Highlights of the 2021 Quality Payment Program Proposed Rule

Transcript from Live Session

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Quality Insights
Quality Payment Program Support Center

April Faulkner:

The Quality Insights QPP Support Center team welcomes you to today's webinar, *Highlights of the 2021 Quality Payment Program Proposed Rule*. We will review just a few items before we begin the presentation. All participants entered today's webinar in a listen-only mode. Should you have any questions during today's presentation, please type them into the Q&A box at the bottom right of your screen. We will answer as many questions as time allows. Today's webinar is being recorded. The recording, along with the slide deck and a transcript of the webinar, will be posted on the Quality Insights QPP Support Center website within the next few days. These resources can be found on our Archived Events webpage. A link to that page is posted in the chat box. At this time, I would like to introduce our presenters. Joining us today are two members of the Quality Insights QPP Support Center team, Kathy Wild and Amy Weiser. I will turn the presentation over to them to get us started.

Kathy Wild:

Thank you, April, and good afternoon everyone, and thank you for joining us. Before I get started with the topics for our agenda today, I'd like to remind everyone that the information we're giving you today in this presentation is simply proposed, meaning that nothing is set in stone yet. There are still 13 days left to submit comments to CMS. So if you hear anything today that you disagree with, or think that should be changed, you still have 13 days to submit your comments. What CMS will do is then review all of the comments that have been submitted, and then they have 60 days to address each comment and make a final determination. We expect the Final Rule for 2021 to be released in early December.

So the topics for today, first, we're going to talk about the MIPS categories and I will be covering that section. I'll be going over reporting changes, category changes and the MIPS Value Pathways. And then I'll be turning the presentation over to my peer, Amy Weiser. And she'll be talking about Alternative Payment Model changes, the APM Performance Pathway, which is a new model, and telehealth changes.

Kathy Wild:

On August 3, CMS came out with two proposed rules, the calendar year 2021 Medicare Physician Fee Schedule Rule and the Quality Payment Program Proposed Rule. They are separate rules, both have over thousands of pages. And so today what we're going to focus on is actually just the Quality Payment Program Proposed Rule. That will impact what you need to do for MIPS starting January 21. And that will affect payment adjustments that you receive in 2023.

Kathy Wild:

I'm going to begin, before I go into details, with a high level overview. CMS, because of COVID this year, limited the number of significant changes. So clinicians can continue to focus on COVID, reopening their practice, implementing telehealth and all that. You'll see that there really are not a lot of changes, and as a matter of fact, the changes that they have proposed really should help you reduce your clinician reporting burden.

Kathy Wild:

As always, the goal of the Quality Payment Program remains for clinicians to join Alternative Payment Models. They did come up with a new pathway for APM participants that's going to kind of mirror the MIPS Value Pathways, and we'll talk about that. And then I'll also talk a little bit about the MVPs and the fact that they're going to be delayed.

Kathy Wild:

So before we start with the proposed changes, I have one slide to tell you what is not going to change in January. So these are the things that are going to be the same as they have been in the previous years.

Number one is the same MIPS eligible clinician types. That includes the physicians, nurse practitioners, PAs, physical therapists, all of those people that have been eligible up till now will stay. No one's been removed and no one's been added.

Next is the low volume threshold. And that's the terminology that CMS uses to determine who is actually eligible. And there's three criteria, and you have to meet all three of them during both look-back periods in order to be MIPS eligible, which means you have to report in MIPS or you receive a penalty. So those have to do with the number of patients you see during the 12-month determination period, how much you bill Medicare Part D for, and how many covered professional services you have. And those numbers have not changed at all from the previous year.

There's also the MIPS determination period. There's still two segments where they look back. And as a matter of fact, the first segment that will determine who's eligible and have to report next year is going to end in eight more days. So at the end of September 30, CMS will look at those three criteria at your billing, your patients and your services, and they'll look at that from October 1 of last year through this September. And if you meet all three of those criteria, they'll go ahead. And probably in early January on the QPP website, you'll be able to enter the NPI and see if you are MIPS eligible in 2021.

Remember there's always a second look-back period. And the date for that will be October 1, 2020 through September 30, 2021. And if you don't meet one of those criteria, even during the second look-back period, then you're no longer eligible. So someone could potentially be MIPS eligible in the first period but not in the second, which would mean you would not have to participate if you didn't want to.

