April Faulkner:

The Quality Insights QPP Support Center team welcomes to you today's webinar, 2021 MIPS & QPP Reporting Requirements. 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 the archived events page. A link to that webpage is posted in the chat box. At this time, I'd like to introduce our presenters. Joining us today are two members of the Quality Insights QPP Support Center team, Amy Weiser and Kathy Wild. I'll turn the presentation over to them to get us started.

Amy Weiser: (slide 3)

Thanks so much April, and thank you all for joining us today. I hope that wherever you are, you are safe and warm. So our agenda today is going to cover MIPS, what stays the same, what has changed, and category specifics. And then Kathy is going to cover the Alternative Payment Model changes, the APM Performance Pathway, which is the new pathway or the APP, the Medicare Shared Savings ACO changes, updates to the MIPS Value Pathways or MVPs, and tips for success.

Amy Weiser: (slide 4)

We're going to start with a high level overview. It's hard to believe but 2021 is the fifth year of the Quality Payment Program, and CMS limited the number of significant changes so that clinicians can continue to focus on COVID-19. A new pathway is available. As I mentioned, it's the Alternative Payment Model for APM participants, but the MIPS Value Pathways, or the MVPs, has been delayed until 2022 at the earliest. This slide includes a link for the 2021 MIPS Quick Start Guide.

Amy Weiser: (slide 6)

Now we're going to talk about what is staying the same in 2021. First, all MIPS eligible clinician types are the same. So again, this includes physicians, chiropractors, PAs, nurse practitioners, clinical nurse specialists, CRNAs, PTs, OTs, speech-language pathologists, clinical psychologists, audiologists, and registered dietitians and nutritionists. The low volume threshold criteria, which determines your eligibility for the program, is also the same. For example, billing greater than $90,000 for Part B covered professional services, seeing greater than 200 Part B patients and providing greater than 200 covered professional services to Part B patients.

The MIPS determination periods are October 1, 2019 to September 30, 2020 and October 1, 2020 to September 30, 2021. There is still an opt-in policy for MIPS eligible clinicians who are excluded from MIPS because they don't meet all three of the eligibility criteria. And if you are in that position and you would like some additional guidance as far as opting in, we really encourage you to reach out to us to get some exceptional and customized advice for your situation. As far as the submission methods, 2021 is the last year that the CMS web interface can be used for quality measure submission.

Amy Weiser: (slide 7)

More of what is staying the same in 2021 includes the category performance periods. Again, it's a full year for Quality and Cost, and 90 days reporting for the Promoting Interoperability and Improvement Activity categories. The exceptional performance threshold remains 85 points for 2021. The maximum negative payment adjustment remains 9%, which is what we want you to avoid. There also continues to be the small practice flexibility. You have eligibility to reweight the Promoting Interoperability category. You can earn double points for Improvement Activities. And earn six quality points for reporting at least one quality measure. And again, our no-cost assistance is available now through February of 2022, so take advantage of our no-cost assistance and expertise to help you through and navigate the program.

Amy Weiser: (slide 9)

So what is changing in 2021? Fortunately not a lot, but I do want to highlight a few things here. There are four choices for participation in 2021. You can participate as an individual clinician, as a group, as a virtual group, or through an APM entity – this is new. CMS will no longer evaluate APM entities for the low volume threshold. Clinicians will be evaluated for eligibility at the individual and group levels.

Amy Weiser: (slide 10)

Let's talk about the category weight changes that have occurred for 2021. Of note, the Quality category weight decreased to 40%, so that was a -5% adjustment, and the Cost category weight increased to 20%, which is a positive adjustment of 5%. By law, Cost and Quality categories must have an equal 30% weight beginning in 2022.

Amy Weiser: (slide 11)

This slide is very important. The performance threshold has increased for 2021. You must have 60 points to avoid a negative payment adjustment, and this is a 15 point increase from 2020. A score of 15 points or lower will result in the full -9% adjustment. It was 11.25 points in 2020. This slide gives you a really nice breakdown of the final MIPS score achieved in 2021, and then the associated payment adjustment that you would receive in 2023. It's always two years after the performance period when you would see that payment adjustment. CMS is estimating that the performance threshold will be approximately 74 points in 2022, and 2022 is the last year for the exceptional performer bonus as well.

