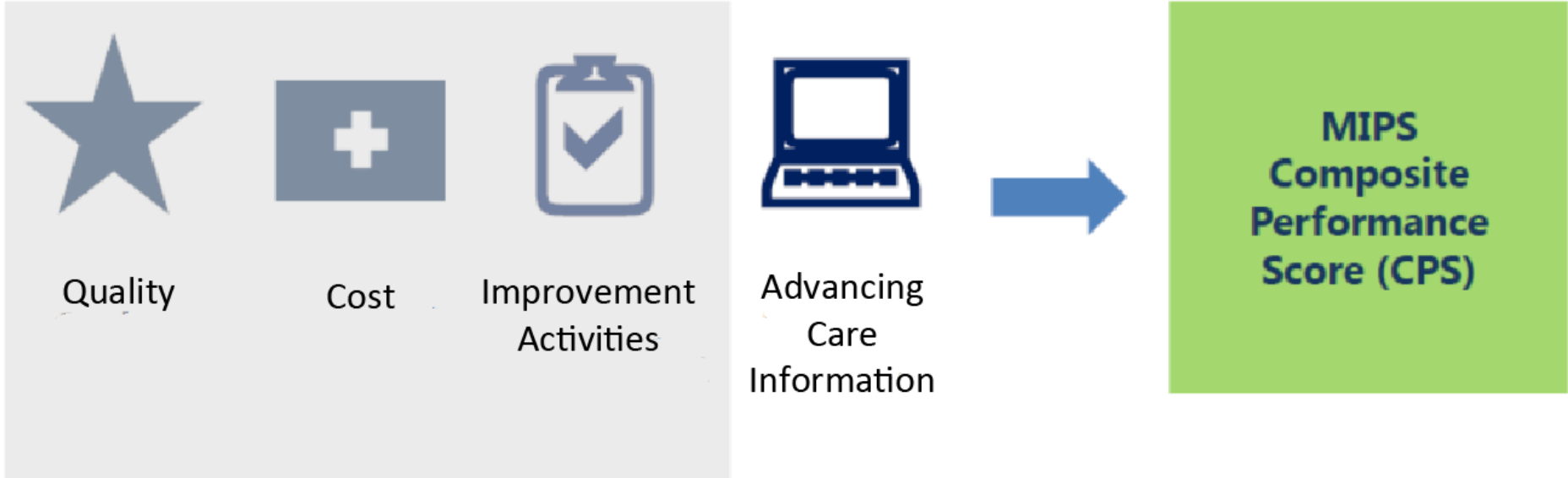


Adapted from CMS.gov

Cost

- CMS calculates quality and efficiency of care delivered to your patients
- Calculated and reported back to you, but NOT being used for payment adjustment in 2017
- > 40 episode-specific measures, each worth up to 10 points
- Requires at least 20 patients to whom measure is applicable for measure to be assessed
- “Risk-adjusted”





Adapted from CMS.gov

Advancing Care Information

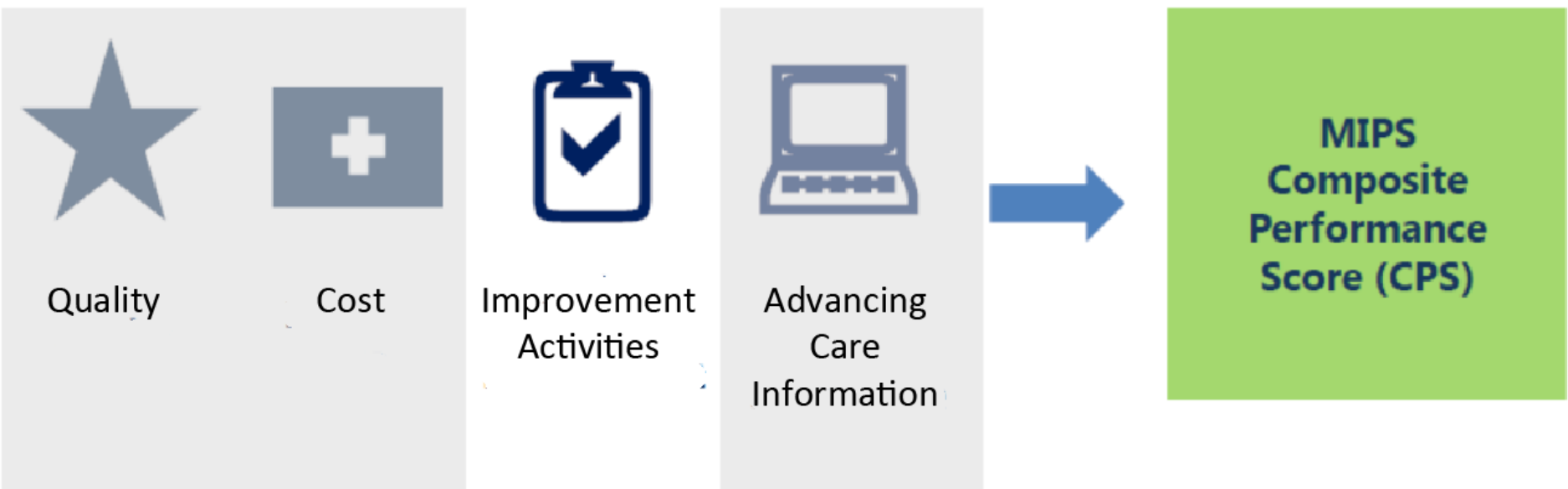
- Meaningful Use was an “all or nothing” program
- With Advancing Care Information, can get partial credit
- Still must use certified EHR technology to report



Advancing Care Information: 5 measures

- 1) Protect Patient Health Information (security risk analysis)
 - 2) Electronic Prescribing
 - 3) Provide Patient Electronic Access
 - 4) Send Summary of Care
 - 5) Request / Accept summary of Care
- (in 2017, also have optional measures that can add to score, such as practice improvement using cEHR, reporting to public health or registries)





Adapted from CMS.gov

Improvement Activities

- Over 90 possible activities identified by CMS
- Minimum of 90 days participation
- Complete enough activities to get the maximum of 60 points (10 – 20 points each)
[in 2017, only need 40 points, and only 20 for small practices]



9 Categories of Improvement Activities

1. Expanded Practice Access
2. Population Management
3. Care Coordination
4. Beneficiary Engagement
5. Patient Safety and Practice Assessment
6. Participation in an APM
7. Achieving Health Equity
8. Integrating Behavioral and Mental Health
9. Emergency Preparedness and Response

