Quality Measures- Questions and Answers (QAs)
Updated: July 2023

This document provides questions and answers for a variety of BPCI Advanced Quality Measure topics in Model Year 6 (MY6). The BPCI Advanced Quality Measures webpage contains all resources for Quality Measures, including fact sheets for the Administrative and Alternate Quality Measures Sets and the Clinical Episodes to Quality Measures Correlation Tables for each Model Year.

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A. Quality Measures Sets in BPCI Advanced

A-1: What are the Alternate and Administrative Quality Measures Set options?

BPCI Advanced started with the Administrative Quality Measures Set in Model Years 1&2 (MY1&2) and Model Year 3 (MY3), and added an Alternate Quality Measures Set in Model Year 4 (MY4). The Administrative Quality Measures Set is comprised of six quality measures. The Alternate Quality Measures Set includes up to five quality measures per Clinical Episode Category, derived from a combination of Quality Data Codes (QDC), claims, and registry data sources. CMS developed the Alternate Quality Measures Set with extensive input from stakeholders, including professional health associations, clinical data registries, and clinicians. CMS added the Alternate Quality Measures Set to allow BPCI Advanced participants to have more choices on how quality of care is measured in the model. Participants have the option to select either the Administrative Quality Measures Set or the Alternate Quality Measures Set for each of the Clinical Episode Categories in which they participate before the start of each model year.

A-2: Where can I find details about the Alternate and Administrative Quality Measures Sets for MY6?

CMS created Quality Measure Fact Sheet packages for both the Administrative and Alternate Quality Measures Sets for MY7 that provide:

- Detailed technical guidance to participants about the rationale for selecting each of these Quality Measures
- The Clinical Episode Categories to which they may apply, measure specifications, how the numerator and denominator are to be calculated for each measure
- How data is submitted to CMS

CMS also created a BPCI Advanced Clinical Episodes and Quality Measures Correlation Table, which identifies:

- Each MY7 Clinical Episode Category with its corresponding Medicare Severity–Diagnosis-

Related Groups (MS-DRGs), Healthcare Common Procedure Coding System (HCPCS) codes, or International Statistical Classification of Diseases (ICD) 9th or 10th revision codes and aligned Administrative/Alternate Quality Measures.

The MY7 Quality Measure Fact Sheets and Clinical Episodes to Quality Measures Correlation Table are available on the Quality Measures Resources website, along with historical fact sheets and correlation tables for each of the previous model years. Other supporting documents will be posted to the BPCI Advanced website as they become available.

A-3: What changed in quality measurement for BPCI Advanced in MY6?

Starting in MY7, the model removed two measures due to the discontinuation of the Healthcare Common Procedure Coding System (HCPCS) codes used for their claims-based reporting. These two removed measures are listed below.

- From the Administrative Quality Measures Set: Perioperative Care: Selection of Prophylactic Antibiotic – First or Second Generation Cephalosporin (NQF #0268)
- From the Alternate Quality Measures Set: Claims-based reporting for the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (NQF #0028)
    - Note that participants who are reporting this measure through the American Heart Association© (AHA) Get With The Guidelines© (GWTG) – Stroke Registry will still report on this measure since it is registry-based and therefore not impacted by the HCPCS code discontinuation.

The six remaining Administrative Quality Measures are:

- Advance Care Plan (NQF #0326)
- All-Cause Hospital Readmissions (NQF #1789)
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)
- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
- CMS PSI 90 - CMS Patient Safety Indicators

A-4: Can we choose some quality measures from the Administrative and some from the Alternate Quality Measures Sets?

BPCI Advanced participants must select *either* the Administrative or Alternate Quality Measures Set for *each* Clinical Episode Category. However, participants do not need to select the same Quality Measures Set across all of their Clinical Episode Categories. For example, if a participant is participating in a Clinical Episode Service Line Group (CESLG) that has five Clinical Episode Categories, the participant can select the Alternate Quality Measures Set for three of the Clinical Episode Categories and the Administrative Quality Measures Set for two of the Clinical Episode Categories.