Amy Weiser: (slide 12)

So there has been a policy change in the application of payment adjustments I want you to be aware of. If a clinician has more than one MIPS score associated with a single TIN/NPI combination, CMS will use the highest available score to determine the payment adjustment. There is one exception. Virtual group final scores always take precedence over the highest available score.

Amy Weiser: (slide 13)

The complex patient bonus was reduced in 2021. It is worth five points. It was temporarily increased in 2020 due to the additional complexity of treating patients with COVID-19.

Amy Weiser: (slide 14)

Next, we'll discuss third party intermediaries. New intermediaries face increased criteria for consideration, including the capability to submit data for all MIPS categories except for Cost. Registries and QCDRs are required to conduct annual data validation audits and address remedial action for inconsistencies. They can be terminated from the Quality Payment Program if they're non-compliant. We've included links to a few resources to help you identify qualified registries and qualified clinical data registries.

Amy Weiser: (slide 16)

Now we'll talk about some category changes for MIPS. The first category is Quality and there've been a few changes. They decreased the number of quality measures to 209 total. There are 47 Medicare claims based measures available, 47 electronic clinical quality measures available, 185 registry measures, and 10 CMS web interface measures. They removed 11 measures and made substantive changes to 113 existing measures. Just a reminder that looking at the specification sheets every year is very, very important to make sure that you're understanding the changes that are occurring. They added, removed and modified specialty measure sets, and they added two administrative claims measures. So what's the same? You can still report at least six quality measures, one outcome or high priority measure. Each measure must meet the 70% data completeness and 20-case minimum to earn a maximum potential points, and CMS will use historical benchmarks based on 2019 data.

Amy Weiser: (slide 17)

I'm not going to read through this entire slide, but this is the list of the 11 quality measures that were removed for 2021.

Amy Weiser: (slide 18)

This slide covers the two new administrative claims measures. One measure is applicable to large practices, that's practices with 16 or more clinicians, and the other is applicable to orthopedic surgeons. Both measures have a three-year performance period and require a minimum of 25 cases to be reported. So the measures are *Hospital-wide 30 day all-cause unplanned readmission rate for MIPS groups of 16 or more*, this replaces the all-cause readmission measure, and *Risk-standardization complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty*.

Amy Weiser: (slide 19)

For the next few slides, we'll talk about some substantial changes to the measures. We're going to highlight what they are first: Diabetes Hemoglobin A1c Poor Control, which is ID 001; ID 128, Preventive Care and Screening: Body Mass Index Screening and Follow-up Plan; and ID 130, Documentation of Current Medications in the Medical Record. You can find these located in Table Group D on page 762 of the Final Rule. We were also made aware recently of another measure change that is very significant for 2021. It is not included on the slide, but we do want you to be aware of it. It is ID number 317, High Blood Pressure Screening and Follow up. The reporting frequency has been changed. It is every visit, no longer annually.

Amy Weiser: (slide 20)

So let's talk a little bit about Diabetes Hemoglobin A1c Poor Control. A lot of practices use this measure so we wanted to make sure you were aware of what has been changed. The measure description has not changed, so it is still the percent of patients 18-75 with diabetes who had a hemoglobin A1c greater than nine during the measurement period. They updated the denominator exclusions. Also, they updated the numerator instructions not to include hemoglobin A1c levels reported by the patient, and they stratified NOT MET numerator options, but only when reported via claims or registry. We want to make sure you understand that. There are 3 stratified numerator options: 1) the most recent hemoglobin A1c less than seven, 2) the most recent hemoglobin A1c equal or greater than seven and less than eight, and 3) the most recent hemoglobin A1c equal to or greater than eight and equal to or less than nine. You can find that on page 763 of the Final Rule.