One thing to note is, because of COVID, a lot of practices shut down for several months and weren't seeing patients. It will be interesting to see if people that have been eligible in the past are going to be eligible for 2021. I expect that the number will be reduced a little bit, but we'll have to see.

The other thing that is not changing is the opt-in policy. So if a clinician does not meet this criteria and does not have to report in MIPS, then they have that option to opt-in and report and try to get a payment adjustment.

Kathy Wild:

So now we're actually going to get into what CMS has proposed for some changes for next year. One thing is the new performance threshold. Every year since the program started in 2017, they have slowly increased the performance threshold. That is the number of points you need to just have a neutral payment adjustment. The first year, if you recall, it was three points, so you only had to report 1 thing. The next year it was 15, then the next year it was 30. This year it's 45. So next year for 2021, CMS

increased it only by 5 points- it's 50 points for the threshold next year. It was supposed to be 60, but because of COVID and everything that's happened, they decided to only increase it 5 points instead of 15. So that's a good thing. They did not change the exceptional performance threshold. That is going to stay at 85 points.

Kathy Wild:

This next slide tells you the payment adjustments that are going to coincide with the MIPS scores in 2021. So if you look in the middle row, 50 points, that's that neutral payment adjustment. If you look at the bottom row, anyone that has a score of 0 to 12.5 points, they're the ones that are eligible to get the full negative payment adjustment of -9%. So you definitely want to get above 12.5 points or you'll have that -9%. If you get 12.51 to 49.99 points, you would still have a negative payment adjustment, and it would be somewhere between 0 and -9%.

Now, if you look at the second from the top row, anyone with a MIPS score next year of 50.01 to 84.99 points, they are due to have a positive payment adjustment more than 0%. The caveat is to remember that the Quality Payment Program is a budget neutral program. So people with these points can only get a positive payment adjustment if there are people that have a negative payment adjustment. And you'll find out if you've been looking at your 2019 feedback score, a lot of people are disappointed with a score above the performance threshold, unless they met the high exceptional performance threshold. They are the only people that got a positive payment adjustment. So we'll have to see how this goes, how it works in 2021.

And then the top row is anyone over 85 points. In addition to getting a positive payment adjustment, if there is money available, they will automatically also get extra money from an extra fund for the exceptional performance bonus. And that money has been set aside already. So they will definitely get that payment adjustment.

Kathy Wild:

The application of the payment adjustments. CMS actually created a new hierarchy. And this is when a clinician has multiple MIPS scores associated with the single TIN/NPI combination. CMS, in the future, is going to use the highest available final MIPS score to determine what type of payment adjustment a provider will get. The only exception is anybody that reports through a virtual group will always take the virtual group score, even if it's less than the highest available score. So if you don't participate in a virtual group, you don't have to worry about it.

You might ask how does one clinician get more than one MIPS score if they're working at the same TIN? And I can give you an example. You are allowed to report quality measures and other things using more than one submission method. So if you report a quality measure using your claims, and then you also report that same measure using your electronic health record, based on benchmarks, you will get different MIPS scores and achievement points for each quality measure. Therefore, if you submit all your quality measures using two methods, CMS is going to take the method that scored the highest, and that's how you will get your payment adjustment.

Kathy Wild:

MIPS category weights. It always has to equal 100% and legislation passed at the beginning when they first instituted the program stated that by the year 2022, the Cost and the Quality categories have to equal 30%. They must equal each other. So what CMS has been doing is slowly decreasing the weight of the Quality category and increasing the weight of the Cost category. So for next year, the Quality category is going to be 40%. And this year we know it is 45, so that's -5%. And the Cost category weight is going to increase to 20%. And this is 5% more than this year, where it's 15%.

Kathy Wild:

There is a new MIPS participation option next year. We know that you can report as an individual clinician and you can also report as a group or virtual group. And now the new option is you can actually participate and submit your data at an APM entity level. Amy will be going over that a little bit later.

Kathy Wild:

The complex bonus. So this is a good thing also. CMS has increased the weight from 5 points to 10 points. They've done this to account for the additional complexity of treating patients due to COVID this year. The complex patient bonus is added to your final MIPS score. It will be the total you get from your four categories, and then if you qualify for any bonus points, they get added to that number. The bonus is actually determined by the medical complexity based on your HCC risk scores for the patients you see. They also look at social risks based on who is Medicaid and Medicare dual eligible.

