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CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

Quality and Cost Deep Dive
Questions and Answers

Moderator

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Questions	Answers
Question 1	**When joining an Accountable Care Organization (ACO) a few months into the year, how do you report for the full year?** Great question! If you are considered a Qualified Provider (QP) during one of the four snapshot dates with the ACO, you may be included in the ACO's data submission for Quality and receive the Improvement Activities score of the ACO. For the Promoting Interoperability (PI) category, typically ACOs do not submit this category's data for you and you would be required to submit this data through the Quality Payment Program (QPP) Data Submission Portal, or perhaps using your electronic health record (EHR) vendor. The PI category requires a minimum of 90 consecutive days of data to be submitted to receive a score and you must be using 2015 certified EHR (CEHRT). Please be sure you communicate with your ACO frequently. You can call HSAG's QPP Service Center at 1.844.472.4227 regarding any follow-up PI category questions.
Question 2	**Items related to small group** We spoke about bonus and collection types for small groups in today's session. We encourage you to register for the March 8th Learning Forum Friday event, "*First Base: What's New in QPP for Year 3,*" for a full overview of the Final Rule for 2019. If you have additional questions that were not answered today, please contact HSAG's QPP Service Center at 1.844.472.4227.
Question 3	**How will cost be paid out? If you received the exceptional bonus will that be paid out differently?** Cost is a category in the QPP and was discussed in today's event. I think you may be referring to the positive payment adjustment awarded for your performance/participation. If so, the payment adjustment is made on a per-claim basis for Medicare Part B Fee-for-Service claims you submit in 2021 for reimbursement. The exceptional performance bonus is added to the positive payment adjustment awarded to any positive payment adjustment for your performance. On the Feedback report, the Centers for Medicare & Medicaid Services (CMS) will show the breakdown of the two incentive amounts and add them together for a total payment adjustment. Example: .51 percent payment adjustment and 1.31 percent for the exceptional performance adjustment equals a 1.82 percent overall positive payment adjustment applied to each claim in 2021.
Question 4	**Moving from previous Physician Quality Reporting System (PQRS) group report to Merit-based Incentive Payment System (MIPS) reporting as individuals, and now move [*sic*] back to group reporting and reporting quality from providers documenting in multiple EMRs, but all bill under the same TIN number.** If your group is planning to report at the group level using electronic clinical quality measures (eCQMs) EHR and the eligible clinicians (ECs) are using different eCQM vendors, you will need a certified data aggregator that can aggregate the data for you. The Quality category does not allow for any manual manipulation of data. Perhaps you can consider MIPS clinical quality measure (CQM) (registry) or if the practice has fewer than 15 ECs, you can consider claims as a submission type. Please call our QPP Service Center for further assistance.
Question 5	**Why is the selected measure's value altered for 2018?** We need a little more information to answer this question (i.e., a question related to an actual measure, decile column on the benchmark, etc.). Please contact HSAG's QPP Service Center 1.844.472.4227 for further assistance.
Question 6	**As an orthopedic surgery practice, our providers do not often code the patient's other medical conditions (i.e, hypertension, CAD, etc.). Should we be on all patients in order for it to count for [*sic*] Cost Measure?** The risk adjustment methods used for the eight episode-based measures across groups adjusts for differences in clinical complexity at the time each episode begins, and includes risk adjustors from the CMS-Hierarchical Condition Category (HCC) model and additional measure-specific risk adjustors. Risk

Questions	Answers
	adjustors are identified using beneficiaries' Medicare claims history during the period prior to the start of the episode. Claims from the triggering hospitalization or on the triggering Part B Physician/Supplier claim are typically not included.
Question 7	**How can you effectively manage your group cost?** In today's session, we discussed a few ways you may be able to lower cost and earn a higher Cost score for your group. We certainly hope these suggestions met your needs.
Question 8	**How to obtain a letter from CMS to boost score?** Please call our QPP Service Center at 1.844.472.4227 and let us know what type of letter you are looking for.

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