A-5: We are a Convener. Do all of our Downstream Episode Initiators need to participate in the same Quality Measures Set?

No, each Episode Initiator can select either the Administrative or the Alternate Quality Measures Set for each Clinical Episode Category that they have selected. Episode Initiators will make these selections in the Participant Profile. The Participant Profile is due in December 2023 for active model participants, and October 2023 for applicants who are applying in 2023 for Model Year 7 (CY 2024).

A-6: Can Episode Initiators change their Quality Measures Set selections?

Participants are required to select either the Administrative or Alternate Quality Measures Set for their Clinical Episode Categories on an annual basis. Participants typically cannot add more Episode Initiators and Clinical Episode Service Line Group (CESLG) selections in the model, but there is a new application period in 2023 for those applying for MY7 (CY 2024) in which, active participants have the option to make changes to their selections. For more information, refer to the MY7 Options for Active Model Participants Job Aid. Participants make their quality measure selections with the Participant Profile submission prior to the start of each model year. Once a Quality Measures Set selection is made, it applies for the entirety of that model year.

A-7: I see that quality measure numbers on the Fact Sheets and Correlation Table now include additional identifying numbers. Why was this change made?

CMS contracts with a Consensus-Based Entity (CBE) for quality measure endorsement and maintenance processes. On March 27, 2023, the Partnership for Quality Measurement (PQM) replaced the National Quality Forum (NQF) as the current CBE. The NQF measure numbers remain the same, however the naming convention now references CBE instead of NQF. CMS added the CMS Measure Inventory Tool (CMIT) numbers for consistency across Model resources. CMIT is the repository of record for information about the measures which CMS uses to promote healthcare quality and quality improvement. The CMIT ID numbers were added to the Model resources to facilitate references across programs but do not represent a change in the quality measures or their specifications.

More information on CBE can be found at https://mmshub.cms.gov/sites/default/files/Blueprint-CMS-CBE-Endorsement-Maintenance.pdf.

B. Submitting Quality Measure Data in BPCI Advanced

B-1: Do I need to be a registry member to submit quality data for certain Clinical Episode Categories? Is this different if I am an Acute Care Hospital (ACH) or Physician Group Practice (PGP)?

Yes, participants will need to be, or become, members of the relevant registry, or multiple registries, if they select Alternate Quality Measures that are reported by CMS registry partners. However, participants do not need to be a registry member to submit quality measures through the Administrative Quality Measures Set. All measures in the Administrative Quality Measures Set and some measures in the Alternate Quality Measures Set are calculated using claims data or

Quality Data Codes (QDCs) submitted through claims. Please see the BPCI Advanced Clinical Episodes and Quality Measures Correlation Table or the Alternate Quality Measures Fact Sheet Package on the BPCI Advanced Quality Measures webpage to determine which registry or registries are reporting data for specific quality measures in the Alternate Quality Measures Set.

B-2: For the Patient-Centered Surgical Risk Assessment and Communication measure, it looks like the data are captured via a Quality Data Code (QDC) or a registry. How do we know which submission method applies?

The BPCI Advanced Alternate Quality Measures Set includes one measure, the Patient-Centered Surgical Risk Assessment and Communication (Quality Payment Program (QPP) #358) measure, that can be submitted using either QDCs or a registry. The data submission method for this measure is dependent on the Clinical Episode Categories selected by the participant. Please refer to the BPCI Advanced Clinical Episodes and Quality Measure Correlation Table document on the BPCI Advanced Quality Measures webpage to determine which data submission method applies for each specific Clinical Episode Category.

C. Alternate Quality Measures Set

C-1: What additional data will a participant receive from registries if they enroll in Alternate Quality Measures?