Kathy Wild:

CMS also addresses third party intermediaries in the Proposed Rule. They are going to require them to conduct an annual data validation and audit. They want to make sure that the information they're giving you is completely accurate and the way they're calculating it is accurate. So that will be required. They've also added factors to consider during the approval process when a new third party registers and wants to participate in MIPS. Remember, every year CMS has to go through and review who is approved to participate. They've added some new things to make sure that they do qualify to participate. They've also added guidance in the Proposed Rule that addresses remedial action and termination for noncompliance. So if there are problems with the registry not being able to get data or not giving accurate data back, CMS has the right to remove them from the list of approved vendors and terminate them.

Kathy Wild:

Now we are going to look at the individual MIPS categories and I'm going to start with the Quality category. It has the most changes, but like I said, nothing major. Number one is that the CMS web interface measures have been eliminated. If you are in an ACO or in a group with 25 or more clinicians, you were able to report the CMS web interface measures in lieu of selecting six different quality measures. Now, as a QPP service contractor, we only work with small practices with 15 or fewer clinicians. So this will be applicable to those of you who are in an ACO. Because this is eliminated, CMS did come up with a replacement and we will talk about that when we get to the APM section a little bit later.

Kathy Wild:

Number two is benchmarks. So in the past, what CMS would do is use historical benchmarks, look at the data that the clinicians actually reported from two years prior. But what CMS thought is that because of COVID in 2019, they're afraid that some of the benchmarks could be skewed. There might not be a good sample size. So they are proposing that they're going to wait and calculate benchmarks for what you report after the reporting period, and that's kind of important. Previously when you were selecting your measures, you could look at the benchmarks and say, okay, this is one where I know I need a performance rate of X, Y, Z, to get this many points. You're not going to be able to do that if this proposal goes through. Like I said, the big challenge here is that you won't know it until after the reporting period ends, actually when CMS gives you your preliminary data, which would be in July of 2021. If you find that a little distressing, you might want to submit a comment to CMS about that.

Kathy Wild:

Some more Quality category changes. Topped out measures. If a topped out measure is topped out in two or more years, CMS will alter the maximum number of points that can be awarded from 10 to 7 points. CMS is going to do that again, but because of the benchmarks, they're going to include 2021 performance benchmarks. So once again, what you could do now is look at the quality measures in 2020 that are topped out. If they are getting topped out again next year, but you won't know that till after the reporting period ends, then you might think that you could possibly get 10 points, but in reality, you might only get 7. So it might be a good thing not to look at the topped out benchmarks if you want to try to get the full 10 points for each measure.

Then there is a good thing. They've increased the scoring flexibilities. They've expanded the reasons when the performance period can be reduced to nine months, and that usually occurs when there's been significant ICD-10 coding changes. What they might say is that, because of this change that is implemented usually the last quarter of the year, therefore for this XYZ quality measure, we're only going to look at your data from January 1 through September 30, because it changes too much beginning in October.

The other scoring flexibility is if they see some significant practice guidelines have changed for a measure, they might actually suppress the measure. And you wouldn't know that until after you've selected everything. That's okay. You don't get penalized for reporting only 5 measures if they suppress 1. They'll go ahead and alter your points. So they just score you on the 5 and get 5 out of 5 instead of 5 out of 6. But once again, they've gone ahead and written that in to make sure that everyone's aware of that.

Kathy Wild:

So for 2021 they have decreased the number of quality measures available. This year it was 219, and next year they decreased it to 206. If you look at the actual Proposed Rule that's in the Federal Register, and I believe we have links for it here, and if not, we can get them to you, they've added a whole bunch of appendices and tables at the very end, and that's where you can actually find the measures. There are two administrative claims measures, the specialty measure sets are in Table B and Table C lists the 14 measures that have been removed. And then here's a big thing, over half of them have changes to the existing measures. So 112 of them have changes. What that means is that you're really going to have

to look at the specifications sheet for the measures that you want to select next year, because they're not going to be the same as they were for 2020.

Kathy Wild:

I did list the two new administrative claims measures here. One is the hospital-wide, 30 day, All-cause unplanned readmission rate for MIPS groups, and that's going to replace the All-cause readmission measure. And the other one is risk-standardized complication rate for someone that has elective primary total hip or total knee arthroplasty. And we did provide the 43 specialty measure sets that will be available for 2021 also.

