Healthcare Executives of Southern California

presents

CMS Priorities, Health System Transformation and the Medicare Access and CHIP Reauthorization Act (MACRA)

HEALTH CARE EXECUTIVES OF SOUTHERN CALIFORNIA

Health Care Executives of Southern California

THANK YOU SPEAKERS

Cassidy Tsay, MD, MBA
Vice President, Business Development
CAPG

Ashby Wolfe, MD, MPP, MPH
Chief Medical Officer, Region 9
Centers for Medicare & Medicaid Services

Joseph C. Alvarnas, MD
Director of Value-Based Analytics
City of Hope

HEALTH CARE EXECUTIVES OF SOUTHERN CALIFORNIA

Health Care Executives of Southern California

THANK YOU SPONSORS

americancareercollege.edu

Health Care Executives of Southern California

THANK YOU SPONSORS

MolinaHealthcare.com

HEALTH CARE EXECUTIVES OF SOUTHERN CALIFORNIA

Health Care Executives of Southern California

CONNECT WITH US

HCESoCal

HCESoCal

@hcesocal

@HCE_SOCAL

admin@hce-socal.org

www.hce-socal.org

HEALTH CARE EXECUTIVES OF SOUTHERN CALIFORNIA

Getting Started with the Quality Payment Program:

An Overview of MIPS and APMs

Ashby Wolfe, MD, MPP, MPH
Chief Medical Officer, Region IX
Centers for Medicare and Medicaid Services