Partner registries provide additional data so the participant can monitor performance on the quality measures, such as national data benchmarks and "like" comparisons with similar institutions. Each registry has unique tools and dashboards for participants to leverage for monitoring and quality improvement. For specifics on the additional data provided by each of the registries, please reach out to the appropriate point of contact from the specific registries. Participants can identify the registry point of contact by referencing the Professional Association and Registry Point of Contact List on *CMMI Connect* or refer to **Appendix 1** in this document for the registry support email addresses.

C-2: For the Alternate Quality Measures Set with registry-based measures, will there be additional reporting steps to ensure CMS receives quality measure data from the registry?

The only additional step participants need to complete is notifying and confirming with the applicable registry/registries that they are planning to select the Alternate Quality Measures Set and complete any necessary data release forms. Once you submit your data to the appropriate registry in a timely manner, you will not need to take any additional action to have your data submitted to CMS for use in the model. CMS anticipates that data submission via registries will reduce the reporting burden for participants. Please contact the registry representative(s) directly for registry-specific reporting requirements. Participants can identify the registry point of contact for BPCI Advanced by referencing the Professional Association and Registry Point of Contact List on *CMMI Connect* or referring to **Appendix 1** below for the registry support email addresses.

C-3: How will our quality measure results be calculated if we did not join the appropriate registry and did not submit data for a Performance Period where we selected the Alternate Quality Measures Set?

In a case where participant data for the Alternate Quality Measures is not provided to CMS, the participant will be held accountable for and receive a quality measure result based on the Administrative Quality Measures Set.

C-4: How will registry-reported quality measure results be reported for Physician Group Practices (PGPs)?

Quality measure results for registry-reported quality measures will be reported at the acute care hospital (ACH) level for both PGP and ACH participants. Similar to the Administrative Quality Measures, PGPs' quality measure scores will be determined by the performance of the hospitals where they trigger Clinical Episodes. Therefore, PGPs need to verify hospitals' registry participation prior to selecting the Alternate Quality Measures Set. If all of a PGP's hospitals' data are not available, the PGP will be held accountable for and receive a quality measure result based on the Administrative Quality Measures Set.

For PGPs who trigger Clinical Episodes at multiple ACHs, CMS will weigh the quality measure score for each hospital-level quality measure by the PGP's volume of Clinical Episodes triggered and attributed at Reconciliation for each ACH where the PGP practices.

Please note, the registry-reported measure will not be limited to BPCI Advanced practitioners or beneficiaries. For more information on registry-reported quality measures for PGPs, Participants with a *CMMI Connect* user login can review the BPCI Advanced Physician Group Practice Guide to the Alternate Quality Measures Set. Please login in to *CMMI Connect* before selecting the link for ease of navigating to the resource.

C-5: We received our Reconciliation Report. How does our score on the Advance Care Plan (ACP) impact our Composite Quality Score (CQS)?

CMS volume-weights the CQS contribution of each quality measure based on how many applicable Clinical Episodes the participant triggered in a model year. For example, if a participant selected Clinical Episode Categories which all use the ACP, All-Cause Readmission, and CMS PSI-90 measures, such as Sepsis and Stroke, those three measures apply to all episodes the participant has elected to participate in, and the three measures would have equal weights. Therefore, ACP would make up a third of the CQS, All-Cause Readmissions would make up the second third of the CQS, and CMS PSI 90 would make up the last third of the CQS.

The BPCI Advanced Understanding the Composite Quality Score Webcast – MY1&2 walks through a detailed breakdown of how CMS processes and volume-weights the quality measures, with sample calculations. This can be helpful in estimating what proportion of the CQS ACP (or other measures) takes up.

D. Quality Measure Scoring and Performance Data in BPCI Advanced

D-1: What are the baseline and Performance Periods for the Alternate Quality Measures Set that will be used in the Composite Quality Score (CQS)?