Kathy Wild:

Now I'm going to talk about the MIPS Improvement Activity category. And there's just two things here that have changed. One is they've modified two improvement activities. Both of them are medium weight. I don't know if you've used them in the past, but in case you have and you plan to use them again, you should know about these proposed changes. For the first one, it has to do with using the patient portal and they've done two minor adjustments. One is that they included the word “caregivers” as additional potential users. So in addition to the patient using the portal and their designated representative, a caregiver is also going to qualify as a user of the portal. And then the other change for that activity is that in order to get credit for this, the portal should be used for clinical and not administrative bi-directional information exchange. So what they mean there is they don't want to give you credit if you're just using it for scheduling a new appointment or a med refill. It should be more of a clinical review of lab results, or asking a question about a side effect, something that is clinically-based.

The other activity that they've modified expands the types of services that can be promoted to the underserved and/or high risk populations as to what qualifies as an eye exam, if they can't get to an ophthalmologist. They have a list of other services that will count.

The other thing that CMS did for the Improvement Activity category is established policies for nominations for new activities. And what they've said is that everything must be linked to an existing MIPS Quality and Cost measure. And this is in their scope of trying to reduce the burden and simplify reporting so that if you pick an activity, there should be a Quality measure that goes with it and a Cost measure. And then you're tying the three together, so you’re working and improving on all three of those different categories at the same time while focusing on one standard of care.

Kathy Wild:

Now we're going to discuss the Promoting Interoperability category. There are a couple of things here to go over. The first good thing is the PDMP bonus. They kept that, and not only did they keep it, but they increased the number of points that can be awarded. For this year and previous years, it was worth 5 points. They've increased that to 10 points. The next change is one word in one of the measure names. They changed *Support Electronic Referral Loops by Receiving and Incorporating Health Information* by replacing the word “incorporating” with “reconciling.”

Kathy Wild:

The big change for the PI category is a new optional measure that's available. It has to do with health information exchange, bi-directional exchange of information. And what clinicians or groups can do is select to report this measure instead of the two existing HIE measures. The first one is *Support Electronic Referral Loops by Sending Health Information* and then the second one is getting that information back and receiving it and incorporating it.

So the way it's written now for 2020, you have to report those two different measures and each one's worth 20 points for a total of 40. And the way that it will work is this new HIE measure is going to be worth the full 40 points. There are three requirements that must be met to earn credit and actually report this. Of course, the first one is that you have to participate in a health information exchange. And all of our four states do have health information exchanges available, and we can provide you with a list if you need to reach out to any of them. A key point with participation is that you have to make sure that you enable and use that bi-directional exchange for every patient encounter, every transition of care, every referral, and every record in your EHR during the reporting period. So you can't just pick and choose when you're going to use that.

Number two is that the HIE must be capable of exchanging information across a broad network of unaffiliated partners without exclusionary behavior. So if you refer a lot of your patients to a certain orthopedic specialist and you use the HIE with that office, that's wonderful, but you also have to include all the other physician practices that you refer patients to. And of course the third requirement is that you must use certified EHR technology.

So Kathy Wild:

If you can meet those three requirements, then you can select this new option and get your full 40 points. So that sounds really good because otherwise those other two measures are based on performance rates. So you could potentially earn more points. Although if you don't do a lot of referrals, if you're a specialist and you're not referring, then you can still claim the exclusion for that measure, and those points would be based on the performance of a different measure, which is *Provide Patients Access to their Health Information*.

One other thing to think about if you're going to consider using this new HIE measure, is that it must be reported by attestation. It's going to be a yes or no question. And what that does is it limits you to submitting all of your Promoting Interoperability measures by attestation. Is that a big deal? Not really. Attestation is really very simple. There aren't a lot of PI measures, so even though your EHR can give you your numerators and denominators, you would be required to log into the QPP portal and manually enter those numerators and denominators yourself. And that's because for the PI category, you have to submit all the measures in the same way. Once again, you might want to submit a comment if you want that changed.

Kathy Wild:

Another change for the PI category is a CEHRT update, and this is actually a result of the 21st Century Cures Act Final Rule, but I thought it was important to mention. They are requiring technical updates to 2015 edition certification. So they're not going to come out with a new year edition, but they are requiring an update. The deadline to implement all these changes is August 2 of 2022. And yes, that's

correct. It's two years from now, 2022. But for 2021, CMS wanted everyone to know that it's okay if you still use your current 2015 edition, but if you do get that upgrade early, you'll still get credit. So you can use either one.