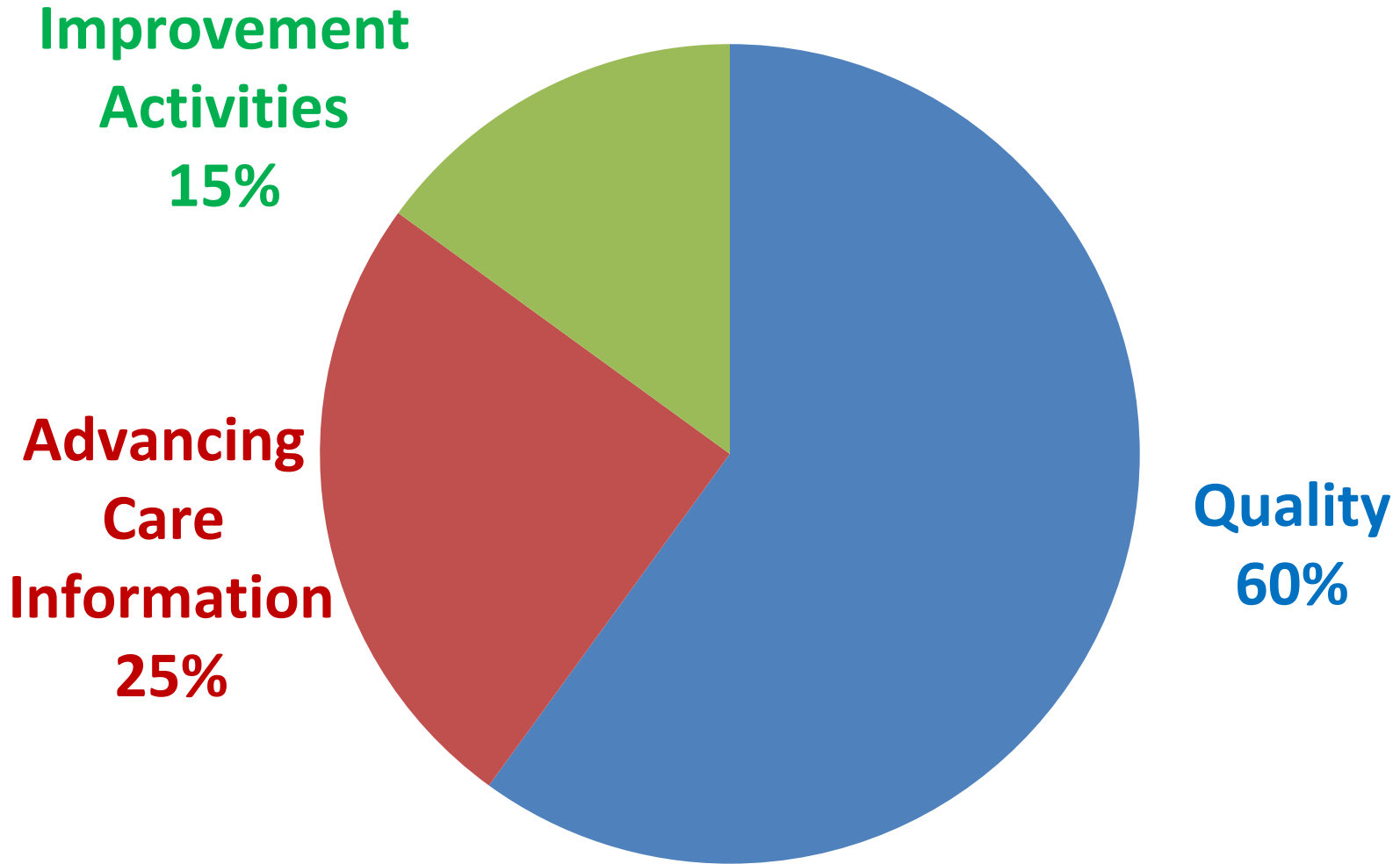


Examples of Improvement Activities

- Collection of patient satisfaction data and development of an improvement plan
- QCDR reports summarizing local practice patterns
- QI projects related to specific populations
- Promotion of standard practices
- Implementation of shared decision making
- Apply patient engagement tools
- Use of patient-reported outcomes (PROs)