Amy Weiser: (slide 21)

The next measure that has some changes is the Preventive Care and Screening: Body Mass Index Screening and Follow-up Plan. They revised the description. It states the percent of patients at 18 or greater with a BMI documented during the current encounter, or within the previous 12 months, and who had a follow-up plan documented if the most recent BMI was outside normal parameters. They added normal BMI parameters, and they updated exclusions and exceptions. You can find this on page 793 of the Final Rule.

Amy Weiser: (slide 22)

And the last one is Documentation of Current Medications in the Medical Record. They revised the description, percent of visits for patients at 18 or greater for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the day of the encounter. They updated the numerator notes section to include: This list must include all known prescriptions, over the counter products, herbals, vitamins, minerals, dietary supplements, and must contain the medication name, dosage, frequency, and route of administration. This can be found on page 795 of the Final Rule.

Amy Weiser: (slide 23)

This slide highlights the specialty quality measure sets for 2021. I'm not going to read through this. It's quite extensive, but it's very comprehensive. So hopefully if you are a specialist, you can find the measure sets easily, and you also can find these on the QPP website.

Amy Weiser: (slide 24)

This slide provides links to the updated Quality category resources, including the Quality Measure List, the Quality Quick Start Guide, the Quality Benchmarks, and the Cross-cutting Quality Measures.

Amy Weiser: (slide 25)

We're going to switch gears and talk about the Improvement Activity category changes. CMS removed one activity, the CMS Partner in Patients Hospital Engagement Network. The network became obsolete in March of 2020. They modified two medium weight activities: Engagement of patient through

implementation of improvements in the patient portal. The change was adding language to include caregivers as additional potential users, and clarify that the portal should be used for clinical, not administrative, bi-directional information exchange. The other activity is comprehensive eye exams. The proposed change is to expand the types of services that can be promoted to underserved and/or high risk populations.

Amy Weiser: (slide 25)

I want to talk about what is staying the same. This category still is 15% of the MIPS final score, and 40 points are needed to earn full credit. So the activity weights remain the same for the small, underserved and rural practices. If reporting MIPS as a group, at least 50% of the clinicians in the group must perform the same activity, clinicians, however, can select a different 90-day reporting period. And the Patient-Centered Medical Home bonuses or activity is still available for practices that have patient-centered medical home recognition.

Amy Weiser: (slide 26)

CMS decided to keep the COVID-19 Improvement Activity *Clinical data reporting with or without clinical trial*, and it's been modified. MIPS eligible clinicians or groups must participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with COVID-19 infection, and report their findings through a clinical data repository or clinical data registry for the duration of the study, or the MIPS EC or group must participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing future COVID research. Again, this is not a mandatory activity but it is available if you want to submit this.

Amy Weiser: (slide 27)

This slide includes some resources. Note that established policies for new activities must be linked to existing MIPS quality and cost measures. So moving forward, that's the plan. We have links to the IA Quick Start Guide and the Improvement Activity Inventory List on this slide.

Amy Weiser: (slide 28)

Now we're going to talk about Promoting Interoperability. Increased points will be awarded for the optional bonus measure, which is the *Query of PDMP,* to 10 points. They changed the name of *Support Electronic Referral Loops by Receiving and Incorporating Health Information*, by replacing the word “incorporating” with “reconciling,” and they added a new optional measure for health information exchange.

Amy Weiser: (slide 29)

There is a new optional Promoting Interoperability measure. The new HIE bi-directional exchange measure can be reported instead of the two existing health information exchange measures. There are three requirements that must be met to earn credit. You must participate in a health information exchange to enable secure, bi-directional exchange for every patient encounter, transition of care, referral and record in the EHR during the reporting period. The Health Information Exchange must be capable of exchanging information across a broad network of unaffiliated partners without exclusionary

behavior, and you must use certified EHR technology. The measure is worth 40 points, and you must report the measure by attestation in the QPP portal.