Presentation to the Healthcare Executives of Southern California
April 27, 2017

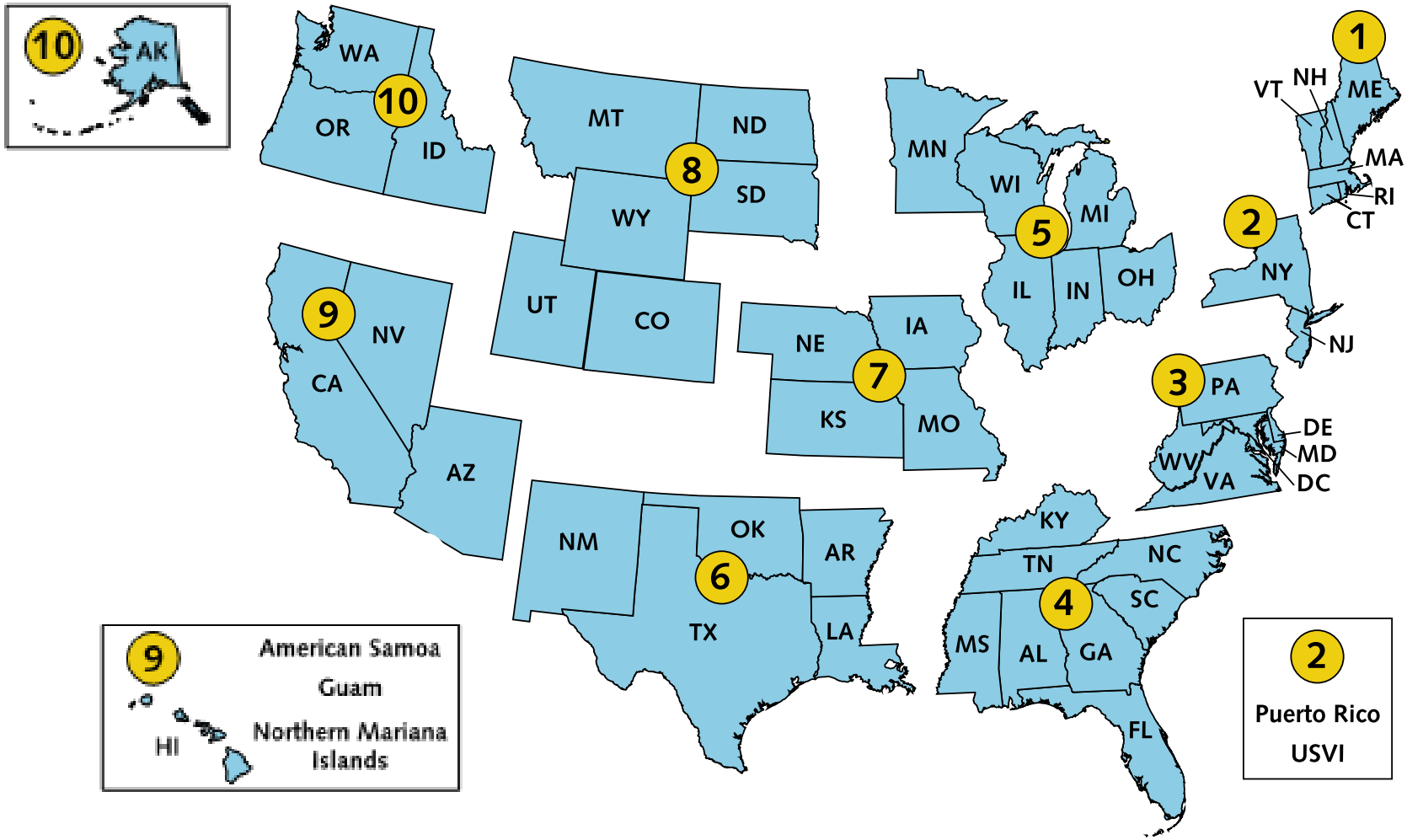
Disclaimer

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

CMS OFFICES


10
AK
WA
10
OR
ID
MT
ND
8
SD
WY
UT
CO
9
NV
CA
AZ
MN
WI
MI
5
IL
IN
OH
1
VT
NH
ME
MA
RI
CT
2
NY
NJ
NE
IA
7
KS
MO
3
PA
DE
MD
DC
WV
VA
NM
OK
AR
6
TX
LA
KY
TN
NC
4
SC
MS
AL
GA
FL
9
American Samoa
Guam
HI
Northern Mariana Islands
2
Puerto Rico
USVI

Better Care, Smarter Spending, Healthier People

Focus Areas	Description
Incentives	▪ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

The CMS Innovation Center

Focus Areas

Pay Providers

Test and expand alternative payment models

- **Accountable Care**
  - Pioneer ACO Model
  - **Medicare Shared Savings Program** (housed in Center for Medicare)
  - Advance Payment ACO Model
  - **Comprehensive ERSD Care Initiative**
  - **Next Generation ACO**
- **Primary Care Transformation**
  - **Comprehensive Primary Care** Initiative (CPC)
  - Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
  - Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
  - Independence at Home Demonstration
  - Graduate Nurse Education Demonstration
  - **Home Health Value Based Purchasing** (proposed)
- **Bundled payment models**
  - **Bundled Payment** for Care Improvement Models 1-4
  - **Oncology Care Model**
  - Comprehensive Care for Joint Replacement (proposed)
- **Initiatives Focused on the Medicaid population**
  - Medicaid Emergency Psychiatric Demonstration
  - Medicaid Incentives for Prevention of Chronic Diseases
  - Strong Start Initiative
  - **Medicaid Innovation Accelerator** Program
- **Dual Eligible (Medicare-Medicaid Enrollees)**
  - Financial Alignment Initiative
  - Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
- **Other**
  - Medicare Care Choices
  - **Medicare Advantage Value-Based Insurance Design** model

Deliver Care

Support providers and states to improve the delivery of care

- **Learning and Diffusion**
  - Partnership for Patients
  - Transforming Clinical Practice
  - Community-Based Care Transitions
- **Health Care Innovation Awards**
- **State Innovation Models Initiative**
  - SIM Round 1
  - SIM Round 2
  - Maryland All-Payer Model
- **Million Hearts Cardiovascular Risk Reduction Model**

Distribute Information

Increase information available for effective informed decision-making by consumers and providers

- **Information to providers in CMMI models**
- **Shared decision-making required by many models**