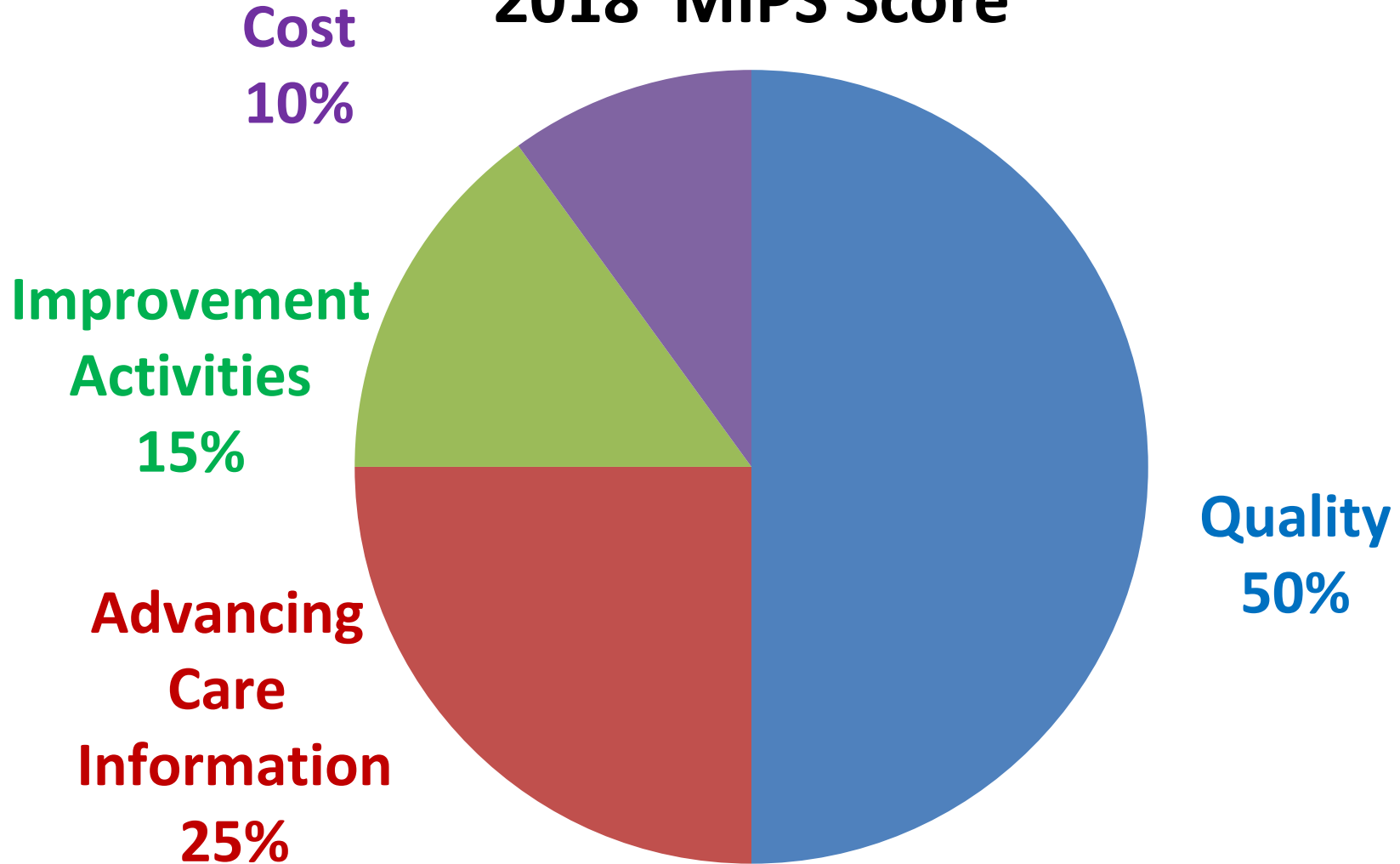
2017 MIPS Score



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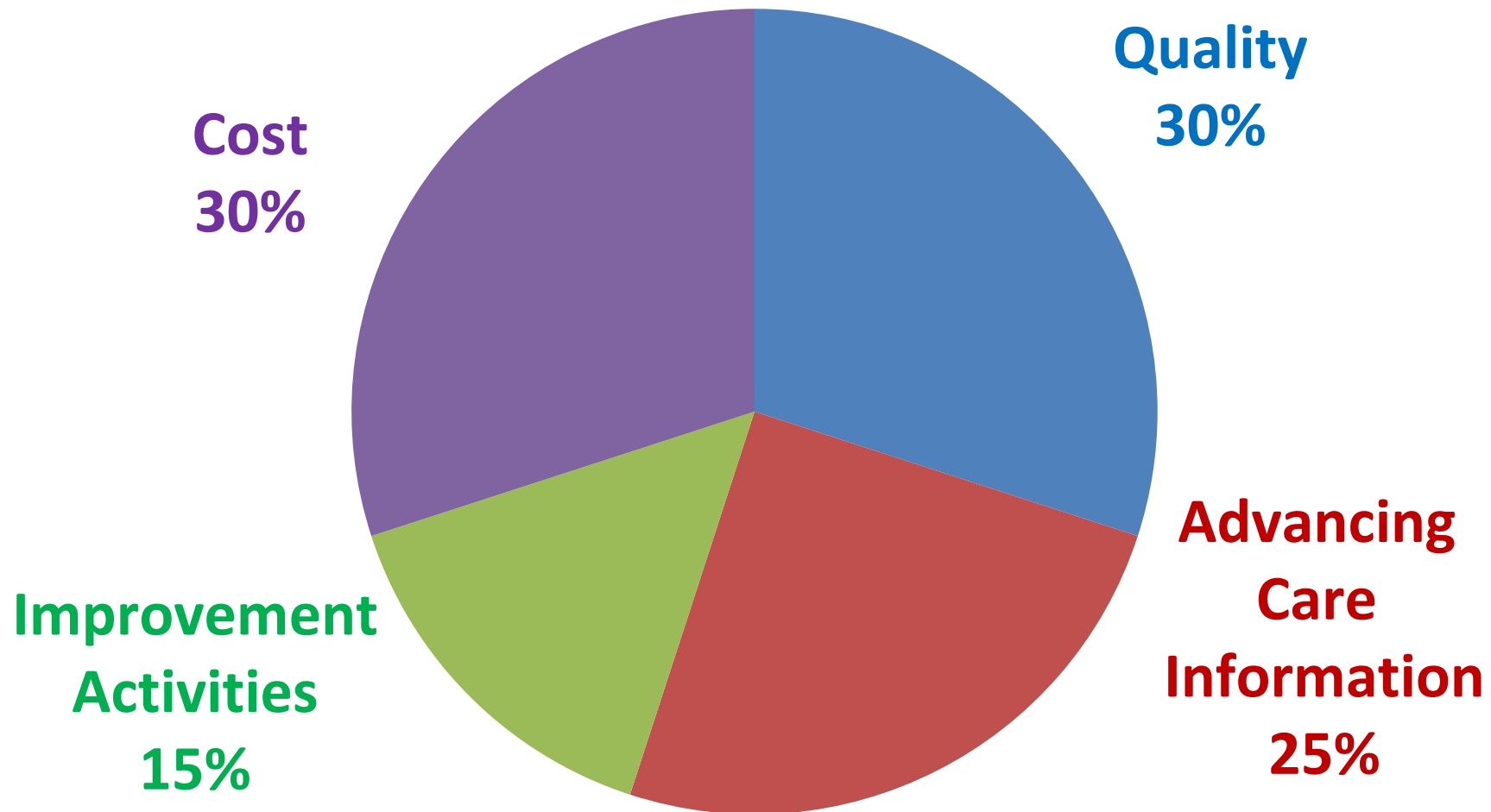
2018 MIPS Score



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2019 MIPS Score



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Data Submission Options

Individual Reporting



Group Reporting



Quality

- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR
- ✓ Administrative Claims (No submission required)
- ✓ Claims

- ✓ QCDR
- ✓ Qualified Registry
- ✓ EHR
- ✓ Administrative Claims (No submission required)
- ✓ CMS Web Interface (groups of 25 or more)
- ✓ CAHPS for MIPS Survey