The Alternate Quality Measures collected using registries and from the Hospital IQR Program are baselined against 2020 for current participants, and 2023 for participants who join in MY7. The Alternate Quality Measures collected using Quality Data Codes (QDCs) are baselined against 2021, for current participants, and 2024 for participants who join in MY7 given that there is no earlier data for these measures. Most registry-based measures are baselined with the calendar year 2020 for current participants, and 2023 for participants who join in MY7, except for the following measures, which have a baseline of the calendar year 2021: Patient-Centered Surgical Risk Assessment and Communications, Substance Use Screening and Intervention Composite, and Bariatric Surgery Standards for Successful Programs Measures.

Quality measures that are also in the Administrative Quality Measures Set have the following baselines:

- Advance Care Plan (NQF #0326): July-December 2019 for participants who joined in MY1&2, Calendar Year 2020 for participants who joined in MY3, and Calendar Year 2024 for participants who join in MY7
- All-Cause Readmissions (NQF #1789): Calendar Year 2018 for participants who joined in MY1&2, Calendar Year 2019 for participants who joined in MY3, and Calendar Year 2023 for participants who join in MY7
- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA): NQF #1550 Calendar Year 2018 for participants who joined in MY1&2, Calendar Year 2019 for participants who joined in MY3, and Calendar Year 2023 for participants who join in MY7

Each participant's performance is scored based on the participant's placement in the performance distribution from the baseline year.

D-2: During reconciliation periods, will participants receive quality measure performance data specific to individual physicians?

No; quality measure performance data will be provided at the Episode Initiator level.

D-3: Will participants receive quality measure scores for all measures that are used to calculate the Composite Quality Score (CQS)?

Yes; individual quality measure results and your percentile within the baseline distribution for each measure are available in the Quality Measure Performance Reports annually, which are located in the Participant Data Portal.

The report shows your percentile within the baseline distribution for Clinical Episodes triggered during the Performance Periods, which factor into the CQS. For all quality measures, a higher percentile indicates better performance, and you can use your comparative performance to develop goals and operational priorities.

D-4: How will CMS calculate the Composite Quality Score (CQS)? Will episode volumes affect the impact of performance on the overall CQS?

The BPCI Advanced Understanding the Composite Quality Score Webcast – MY1&2 describes the CQS calculation methodology, including a walkthrough of a detailed breakdown of how CMS processes and volume-weights the quality measures with sample calculations.
The Measure Specifications section of each quality measure Fact Sheet describes the numerator and denominator population for that measure which may affect the volume of attributed episodes for a Participant. For the Advance Care Plan quality measure, the measure applies to all Clinical Episodes in the Model and is calculated at an Episode Initiator-level based on the Clinical Episodes triggered by the Participant.

E. Quality Data Codes (QDCs)

E-1: What is a Quality Data Code (QDC)?

Health care providers use non-billable QDCs to collect and submit quality data through Medicare Part B Claims. Health care provider billing departments use non-billable QDCs for performance management, quality reporting, and additional data to capture information without having any impact on payment. Health care professionals sometimes refer to QDCs as G codes, Current Procedural Terminology (CPT[1]) II codes, or Level II HCPCS codes. Health care providers can use QDCs to enrich their medical claims data. More information on how to add QDCs to claims can be found on page 17 of the "2023 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices".

E-2: What does a Quality Data Code (QDC) look like on a claim?

QDCs are non-payable codes. When you attach a QDC to a claim, you must include a $0.00 line item charge for the QDC. Health care providers and/or billing departments attach QDCs on a payable claim (on a CMS-1500 or UB04 form), specifically the claim for the visit when the action happened. Some billing software will not accept a code without a charge. If your billing software does not accept a code without a charge, attach a $0.01 line-item charge for the QDC to mitigate these software limitations. This $0.01 is a technicality, and when these claims arrive at the Medicare Administrative Contractor (MAC) for processing, the MAC automatically erases the $0.01. More information on how to add QDCs to claims can be found on page 17 of the "2023 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices"..

[1] CPT® is a registered trademark of the American Medical Association (AMA).

E-3: How must health care providers report a Quality Data Code (QDC) on a claim?