Kathy Wild:

The final note for the PI category is that CMS did extend the automatic reweighting for certain clinician types. When they wrote the Final Rule last year, the plan was for some of these clinicians that have been in the program for two or more years to be dropped off the automatic reweight, meaning they should have had time to implement an EHR and be able to report the PI category. However, with everything that's going on, they decided to extend this automatic reweighting for all of the clinicians that have been able to do so since they've been in the program.

Kathy Wild:

The last category we're going to go over is the Cost category. And there are really no changes here. There's a link for the specifications, but you've got the same 18 episode-based cost measures plus the Medicare Spending Per Beneficiary Clinician and the Total Per Capita Cost measures. And we've got a link in the slides to the specs for 2021.

Kathy Wild:

My last topic is the MIPS Value Pathways. So last year, CMS proposed that, beginning in 2021, MIPS Value Pathways would be available to report. It would be a new reporting option. However, due to COVID and stakeholders' thoughts, CMS has delayed that implementation. They're stating that 2022 will be the earliest date while they refine guidelines, create criteria and clarify the process. So it might be a slow rollout over three to five years. They're trying to make sure they can cover all clinician specialties.

All right, that's the end of the MIPS section for proposed changes. And now I'm going to turn it over to Amy Weiser, who is going to go over the Alternative Payment Model (APM) changes. Amy.

Amy Weiser:

Thanks, Kathy, for that great information. So I'm going to start with an APM overview. There are three types of APMs, Alternative Payment Models. There are APMs, there are MIPS APMs, and there are Advanced APMs. APM participants need to participate in MIPS unless they are in an Advanced APM and receive the Qualifying Participant status or QP status, which means that they meet or exceed the payment amount or patient count thresholds. Partial QPs can choose whether or not to participate in MIPS. The diagram on this slide shows how it's broken down with the different types of APM participants.

Amy Weiser:

So there are some changes that are proposed. The APM scoring standard will no longer be used for clinicians in a MIPS APM who participate in MIPS through their APM. They're proposing to add the APM entity as a submitter type, so MIPS ECs or eligible clinicians in an APM can now participate in MIPS in three ways. At the APM entity level, at the group level or at the individual level, which Kathy mentioned earlier. The APM entity can report Quality and Improvement Activity categories on behalf of its MIPS

ECs. When the APM entity chooses to report to MIPS, a Promoting Interoperability category score will be calculated for the APM entity group. And then groups and individuals can submit MIPS data even when they are included in an ACO level reported data, and CMS will award the highest score.

Amy Weiser:

So this has to do with the APM quality reporting changes that are proposed. The CMS web interface measures will no longer be used to report quality. Again, this is proposed not final, as Kathy had mentioned this earlier. But this is actually a good thing if it passes because it's really designed for burden reduction. You would be able to select measures more meaningful to the scope of practice that you're in. You would report 6 measures instead of 10 and report on all-payer data instead of Medicare only data. And you could report the same measures that were available for CMS web interface reporting if you wanted to, but you would still need to submit that information in a different method.

Amy Weiser:

So the CAHPS for ACOs survey. It will be administered at the group level instead of at the ACO level. And what you should ask is, will your ACO provide assistance in sourcing and funding the surveys and will results be shared or benchmarked? And this is very important. For 2020 only, there's a waiver. ACOs will receive full credit for the patient experience of care measure, so they do not need to administer a CAHPS for ACO survey. And if the ACO administers the CAHPS survey, it can count as a quality measure.

Amy Weiser:

There are a few additional APM changes. CMS will accept targeted review requests when there is evidence that CMS has made a clerical error in determining the participation lists associated with an advanced APM. And Medicare patients prospectively attributed to an APM will not be included as attribution-eligible if the Advanced APM does not allow them to be attributed again.

Amy Weiser:

We're going to talk a little bit about ACO considerations. There are some questions that ACOs and participants need to ask. At what level will quality reporting be done: at the ACO, the TIN or the individual clinician level? And if it is at the ACO level, what is the best model for collecting and calculating the measures? And if at the TIN or the clinician level, what level of insight and operational assistance will the ACO provide?

Amy Weiser:

For extreme and uncontrollable circumstances, beginning in 2020, APM entities can submit an extreme and uncontrollable circumstance application to request reweighting of all MIPS categories. If approved, all clinicians in the APM entity will receive a score equal to the performance threshold, even if data is submitted. And this is different than the policy for individuals or groups.