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Data Submission Options

Individual Reporting



Group Reporting



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care
information



IA

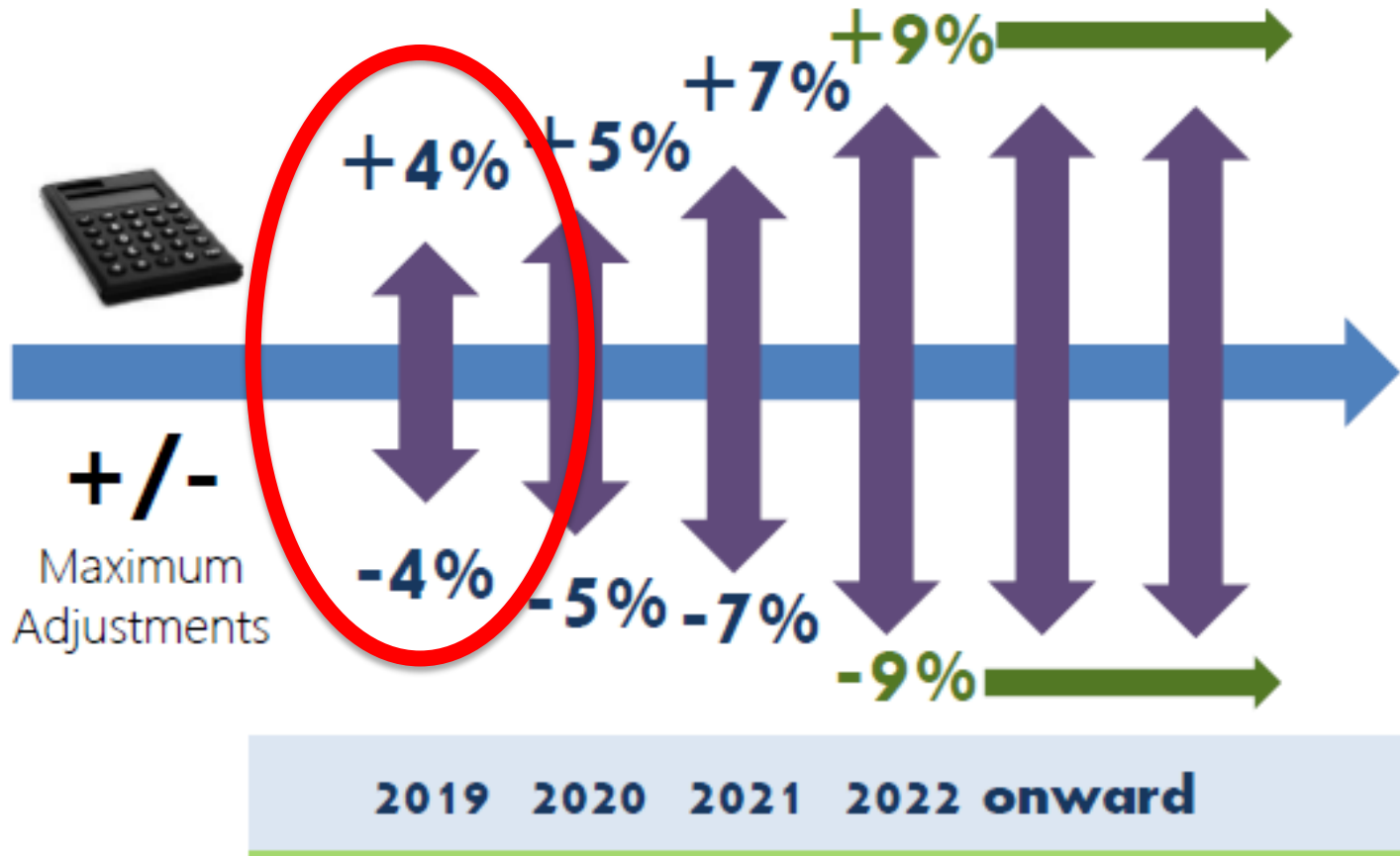
- ✓ Attestation
- ✓ QCDR
- ✓ Qualified Registry
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MIPS Payment Adjustment



Modifications for 1st Year, 2017

- Payment adjustments made 2 years after reporting (payment in 2019 based on 2017 reporting)
- 4 options for 2017 reporting (2019 payments):
 - No participation – 4% penalty
 - Submit partial report (1 quality or improvement measure, or 4 ACI measures) – no adjustment
 - Submit full report, but only 90 days – no penalty, up to 2% bonus
 - Submit full report for full year – no penalty, up to 4% bonus

Modifications for 1st Year, 2017

- After 2017, must submit full report for full year to avoid 5% penalty, and full range of bonus / penalty adjustments start
- Recognizing that MIPS reporting is harder in some settings, \$20 million/year for 5 years to educate clinicians in small practices, rural areas, and underserved areas



Pick Your Pace for Participation for the Transitional Year

Participate in an Advanced Alternative Payment Model



- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

MIPS

Test



Submit Something

- Submit **some** data after January 1, 2017
- Neutral or small payment adjustment

Partial Year



Submit a Partial Year

- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year

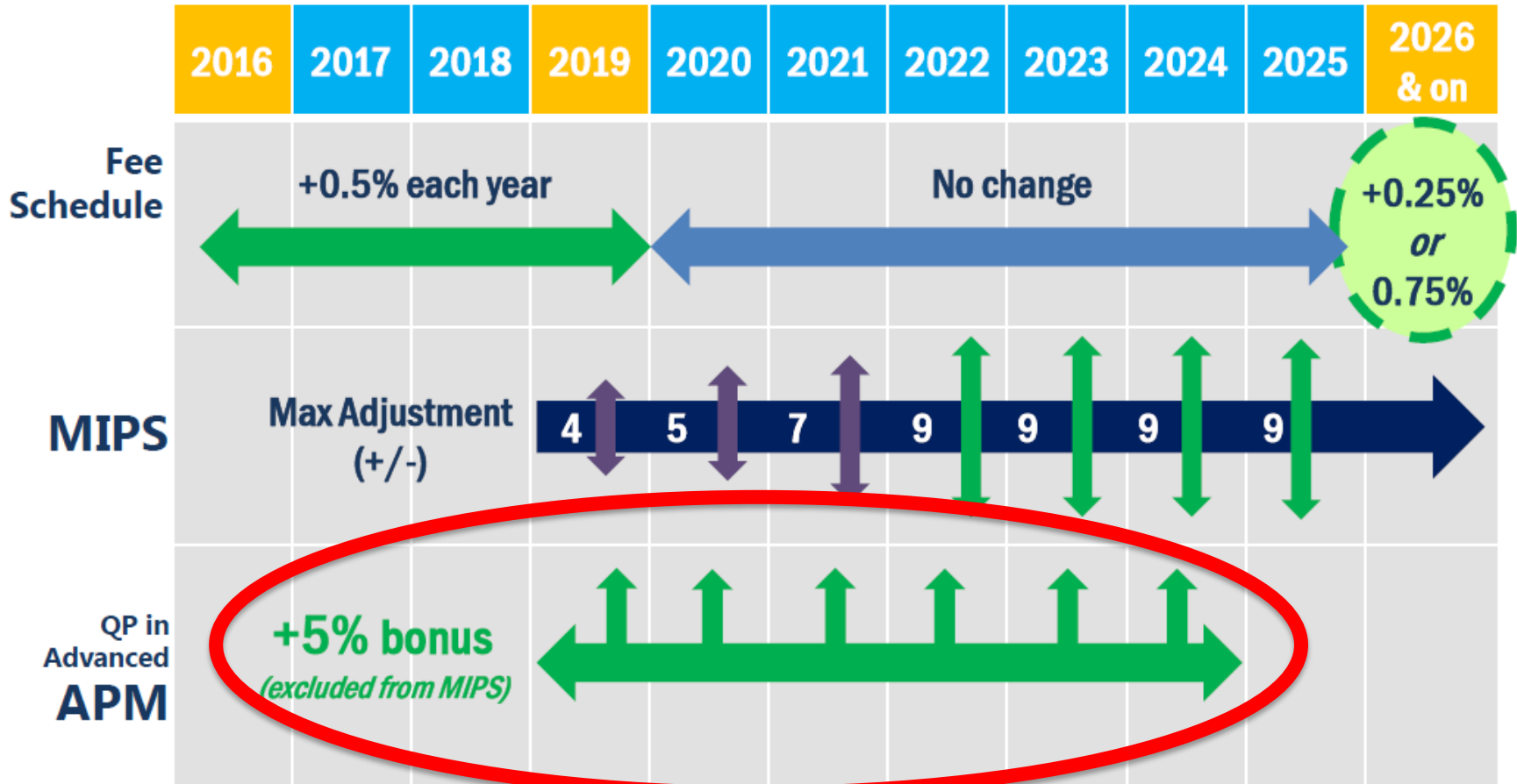


Submit a Full Year

- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.