Amy Weiser: (slide 30)

There are some things to consider with the new optional measure. If you report the two existing HIE measures, worth a maximum of 20 points each, your score is based on performance, so you may earn less than 40 points of the new measure. If you exclude the two existing Health Information Exchange measures, 40 points will be reallocated to the *Provide Patients Access to their Health Information* measure. Only one submission method can be used for the Promoting Interoperability category. So if you report the new HIE measure, you must report all Promoting Interoperability measures via attestation in the QPP portal.

Amy Weiser: (slide 31)

There are some certified electronic health record technology updates. The 21st Century Cures Act Final Rule requires technical updates to the 2015 edition certified EHR technology. The deadline to implement the updated version of the 2015 edition is August 2, 2022. For 2021, you can use the 2015 edition, the updated 21st Century Cures Act version, or a combination of both.

Amy Weiser: (slide 32)

For your convenience, we've included links on this slide to some Promoting Interoperability category resources, including the Quick Start Guide and the Measure Specifications.

Amy Weiser: (slide 33)

Now we're going to talk about Cost. They have increased the weight to 20% of the MIPS final score. It was 15% for 2020. They added codes for telehealth services, which we know was very important in the days of the pandemic. So the 18 episode-based cost measures, the Medicare Spending Per Beneficiary, and the Total Per Capita Cost measures all include codes for telehealth. And we've included a link on this slide to the 2021 Cost Measure Specifications. As a way to help you manage cost each year, it's best to review the previous year's feedback reports and to check your attribution and what it means for your practice.

Amy Weiser: (slide 34)

We've included links to some Cost category resources on this slide, including the Quick Start Guide, the Summary of Cost Measures, and the Cost Measure Code Lists. And now I'll turn it over to Kathy.

Kathy Wild: (slide 35)

Thank you Amy, and welcome everybody. I am going to cover the second pathway of the Quality Payment Program, which is the Alternative Payment Model. Amy did a great job of covering everything to do with MIPS, so we'll talk about APMs now. As you know, it is CMS' intention for all MIPS clinicians to eventually join an APM. The goal is for it to result in improved healthcare and reduced costs. So when clinicians are willing to take a nominal risk by joining an APM, they are more apt to focus on performing

well. If they do, and the big advantage of being in an APM, is that they will receive a 5% incentive payment bonus based on their performance. And this is very high compared to the MIPS bonus, which over the last four years has been less than 2%. Last year, the highest payment adjustment for a perfect MIPS score of 100 points was only 1.79%. So there is an advantage for you to try to get into an Alternative Payment Model. We're going to talk about the changes now.

Kathy Wild: (slide 36)

This slide provides an overview of APMs. I think we've seen this over and over again. But to quickly review, there are three different types of Alternative Payment Models: the APMs, MIPS APMs, and Advanced APMs. The ultimate goal is for somebody to be in an Advanced APM, and then when they're in that, to meet certain criteria, and they would be called a qualifying participant. Those are the ones that would get that 5% bonus based on their performance.

Kathy Wild: (slide 37)

Now we'll go over some of the APM changes from last year to this year. APM scoring has been completely eliminated. So, as you may recall, if you participated in an APM before, it was always different from MIPS. And the reason for that was because the Cost category was always zero, therefore, the weight of the other categories had to be higher to compensate. So the APM scoring standard had the Quality category at 50%, PI at 30%, and Improvement Activities at 20%. That no longer stands. APM entities can now use any submission method. They are no longer restricted to just using the CMS web interface to report quality measures. And one of the things Amy stated earlier is that the CMS web interface measures are actually going away. This is the last year for them. So if an APM wants to report them, this will be the last year.

MIPS eligible clinicians in an APM have three options to report data now. They can do it at the individual level, the group level, or the APM entity level, and that's the new one. And what's great is that individuals and groups can submit data even when they are included in the ACO-level data. So if the ACO submits at the APM entity, a MIPS clinician can still report data either at the individual or group level, and then what CMS will do is award the highest score. So there are advantages. And once again, the Cost category is reweighted for all APM entities because cost containment is all-inclusive of being in an APM. So that will never be applicable.