Health care providers must report QDCs:

- On the claim(s) with the denominator billing code(s) that represent(s) the eligible Medicare Part B Physician Fee Schedule (PFS) encounter
- For the same patient
- For the same date of service
- By the same clinician who performed the covered service, applying the appropriate encounter codes (International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), CPT Category I, or HCPCS codes). CMS uses these codes to identify the measure's denominator
- On a UB-04 or a CMS 1500 form

Health care providers must also make sure that the claim has a total positive payable amount. CMS has provided further guidance on how to report a QDC on page 17 of the "2023 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices".

E-4: Can health care providers add a Quality Data Code (QDC) after the submission of a claim?

Health care providers cannot add QDCs after they have submitted a claim. Claims may only be resubmitted if a material change impacting payment is involved. Since QDCs are non-payable codes, MACs will not allow health care providers to retroactively correct or add them to the claim after submission or processing. More information on QDCs can be found on page 17 of the "2023 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices".

E-5: Can health care providers submit a Quality Data Code (QDC) as the only line on a claim?

Health care providers cannot submit a QDC as the only line(s) on a claim. Health care providers and billing departments can only add QDCs to payable claims; the claim itself must have a total positive value. The $0.01 that may accompany a QDC does not count as a reimbursable service. Therefore, health care providers must submit QDCs with an accompanying payable line. For example, a CPT code for an office visit. If a claim only contains codes for non-payable services, the health care provider cannot submit a QDC with that claim. In short, health care providers cannot file a claim that only consists of one or more QDCs. To ensure the MAC processes the QDC correctly, CMS advises health care providers to add the QDC to the claim relevant to the measure. More information on QDCs can be found on page 17 of the "2023 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices".

E-6: What happens if a Medicare Administrative Contractor (MAC) denies the claim?

If a MAC denies a claim, the health care provider generally cannot resubmit the claim; she or he must appeal it. If the appeal is successful, then the MAC will reverse and pay the claim, and the QDC submitted with the original claim will still be there. If the MAC rejects the claim back to the health care provider, and the health care provider fixes the issue and resubmits, the health care provider should ensure the appropriate QDC is on the claim. More information on QDCs can be found on page 17 of the "2023 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices".

E-7: If a health care provider did not bill the Advance Care Plan (ACP) Quality Data Codes (QDCs) with the first inpatient claim, can the health care provider add them on the post-op follow-up visit?

Health care providers should not bill the ACP QDCs on a postoperative follow-up visit. This is because health care providers bill postoperative visits using the CPT code 99024 – "Postoperative follow-up visit, normally included in the surgical package, to indicate that the physician performed an evaluation and management service during a postoperative period for a reason(s) related to the original procedure." CPT code 99024 has a zero-dollar amount associated with it. Per the explanation above, coding 99024 with a QDC will result in a zero-dollar claim, and the MAC will not accept the QDC.

E-8: Who can bill the 99497 and 99498 codes for Advance Care Plan (ACP) in BPCI Advanced?

Any Medicare-enrolled health care provider can submit Qualifying CPT or CPT II codes, including physicians, advance practice nurses, and physician assistants, regardless of the health care provider's participation in the model. Billing departments can include ACP discussions held by other members of the health care team if they are held "incident to" the services of a billing practitioner, including a minimum of direct supervision. This could include a registered nurse (RN) or licensed social worker, assuming they meet supervision requirements. In settings in which "incident to" does not apply (such as an inpatient setting), only physicians and non-physician health care providers (including nurse practitioners, physician assistants, and clinical nurse specialists), are qualified to perform and report ACP discussions.

E-9: Will the Advance Care Plan (ACP) Quality Measure accept both Quality Data Codes (QDCs) and Current Procedural Terminology (CPT) codes?

The ACP Quality Measure is informed by both QDCs and CPT codes. Participants can document the ACP using the following CPT codes or combinations of codes:

(1) 99497;
(2) 99497 and 99498;
(3) 1123F; or
(4) 1124F.