Payment Incentives

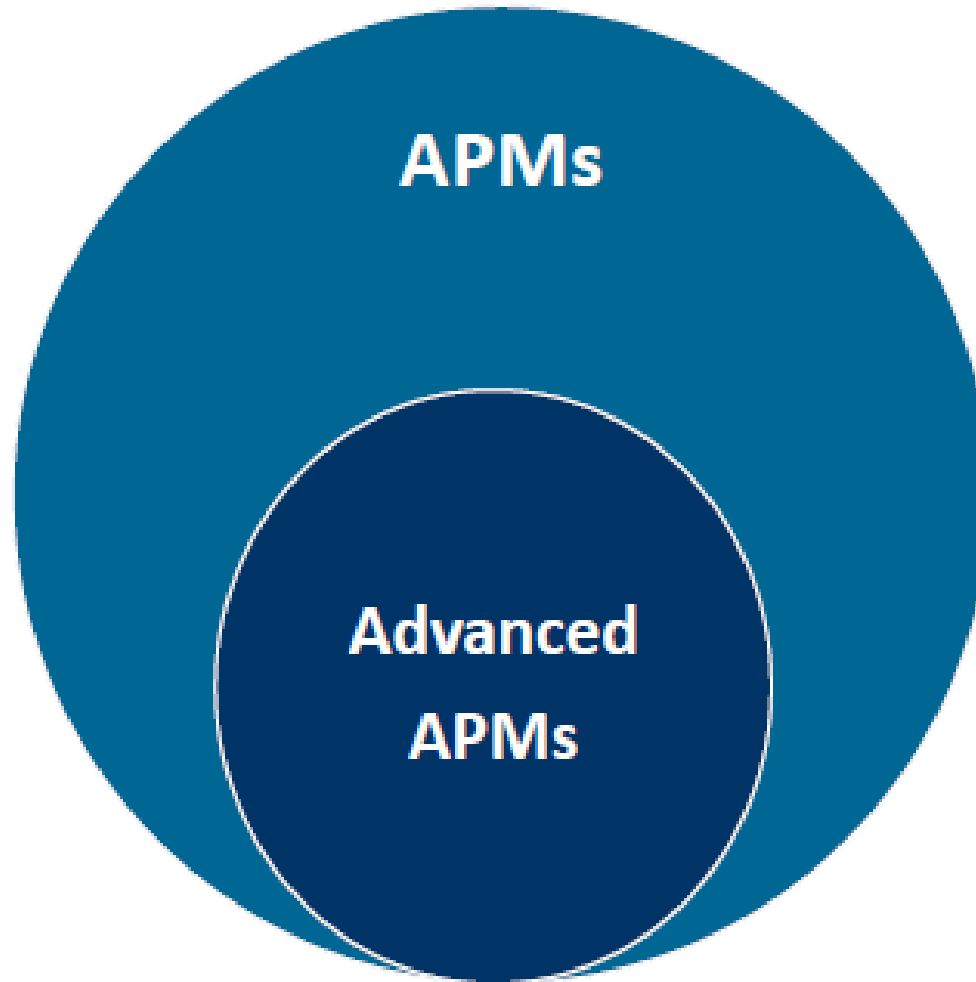


Alternative Payment Models (APMs)

- Payment approach that gives financial incentives to clinicians to provide high-quality and cost-efficient care
- “Value-based healthcare”
 - Pay for Value, not Volume
- Can apply to a specific clinical condition, a care episode, or a population



Advanced APMs are a Subset of APMs



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Advanced Alternative Payment Models (A-APMs)

- Must use certified EHR technology
- Use quality measures comparable to those in MIPS quality performance category
- At least **25% of total CMS payments**, or at least **20% of CMS patients**
- Either: (1) APM must bear “more than nominal” **financial risk for monetary losses**; OR (2) is a Medical Home Model



Another Option: MIPS-APMs

- For interested providers who cannot take on risk and requirements of A-APMs
- APMs that do not meet criteria for A-APMs
 - A-APM, but insufficient payment or patient participation
 - Not enough financial risk to be A-APM
- Do not get 5% bonus as per A-APMs, but eligible for positive MIPS adjustment





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How to Prepare

1. Get educated about the new programs
2. Determine if you are exempt from MIPS
3. Meet CMS objectives for Meaningful Use (MU) of your EHR
4. Decide on MIPS vs MIPS-APMs vs A-APMs



How to Prepare

5. Decide on individual versus group reporting (for solo and small group, can join together into “virtual groups”)
6. Decide on reporting mechanism: claims, EHR, registry, qualified clinical data registry (QCDR) or web interface
7. (Enroll in AQUA) 😊



The AUA Quality (AQUA) Registry

Launched in 2014, to collect national process and outcomes data for patients with urologic diseases

- Primary goal
 - Quality improvement
- Secondary goals
 - Satisfy regulatory requirements
 - Next-generation research
 - Inform Urology policy efforts

Rationale

- Study of complex conditions requires *clinical* data, ideally collected prospectively
- Existing clinical registry efforts have excellent track records in quality improvement and research, but based on manual data collection and difficult to scale



Key Principles

- Software (FIGMD) minimizes data entry burden – **data extracted from EMR**
- Data ownership by individual practices and the AUA only
- Practice-level data shared only with individual practice, benchmarked against aggregate data
- No practice will see any other individual practice's data