Amy Weiser:

So for 2020 only, they've proposed this modification. CMS is seeking comment on the 2020 alternative approaches to scoring ACOs under the Extreme and Uncontrollable Circumstances Exception Policy. And as Kathy mentioned, there are 13 days left for you to submit comments about this.

So in the first year (if you see on the left, it says ACO performance year), if the first year participants completely report CMS web interface measures, they would receive a 100% Quality score and if they did not completely report CMS web interface measures, the 2020 ACO mean Quality score would apply. Those in their second or more years of being in an ACO would receive the higher of the 2020 ACO quality score or 2019 quality score if they completely reported CMS web interface measures and if they did not completely report the CMS web interface measures, they would receive the 2020 ACO mean Quality score.

Amy Weiser:

So there is a new optional reporting method for APMs, and Kathy mentioned this earlier as well. MIPS APM participants have an option to report the new APM Performance Pathway or the APP. This is very similar to the MIPS Value Pathways that have been proposed. It's required though for ACOs participating in the Medicare Shared Savings Program, but is optional for other APMs.

Amy Weiser:

So we're going to talk a little bit more about the APM Performance Pathway, or APP. It is comprised of a fixed set of measures for each performance category. And participation is optional, like I said, for MIPS APM participants, but is required for ACOs in the Medicare Shared Savings Program. You can report at the individual, group and/or APM entity level and CMS will award the highest available score.

Amy Weiser:

This slide shows the category weights for the APP. Quality would be 50%, Promoting Interoperability would be worth 30%, Improvement Activities would be worth 20%, and Cost would be zero because cost is already considered when you're in an advanced APM or shared savings program.

Amy Weiser:

So this is some information about the APP Quality category. It's composed of six population health measures that are widely available to all MIPS APM participants. And reporting these measures will meet requirements under both MIPS and the Medicare Shared Savings Program. So this is really designed to help with that burden reduction. The quality performance standard to share in ACO savings was increased to the 40th percentile. So you're not eligible to share and earn savings if it's less than 40%. And the ACO will owe losses based on track one or track two participation. And the ACOs must improve quality. If the ACO is noncompliant in meeting the quality performance standard, it may be terminated from the program.

Amy Weiser:

This slide shows the APP quality measure sets. You can see that there are several measures that are very familiar to most practices. For example, the Diabetes: Hemoglobin A1c Poor Control would remain, the

Preventive Care and Screening or Screening for Depression and Follow-up and Controlling High Blood Pressure. Again, these are very commonly-used measures and are very important in helping patients with their chronic disease and mental health wellness. And then we have the CAHPS for MIPS, or the CAHPS survey. And then a couple that have IDs that are to be determined, which are the Hospital-wide, 30 Day, All-cause Unplanned Readmission Rate for MIPS Eligible Clinicians and the Risk-standardized, All-cause Unplanned Admissions for Multiple Chronic Conditions for ACOs. These 2 measures will be administrative claims measures.

Amy Weiser:

The other APP performance categories include Promoting Interoperability. It's reported and scored at the individual or group level as required for the rest of MIPS. The Improvement Activity category. In 2021, all APM participants reporting through the APP will earn a score of 100%. And then for Cost, the weight is zero because MIPS APM participants are already responsible for cost containment under their APM.

Amy Weiser:

Next we're going to talk a little bit about telehealth changes in the Medicare Physician Fee Schedule Rule. This rule addresses how CMS will treat telehealth codes for the duration of and after the COVID-19 public health emergency. The audio-only telephone E/M visits cannot continue after the public health emergency, so CMS is seeking comment on whether it should develop coding and payment for audio-only to remain in place on a provisional basis. We know that this is very important because there are many people that don't have the ability to use FaceTime or don't understand how to use it, and those kinds of things. There can be a lot of barriers related to that. So if you are interested and wanting this to continue, utilize the comment period to make your voice known.

They will extend the public health emergency flexibility that allows supervising physicians to provide direct supervision using audio-video real time technology. And they're seeking comment if there are additional services that use telecommunications technology, like remote patient monitoring and virtual check-ins that should receive payment, but are not a "telehealth" service. For remote patient monitoring, that would be something like if someone had an ambulatory blood pressure monitor or someone had a continuous glucose monitoring or those kinds of things. And then CMS proposes to change the definition of telecommunications system to include telephones, fax machines and electronic mail systems.