Participants that submit CPT codes 99497/99498 do not need to include the CPT II 1123F or 1124F codes to receive credit for this measure. Participants using the CPT II codes must include these codes on a claim with a billable service.

F. Discontinued Quality Data Codes (QDCs)

F-1: Which quality measures had discontinued Quality Data Codes (QDCs)?

Quality Measure	Quality Measure Set	Associated Clinical Episode Categories
Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin (NQF #0268)	Administrative	• Cardiac Valve • Coronary Artery Bypass Graft (CABG) • Bariatric Surgery • Major Bowel Procedure • Double Joint Replacement of the Lower Extremity • Hip and Femur Procedures Except Major Joint • Lower Extremity/Humerus Procedure Except Hip, Foot, Femur • Major Joint Replacement of the Lower Extremity • Major Joint Replacement of the Upper Extremity • Back and Neck Except Spinal Fusion • Spinal Fusion
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (NQF #0028)	Alternate	• Chronic Obstructive Pulmonary Disease (COPD), Bronchitis, Asthma

F-2: Does CMS plan to replace the measures with these discontinued codes with new measures for either the Administrative or Alternate Quality Measures Sets?

No, CMS does not plan to change either measure set to replace these two claims-based measures in Model Year 6.

F-3: Do model participants who were reporting the Perioperative Cephalosporin or Tobacco Use and Cessation measures through claims for BPCI Advanced need to take any specific action due to the removal of these measures from the model?

Model participants who were reporting these measures via claims do not need to take any specific action related to this change. CMS will calculate your Composite Quality Score (CQS) using the other measures you are already reporting for relevant clinical episodes.

F-4: Does this issue impact model participants who were reporting the Tobacco Use and Cessation measure through a registry?

Model participants who were reporting Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (NQF #0028) through American Heart Association® (AHA) Get With The Guidelines (GWTG)® - Stroke Registry are not impacted by this HCPCS code discontinuation. This only impacts those who were reporting the measure for the COPD Clinical Episode, whereas the registry-reported version applies to the Stroke Clinical Episode. The Tobacco Use and Cessation measure will continue to be included in the CQS of participants who selected registry reporting for this measure, and these participants should continue to submit their data to AHA in accordance with the registry's data submission guidelines.

Resources

Resource	Website Address
BPCI Advanced Quality Measures Resources • Quality Measure Fact Sheets • Clinical Episodes to Quality Measures Correlation Table • Quality Methodology Webcast Recording and Slides	https://innovation.cms.gov/innovation-models/bpci- advanced/quality-measures
BPCI Advanced Physician Group Practice Guide to the Alternate Quality Measures Set.	https://app.innovation.cms.gov/CMMIConnect/s/contentdocument/069t000000FoXeTAAV
BPCI Advanced Registry Contact Information	https://app.innovation.cms.gov/CMMIConnect/s/contentdocument/069t000000T34eNAAR or **Appendix 1**
2023 Reporting MIPS Quality Measures through Medicare Part B Claims Quick Start Guide for Small Practices	https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2231/2023%20Part%20B%20Claims%20Reporting%20Quick%20Start%20Guide.pdf

Appendix

Appendix 1 – Registry Support Emails

Registry	Support Email
American College of Cardiology (ACC)	NCDR@acc.org
American College of Surgeons (ACS)	mbsaqip@facs.org
American Heart Association (AHA)	GWTGSupport@heart.org
Society of Thoracic Surgeons (STS)	stsdb@sts.org

Appendix 2 – Clinical Episodes with Quality Measures Reported by Registries

Clinical Episodes	Association
• Acute Myocardial Infarction • Cardiac Defibrillator • Percutaneous Coronary Intervention	**American College of Cardiology (ACC)**
• Bariatric Surgery	**American College of Surgeons (ACS)**
• Acute Myocardial Infarction • Cardiac Arrhythmia • Congestive Heart Failure • Stroke	**American Heart Association (AHA)**
• Cardiac Valve • Coronary Artery Bypass Graft	**Society of Thoracic Surgeons (STS)**