**Patient
Reported
Outcomes (PRO)**

**Patient Information &
Clinical Records from EHR**

**Other Data
Sources (Claims,
Genotype Data)**

**AQUA REGISTRY
DATA CLOUD**

**QCDR for Quality
Reporting
with Urology-Specific
Measures**

**Interactive Dashboard
with Process, Outcomes
and Physician
Performance Measures**

**Smart Report for
Facilitating Quality
Improvement Activities
& Earning MOC Part 4
Credits**

**Data Repository to
Support Basic Science,
Translational &
Outcomes Research**

**QCDR for Advancing
Care Information (ACI),
Clinical Improvement
Activities (IA)**

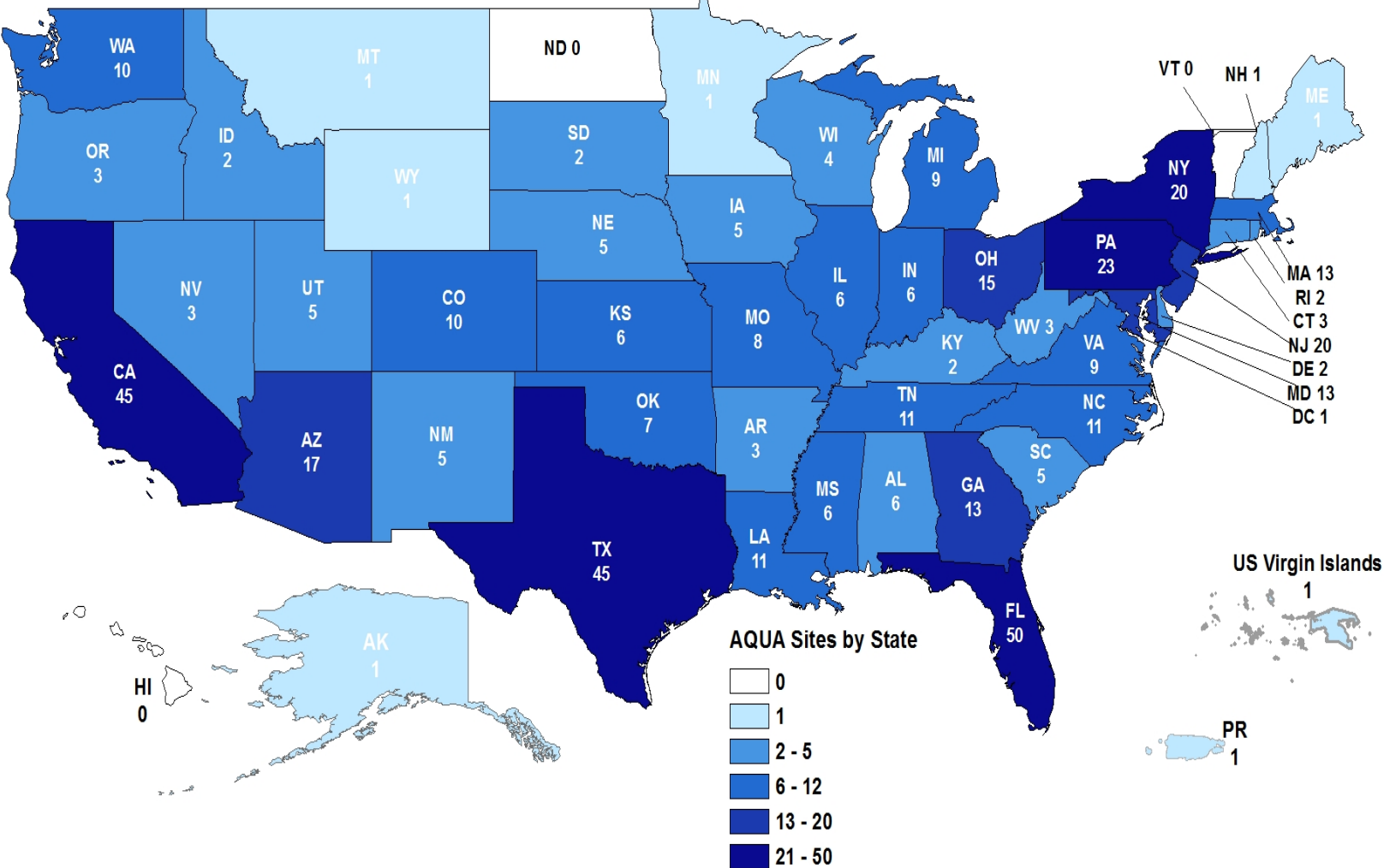
Current Status

AQUA Registry — Progress as of May 2017

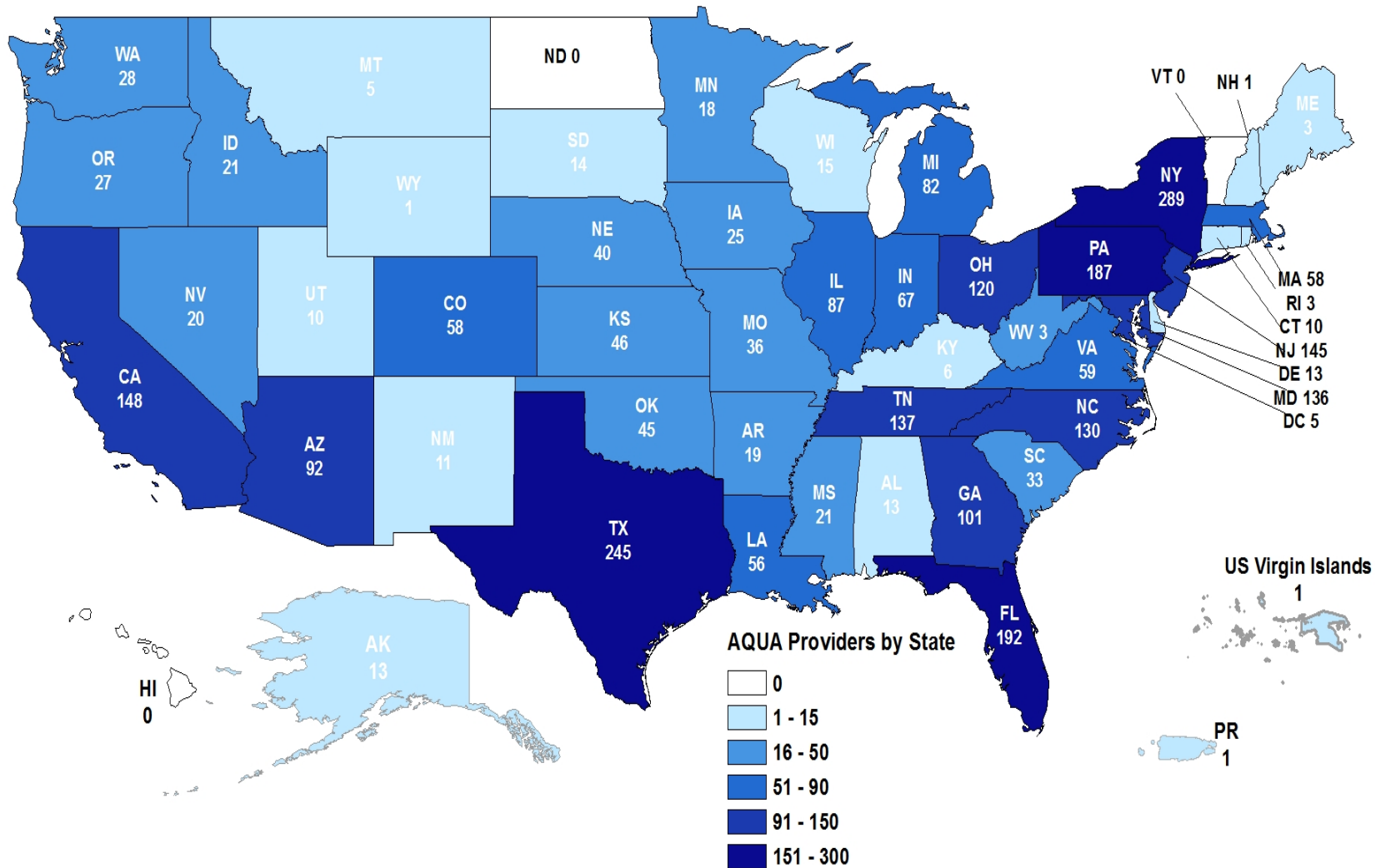
- 453 practices that include 2,925 Urology Care Providers
- Submitted PQRS for 215 providers, QCDR in 2017
- A combination of private and academic practices from 47 states, Puerto Rico, US Virgin Islands and DC
- 2.49 million patients with 8.25 million patient encounters
- 243,000 prostate cancer patients or 8.5% of prostate cancer patients in the United States
- PRO program piloted at 4 sites