Origins of the Quality Payment Program: MACRA

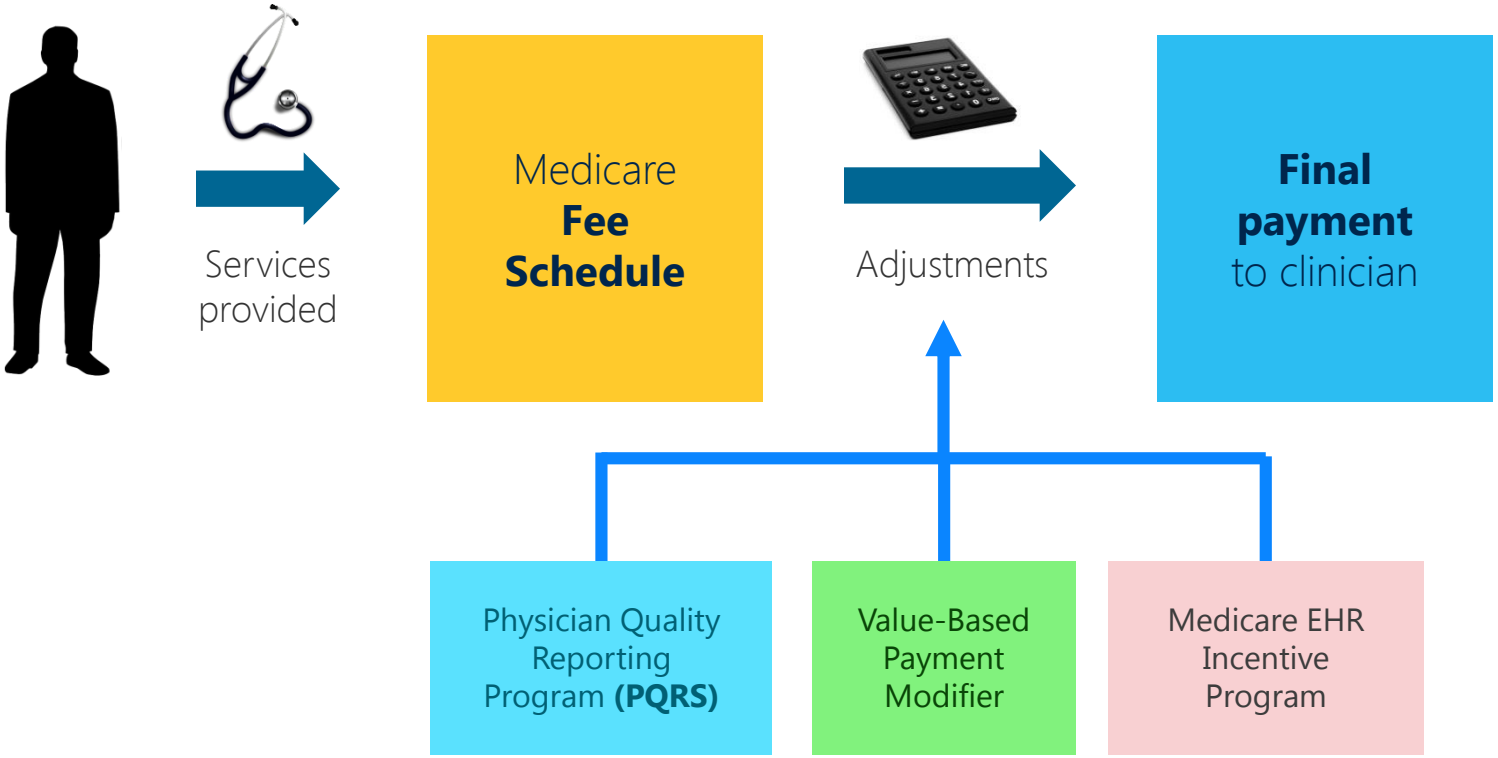
- Bipartisan Legislation: the "Medicare Access and CHIP Reauthorization Act," 2015

- Increases focus on quality of care delivered
  - Clear intent that outcomes needed to be rewarded, not number of services
  - Shifts payments away from number of services to overall work of clinicians
- Moving toward patient-centric health care system

- Replaces Sustainable Growth Rate (SGR)

Medicare Payments Prior to MACRA

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



MACRA changes how Medicare pays clinicians.

- The Quality Payment Program policy will **reform Medicare Part B payments** for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system

Services provided

Medicare **Fee Schedule**

Adjustments

Final payment to clinician

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

The Quality Payment Program

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternative Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