Kathy Wild: (slide 38)

CMS makes QP and partial QP determinations four times a year. If an advanced APM believes that CMS made an error and omitted a clinician who really should be a QP or partial QP, they can request a targeted review, and that wasn't allowed before. Another change has to do with patient attribution in an Advanced APM. Medicare patients prospectively attributed to an APM will not be included as attribution eligible a second time if the Advanced APM does not allow it. So that's a little change in the attribution.

Kathy Wild: (slide 39)

CMS included COVID-19 in the list of extreme and uncontrollable circumstances last year, and actually in 2019 when it first became a problem. So APM entities can now submit an EUC application to request reweighting of all the MIPS categories. There are nine models of APMs that can do that: the Medicare Shared Savings Plan, Next Generation, CPC+, Bundled Payments for Care Improvement, and then we also have the condition-specific models of APMs, which are the comprehensive end stage renal disease care, and the oncology care model, and the independence at home demonstration. There's also two state specific APM models that can do this, and that's Vermont Medicare and Maryland Primary Care.

We also want to note that there is a difference in the EUC hardship applications between MIPS and APMs. If an EUC is approved for an APM, all clinicians in the APM entity will have a neutral payment adjustment even if data is submitted. And once again, this is different from MIPS, because if you have an approved hardship exception application with MIPS and you submit data, then the EUC application is null and void and your data will be scored. So everyone in an APM needs to note that.

Kathy Wild: (slide 40)

At the very end of 2020, Congress passed what's called the Consolidated Appropriation Act of 2021. It froze the threshold for the payment amount and the patient count that determines QP status. So the percentages for this year and next year are actually going to be the same as they were last year. The payment amount is going to remain at 50% and the patient count will remain at 35%. This is great news for anybody that was a QP this year. They should be able to meet QP status again, this year and next year, because of that freeze.

Kathy Wild: (slide 42)

Amy alluded to the new change of APM Performance Pathways. Its acronym is APP and we're going to go over them now. As I've said before, CMS is trying to make it easier for clinicians to follow the APM pathway instead of MIPS. So this year, they created a new reporting option for the MIPS APMs. This is optional for everyone except the Medicare Shared Savings Program ACOs. It's mandatory for them, and I'll go over that in a bit more detail. So the APP is comprised of a fixed set of measures for each of the different categories. It can be reported at the individual, group and/or APM level, and if data is reported at different levels more than one time, CMS will award the highest score. And from what we can tell, the data will have to be reported through the QPP website portal. This slide includes a link to the 2021 APP Fact Sheet.

Kathy Wild: (slide 43)

These are the APP category weights. As you know, everyone in an APM does not have to report cost. That has been reduced to zero, because APMs are already involved in cost containment. So when you look at this table, you'll see that the proposed weights are exactly the same as the APM scoring standard that CMS eliminated this year. They kept it the same but it is under this new pathway. They took it into consideration where they had to increase the weights for the Quality, PI and IA categories because the Cost coding category is zero.

Kathy Wild: (slide 44)

This table provides brief descriptions of the different categories. It includes all four categories. For the Quality category, there are two options in 2021. One option is that you can report the APP measures, and I'll review them shortly but there are six of them. Only three of them require data submission on the part of the clinician or group, or you can report the CMS web interface measures. Remember there are 10 of them, and you do have to report all of them if you pick that option. The Promoting Interoperability category stays the same. They have the same guidelines as MIPS, and you can report them either at the individual or group level, but they must be reported. And the good thing with the Improvement Activities category is that if you select to participate in the APP this year you will get full credit for this category. I'm not sure if that will happen again in 2022, but full credit will be awarded and no reporting is required for 2021. And as we said earlier, there's nothing with the Cost category.

Kathy Wild: (slide 45)

This is a list of the six quality measures that are in the APP quality measure set. We have Diabetes: Hemoglobin A1c Poor Control, Screening for Depression and Follow-up Plan, Controlling High Blood Pressure, which are the three measures that would be reported, then there's also the CAHPS for MIPS Survey, and then the two administrative claims measures. Amy reviewed those earlier. If you participated in the APM previously, you probably noticed that the three measures that must be reported are also CMS web interface measures. Another thing to note is that these measures must be reported either electronically or through a registry.