Distributions of AQUA Practices



Distributions of AQUA Providers

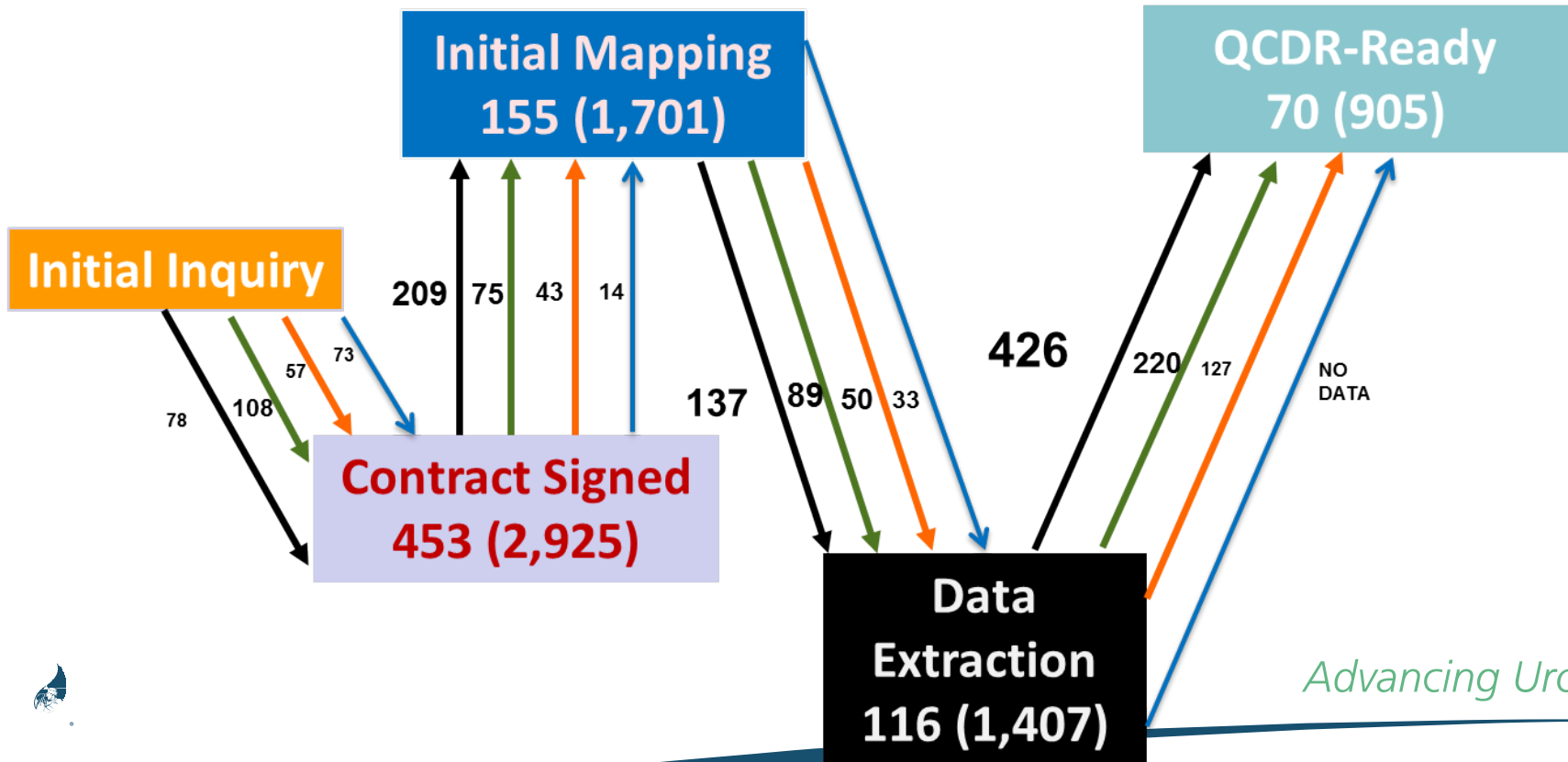


Progress Chart by Year



Number of Days Taken to Proceed by Year

Legend: # of Sites (# of Providers)



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Dashboard Preview

matthew.cooperbe...

- Dashboards
- Practice
- Practice Group
- Provider
- Location
- Forms
- RPC
- Administration
- Help
- Logout



Dashboards > Practice

Practice: [Redacted]

2014Q4 [ALL] [FAVORITES]

Practice		Exceeding	Below
[Redacted]		7	1
ID	MEASURE	PERFORMANCE	
AQUA 01	Documentation of DRE findings in the MD note	24.08% (Registry Benchmark: 52.02%)	>
AQUA 02	Documentation of Gleason score in the MD note associated with the diagnosis	90.13% (Registry Benchmark: 87.77%)	>
AQUA 03	Documentation of clinical stage in the MD note associated with the diagnosis	47.79% (Registry Benchmark: 45.36%)	>
AQUA 04	Documentation of PSA in the MD note associated with the diagnosis	88.19% (Registry Benchmark: 67.91%)	>
AQUA 05	Documentation of extent of biopsy involvement in the MD note associated with the diagnosis	0.00% (Registry Benchmark: 0.00%)	>
AQUA 06	Documentation of family history in the MD note associated with the diagnosis	0.00% (Registry Benchmark: 0.00%)	>
AQUA 07	Use of bone scan in low-risk disease	8.96% (Registry Benchmark: 10.94%)	>
AQUA 08	Use of neoadjuvant/adjuvant hormonal therapy in high-risk disease	81.67% (Registry Benchmark: 49.66%)	>