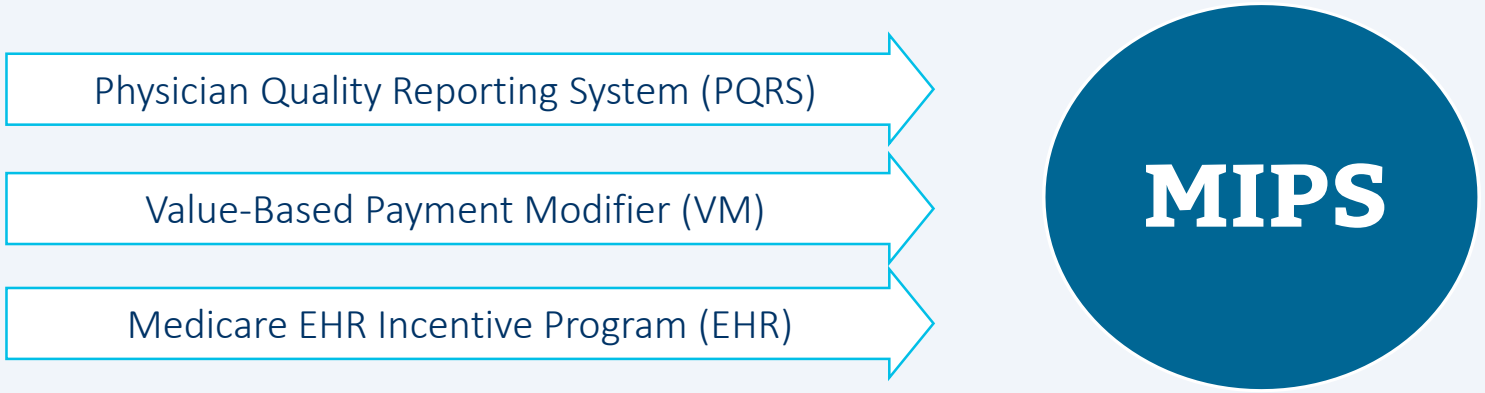
Discussion Structure

- Part 1: What do I need to know about MIPS?
- Part 2: What do I need to know about APMs?
- Part 3: How do I prepare for and participate in The Quality Payment Program?

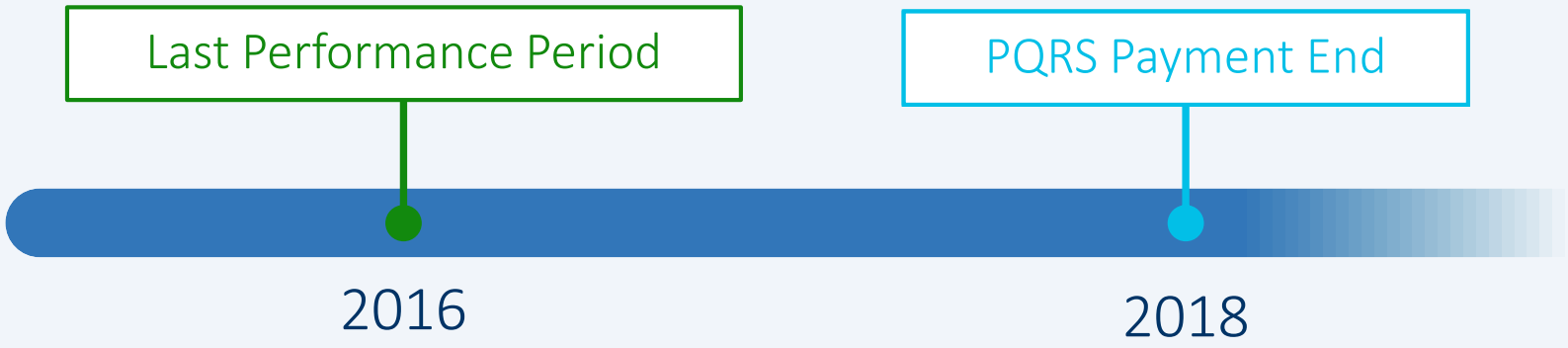
Part I:
MIPS Basics
What Do I Need to Know?

What is the Merit-based Incentive Payment System?