Kathy Wild: (slide 47)

Now I'll review the requirements specifically for the Medicare Shared Savings ACOs. The reason for that is because they are required to use the new APM Performance Pathway. So for the Quality category, there are two options. One is to report the three APP measures, which again are diabetes, depression, and controlling high blood pressure, or the other choice is to report the 10 CMS web interface measures. You've got the three that are in the APP pathway, plus the seven others which are influenza immunization, breast cancer screening, colorectal cancer screening, tobacco use screening and cessation intervention, screening for future fall risk, depression remission at 12 months, and statin therapy for prevention and treatment of cardiovascular disease.

When you look at the two choices, you can just report three measures or you can report those three plus seven other measures for a total of 10. That's the choice you have if you're in a Medicare Shared Savings Program. I want to note that there are three CMS web interface measures that currently don't have a benchmark, so those measures won't even be scored. That's why the third bullet says that only seven will be scored if you use the CMS web interface measures. The ones without a benchmark are the screening for depression and follow up, depression remission at 12 months, and the statin therapy for prevention and treatment of cardiovascular disease. And once again, CMS web interface reporting will go away next year and MSSP ACOs will have to report those three APP measures.

Kathy Wild: (slide 48)

Now we'll talk about the quality performance standard. Part of being in an APM is to commit to quality improvement. And CMS' plan is to ultimately increase the requirements every year to show increased performance. So instead of every year incrementally increasing it, they agreed to gradually phase-in the performance that is required to meet the quality performance standard. For this year and next year, the minimum standard performance rate is 30%. If you get 30% or more, then you will be able to share in your savings with your Shared Savings Program. Next year the threshold will increase to 40%. And CMS' intent is to move ACOs from upside to downside risk. So those at the bottom of the list that do not meet this threshold could actually be terminated from the program if the ACO was non-compliant in meeting the minimum standards.

Kathy Wild: (slide 50)

Now we'll talk briefly about MVPs. As we know, they were delayed this year. They were supposed to be implemented but due to priorities surrounding the COVID pandemic, they have been postponed to next year. CMS held two different webinars, one in December, and then they recently held a town hall on January 7th. And they have invited stakeholders, such as specialty societies, to submit ideas. The whole idea with the MVPs is that the option will be very similar to the APPs, which we just covered. They will allow CMS to align measures and improvement activities, and group them by common clinical themes across all MIPS categories. An example would be diabetes. You could have a MVP for diabetes or maybe high blood pressure. If you're a surgeon, there might be one that's applicable to you. And then you've got your specialties. This is where it would be very helpful to have an ophthalmology MVP, where they could just focus on those measures and activities.

CMS is collecting a lot of information now, and we're hoping by the time the proposed rule comes out, which is usually late summer or early fall, that it will have some MVPs available, and that some providers might be able to choose that option next year. We have a link on this slide for the town hall presentation. The transcript is also now available. The recording is not there yet, but it should be available in another week on the CMS QPP website. To access these items, go to the resources tab and look for the webinar library. That's where you can find more information about the MVPs.

Kathy Wild: (slide 52)

Next we'll review some tips for success. One of the first things we suggest is that you select your measures and your submission method now. It might be what you've been doing in previous years, but you might see an advantage to switching and changing your submission method. You might plan on submitting data more than one time, as an individual and as a group, there are a lot of options, and it's important to consider them now. You need to check if the quality measures you reported previously are still available. We are in the process of updating resources on our website so you can check there. CMS has a lot of resources on their website as well. And you can always call and ask us for help, and we can guide you to where the current lists are.