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Dashboard Preview

AQUA 02 : Documentation of Gleason score in the MD note associated with the diagnosis



⚡ PERFORMANCE TREND

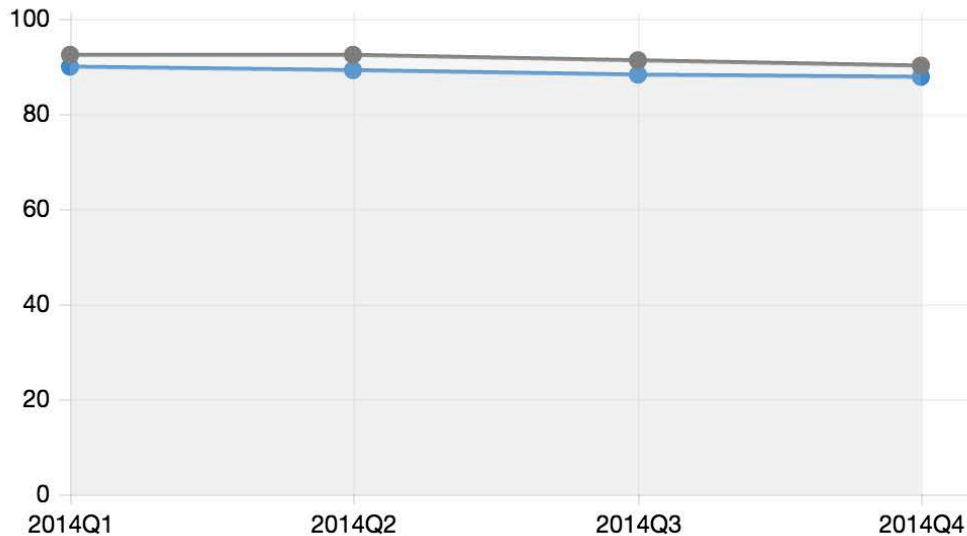
💡 LOCATIONS

👤 PROVIDERS

ALL

PERFORMANCE TREND

● PERFORMANCE ● REGISTRY BENCHMARK



QUARTER	ALL	(+)	(-)	%
2014Q4	1084	977	107	90.13 %
2014Q3	1004	916	88	91.24 %
2014Q2	920	850	70	92.39 %
2014Q1	907	838	69	92.39 %



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Dashboard Preview

AQUA 02 : Documentation of Gleason score in the MD note associated with the diagnosis



PERFORMANCE TREND

LOCATIONS

PROVIDERS

ALL

PROVIDER NAME	QUALIFIED (ALL)	MET (+)	NOT MET (-)	PERFORMANCE
+	12	11	1	91.67% (Registry Benchmark: 87.77%)
+	16	13	3	81.25% (Registry Benchmark: 87.77%)
+	28	25	3	89.29% (Registry Benchmark: 87.77%)
+	20	20	0	100.00% (Registry Benchmark: 87.77%)
+	20	19	1	95.00% (Registry Benchmark: 87.77%)



Annual Reports & Smart Reports

Smart Report on Performance Improvement

Print

Practice: Blue Sky Urology Associates

Can be at either practice or provider levels depending on which level the dashboard is based

Area(s) that Needs Improvement:

Pull data from performance score field if < cutoff point

MD01: Documentation of DRE findings in the MD note **24%**

Definition: Percentage of patients newly diagnosed with Prostate Cancer with documentation of DRE findings in the MD notes before treatment.

Pull data from the corresponding numerator and denominator if performance score field if < cutoff point

Patients Targeted: Newly diagnosed Prostate Cancer patients

2,645

Patients with Specific Task Completed:

637

Patients with Uncompleted Task:

2,008

Click here to see a list of patients with unmet task in a spreadsheet (see next page)

Pull information from recommendation list if performance score field if < cutoff point

Recommendation:

- Please complete documentation of DRE findings in the MD note for every newly diagnosed prostate cancer patient to achieve high performance score in this area

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AQUA

AUA Quality Registry

Quality Measures

Quality measure development

- Documentation quality
- Processes of care
- Clinical outcomes
- Patient-reported outcomes

Multiple data elements also needed for adequate risk stratification



Measures included in the AQUA Registry:

34 QCDR **16** "HOMEGROWN"
UROLOGY-SPECIFIC

CONDITIONS COVERED:

- Bladder Cancer
- Benign Prostatic Hyperplasia
- Cryptorchidism
- Hypogonadism
- Prostate Cancer
- Stones
- Stress Urinary Incontinence

Update at AUA Annual Meeting '17

- 47,288 prostate cancer patients
- 33,186 have localized disease
- 19,040 information sufficient to risk group



Update at AUA Annual Meeting '17

- Marked variation in treatment decisions by location of practice, even when controlled for other variables
- Active surveillance for low risk prostate cancer ranges from less than 1% to 60%



Update at AUA Annual Meeting '17

- Low risk patients
 - active surveillance 28.1%
 - radical prostatectomy 32.1%
 - radiation therapy 24.8%
- High risk patients
 - radical prostatectomy 34.3%
 - radiation therapy 30.8%
 - androgen deprivation therapy 23.4%



SUBSCRIPTION PRIVILEGES AND PRICING	SUBSCRIPTION LEVELS		
	Basic	Classic	Elite
AQUA Registry Dashboard	Partial	Full	Full
CMS PQRS/QPP Measures	✓	✓	✓
Quality Measures Developed for Urology		✓	✓
AQUA Smart Reports for Performance Improvement		✓	✓
AQUA Registry Annual Reports		✓	✓
MOC Part 4 Requirements*		✓	✓
Automate Measure Selection for Reporting			✓
Quality Measure Submission to CMS			✓
ACI Reporting and IA Attestation under MIPS			✓
Fees:	Free	Level I	Level II

CAN YOUR PRACTICE AFFORD NOT TO PARTICIPATE?



Earnings based on average Medicare reimbursement of \$153,000 per physician/year in 2020 and beyond (with maximum 9 percent positive adjustment); costs based on Elite-level AQUA Registry subscription.

Next Steps

- Expand PRO pilot
- Expand measures
 - Female Urology/Incontinence, Urinary Stone Disease, Other Urologic Oncology (including CRPC), Male Sexual Health (e.g., ED, Infertility, T Replacement), BPH/Male Voiding Dysfunction, Pediatric Urology
- Templates
 - More accurate data capture
- Institute formal QI processes



Questions or Concerns

- stuart.wolf@austin.utexas.edu
- Search “MACRA” on AUAnet.org
- Quality Improvement Program
- Quality Hotline (800-689-3925 or quality@AUAnet.org)
- AQUA@AUAnet.org
- www.AUAnet.org/AQUA