Amy Weiser:

They are saying that 12 codes will stay on the approved list after the public health emergency. And they are listed on this slide: the visit complexity inherent to certain office or outpatient E/Ms, group psychotherapy, psychological and neuropsychological testing, prolonged services, cognitive assessment and care planning, domiciliary, rest home, or custodial care services, established patients, and then home visits and established patient.

Amy Weiser:

These 13 codes will stay on the approved list, but only temporarily. CMS created a new category of criteria called category three, for which there is likely clinical benefit when furnished via telehealth, but there is not yet sufficient evidence to make it permanent. The following 13 codes will stay on the approved list through the calendar year in which the public health emergency ends. And you can see them listed here: the domiciliary, rest home or custodial care and established patients, home visits, emergency department visits, nursing facilities discharge day management and psychological and neuropsychological testing.

And then 52 codes are to be removed after the public health emergency ends. I'm not going to read all of these. You have them in your slide deck.

Amy Weiser:

So we just wanted to let you know, again, that you can submit comments. You have 13 days and there are three ways in which to do so. You can submit them electronically and you can follow the link that we've included on this slide, Submit a Comment with Instructions. You can also use regular mail and the address is there for CMS. You can do express or overnight mail to the address that's listed and comments are due by 5:00 p.m. on October 5, 2020. And now if you have any questions, we would welcome you to enter them into the Q&A box.

April Faulkner:

As Amy said, feel free to enter those questions. We have not received any yet, but I'll give you a moment. We'll just pause for a moment. If you would like to enter them, look in the bottom right of your screen, that Q&A box. And in the meantime, I'm going to post a link for you. Just a reminder that the next edition of QPPLive! will be held on Thursday, October 15 at 9:30 a.m. And there is a registration link in the chat box. So feel free to click on that and register if you'd like to make sure you have a spot for that upcoming event. We do have a question that came in. When does the public health emergency end?

Kathy Wild:

This is Kathy, and I can take that. So Brad, unfortunately we do not know that, that is something that the President will declare, and I imagine he'll speak with the CDC and all the other health authorities when they actually decide that it is safe to state that that emergency has been lifted. So I don't know. I mean, I would expect that it's going to continue with flu season coming up, we don’t have treatment and vaccinations are not available yet for everybody. I personally think it's going to be several more months. If not six months, nine months, but we'll have to see. Great question.

April Faulkner:

Okay. Thank you. And another one has come in, are the measures listed already on the QPP website?

Amy Weiser:

If you're talking about the 2021 measures, I do not believe they are on the QPP website yet. The 2020 measures are available if you go to qpp.cms.gov and click on the MIPS tab. And then within that, there's

a tab that you can click on that's called Explore Measures and Activities. That's where you would find them. But the 2021 measures have not been entered there because we are still in the Proposed Rule phase. So it won't be for a while.

Kathy Wild:

I just wanted to ask if someone could post, maybe Rabecca, if you can post the link to the Proposed Rule. What you will have to do is go to the Proposed Rule, which is over a thousand pages, but go toward the very end of it where all the appendixes are. You can see the quality measures there.

April Faulkner:

All right. And another question has come in. If a provider is in an ACO for half the year of 2019 and the rest of the year reported MIPS as an individual provider, which score will CMS use?

Amy Weiser:

The clinician, when in the ACO, left the ACO and they want to report MIPS or they aren't sure if they're going to report MIPS. If the ACO submits data on their behalf and the clinician reports MIPS, let's just say this, then CMS is going to use the higher of the scores is the way that I understand it. But maybe it would be best if you talk to one of us offline and we can walk through that with you in more detail.

April Faulkner:

Okay. We'll pause another moment, if anyone has any more questions, we're caught up right now on our questions. And Amy, that person who submitted the question says thanks. It sounds like you answered it. And just to call everyone's attention to the chat box, Rabecca has posted some links in there for you for the Proposed Rule Fact Sheet, and then a link to the 2021 Proposed Rule.

Kathy Wild:

Thank you, Rabecca.

April Faulkner:

I'm not seeing any other questions. And just a reminder that this event recording, the slide deck and the transcript will all be posted and available for you to download on our Archived Events webpage. And that link is also at the top of the chat box in there for you. So seeing no other questions at this time, I wanted to thank Kathy and Amy for sharing this informative presentation. And thank you everyone for joining us today. Please note that when you do close out of today's session, you will automatically be directed to a very brief evaluation. Please take a moment to complete it. We greatly appreciate your feedback and comments. Thanks again for joining us today and have a great rest of the day. The session has concluded.