Another tip is to review your results from previous years. If your performance rates are low, ask us for recommendations on how to improve, or we may tell you it might be best if you consider selecting a new measure or activity. Another thing is to capitalize on synergies between performance categories. For example, there are Quality, Improvement Activities and Promoting Interoperability measures surrounding care coordination and electronically sharing information when a patient moves from one setting or a clinician to another. Quality measure ID 374 is called *Closing the Referral Loop: Receipt of Specialist Report.* There's an Improvement Activity called IA_CC_1, which is *Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close the Referral Loop*. These align perfectly with the Promoting Interoperability measures that have to do with the Health Information Exchange. So as you can see, if you focus on care coordination you can build in changes so all of your performance rates go higher, and ultimately, this would also help you reduce your costs. This is what an MVP should do. I imagine there might be one MVP for care coordination where they will align those types of things if that's what you're interested in.

Another thing high on CMS' priority list is to focus on patient engagement. It's really important to involve the patient and help them help themselves to improve outcomes. If you report any preventive measures, such as cancer screening, get them involved to use the portal, encourage them to use it and send reminders when things are due, that's going to ultimately help you improve your performance rates.

It's very important that you review HCC coding. Be sure to implement the new 2021 CPT and E&M codes. The AMA recently did a huge overhaul of the CPT and E/M codes. Also, we held a webinar on November 24th. A consultant gave that presentation. The slides, transcript and recording are available on the Quality Insight website on the Archived Events page.

Include all of your office staff in MIPS education. If you decide to select a new quality measure and it involves different people doing different things to help improve the performance rate, it's important to make sure everyone knows their role and the reason why they're doing that. And the last bullet I have here is to take advantage of our free assistance. As Amy noted, we are offering this free assistance through February 15, 2022. You may think that that is an odd date. When the Quality Payment Program was first implemented, CMS provided 5-year contracts to 11 organizations throughout the country, and each one had different states to help those providers. And believe it or not, the five years will be up next February. As of this time, we don't know if CMS will be offering another contract for us to help you. We are certainly hoping that that is the case, because every year, as you can tell from today, the rules and regulations change. And we know MVPs will be coming out. And I'm sure there'll be other things. But in the meantime until we find out otherwise, we are here to help you, and we want to help teach you what you can do if that free assistance isn't available. So please reach out to us.

Kathy Wild: (slide 53)

This slide has a link to the Final Rule and Final Rule resources. There are a lot of them and they're on the CMS QPP website. I hope we've covered enough for you to know about the MIPS and the APM changes for 2021 reporting. We would love to help you, please reach out to us at any time. And we do have a couple of minutes to take some questions.

April Faulkner: (slide 54)

Thanks, Kathy. We'll begin the Q&A portion of today's program. If you have any questions for our presenters, feel free to enter them in the Q&A box or the chat box at the bottom right of your screen. In the meantime, I did receive a few questions. Two came in that were addressed and they are in the Q&A box, along with answers, if attendees would like to see those. Also, another question I received is how does an EC reporting MIPS change to an APM?

Kathy Wild: (slide 54)

An APM, or Alternative Payment Model, is an organization that you would have to join and make commitments to. So it depends upon what type of specialty you are, what you're interested in, and where you live to see what's available, and then you would have to have discussions with that organization, that APM entity and they would explain all the rules and regulations. There is a list of Medicare APM entities available and we can certainly help guide you that way. So there is a process of joining an APM entity and then abiding by their rules and regulations, and then you could report as the APM.

April Faulkner: (slide 55)

If you have a question that needs some detailed back and forth discussion, our contact information is on this slide. I don't see any other questions, but if you think of anything after the event, feel free to reach out to us. We can answer questions beyond just the webinar time. But in the meantime, thank you Kathy and Amy, for sharing this informative presentation. Thank you everyone for joining us today. Please note that when you close out of today's session, you will automatically be directed to a very brief evaluation. Please take just a moment to complete it. We greatly appreciate your feedback and comments. Please note that the next edition of QPP live will be held on Thursday, February 18th at 9:30 a.m., and I have posted a link to the registration for that event in the chat box. Thanks again for joining us everyone, and have a great rest of the day. The session has now concluded.

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