Combines legacy programs into single, improved reporting program

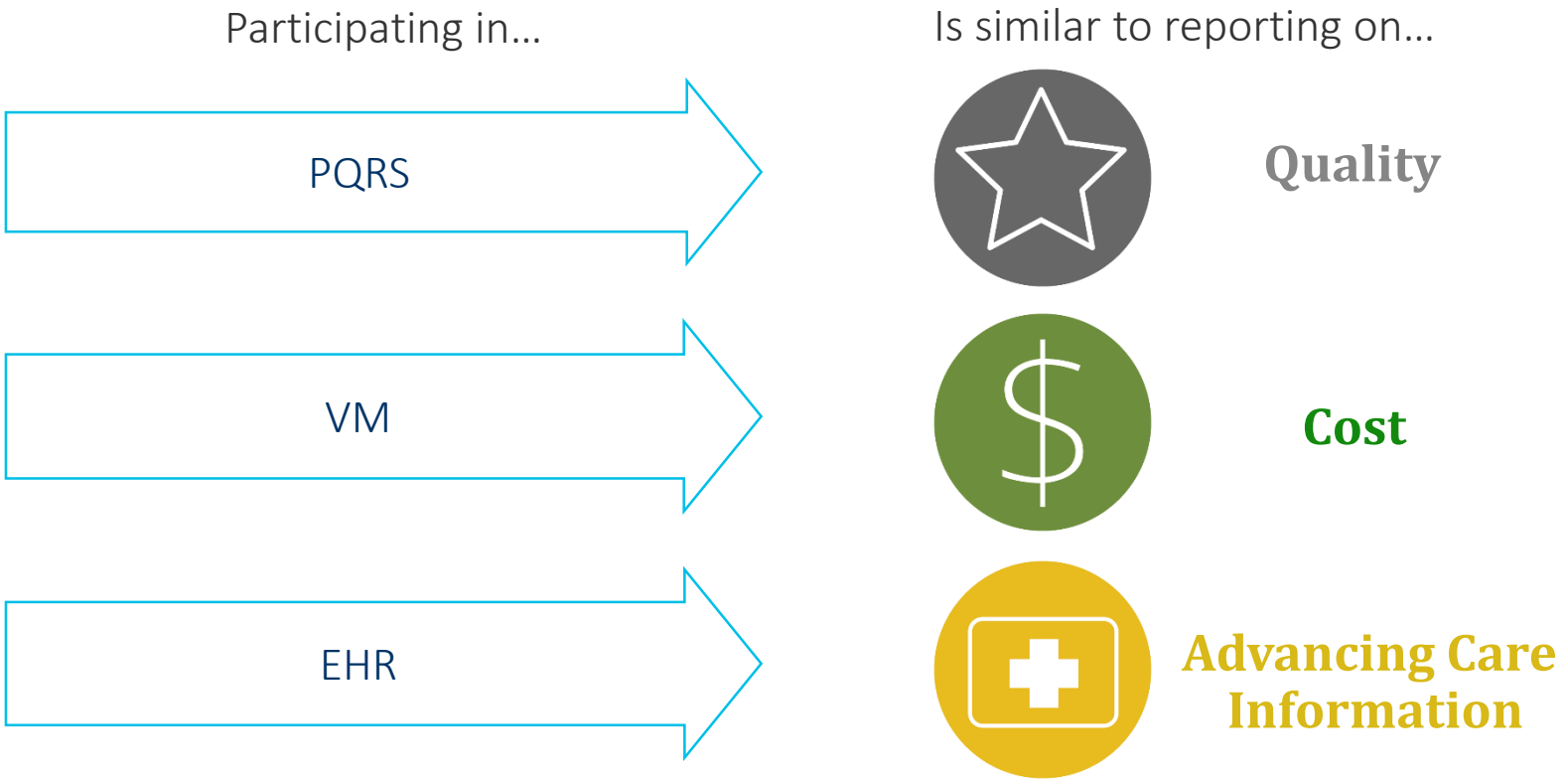


Legacy Program Phase Out



What is the Merit-based Incentive Payment System?

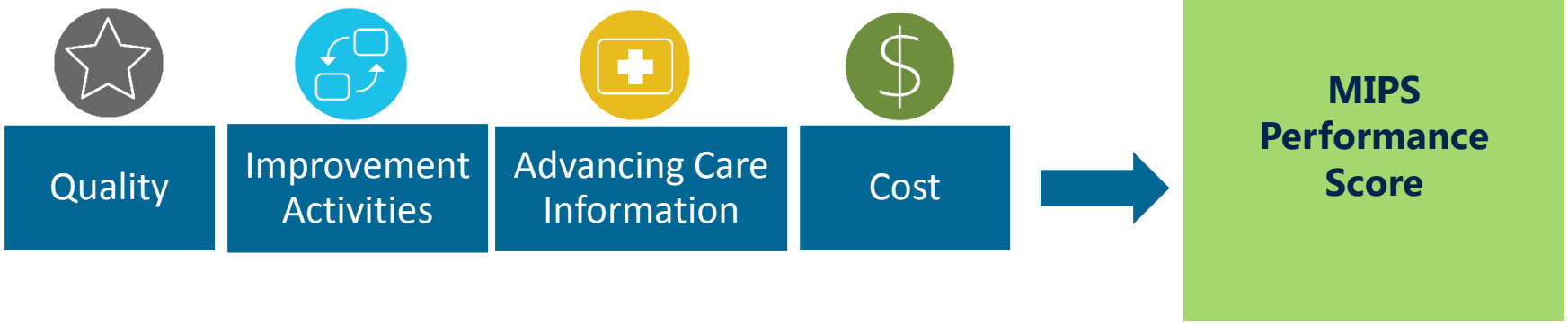
A visualization of how the legacy programs streamline into the MIPS performance categories:



What Is MIPS?

https://qpp.cms.gov

Performance Categories:



- Reporting standards align with Alternative Payment Models when possible
- Many measures align with those being used by private insurers

Clinicians will be **reimbursed under Medicare Part B based on this Performance** Score

MIPS for First-Time Reporters

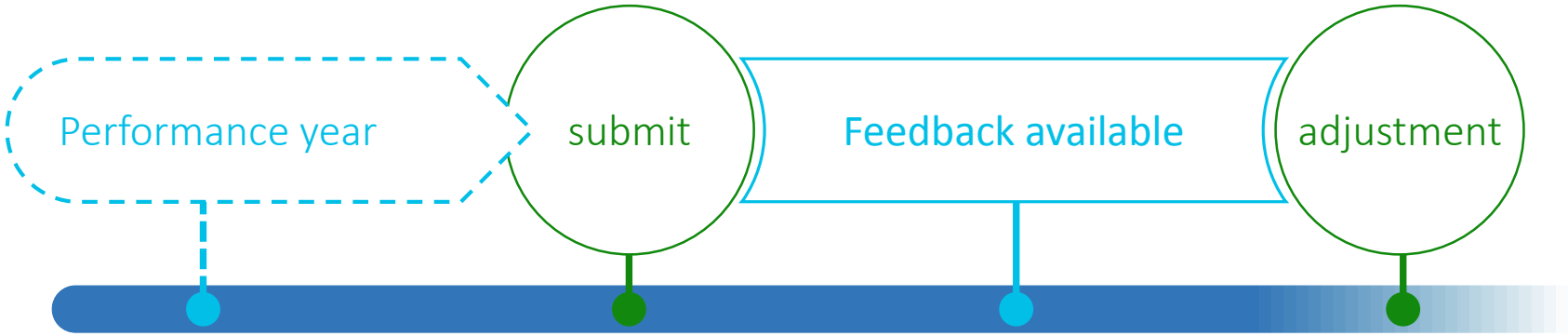
You Have Asked: *"What if I do not have any previous reporting experience?"*

CMS has provided options that may reduce participation burden to first time reporters by:

Adjusting the low-volume threshold to exclude more individual clinicians and groups

Allowing clinicians to pick their pace of participation for Transition Year 2017 by lowering the performance threshold to avoid a negative adjustment

When Does the Merit-based Incentive Payment System Officially Begin?



2017
Performance Year

- Performance period opens January 1, 2017.
- Closes December 31, 2017.
- Clinicians care for patients and record data during the year.

March 31, 2018
Data Submission

- Deadline for submitting data is March 31, 2018.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2019
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim begin January 1, 2019.

MIPS Eligibility
What Do I Need to Know?

Eligible Clinicians:

Clinicians billing more than $30,000 a year in Medicare Part B allowed charges **AND** providing care for more than 100 Medicare patients a year.

These clinicians include:

Physicians	Physician Assistants	Nurse Practitioner	Clinical Nurse Specialist	Certified Registered Nurse Anesthetists

Exempt Example

Dr. "B." is:

- An eligible clinician
- Billed $100,000 in Medicare Part B charges
- Saw 80 patients

Dr. B. would be *EXEMPT* from MIPS due to seeing less than 100 patients.

Remember: To be eligible

Who is Exempt from MIPS?

Clinicians who are:

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to $30,000 a year

OR

- See 100 or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

Eligibility for Clinicians in Specific Facilities

- Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)
  - Eligible clinicians billing under the RHC or FQHC payment methodologies **are not** subject to the MIPS payment adjustment.

    However…

  - Eligible clinicians in a RHC or FQHC billing under the Physician Fee Schedule (PFS) **are** required to participate in MIPS and are subject to a payment adjustment.

Eligibility for Non-Patient Facing Clinicians

- Non-patient facing clinicians are eligible to participate in MIPS as long as they exceed the low-volume threshold, are not newly enrolled, and are not a Qualifying APM Participant (QP) or Partial QP that elects not to report data to MIPS
- The non-patient facing MIPS-eligible clinician threshold for individual MIPS-eligible clinicians is ≤ 100 patient facing encounters in a designated period
- A group is non-patient facing if > 75% of NPIs billing under the group's TIN during a performance period are labeled as non-patient facing
- There are more flexible reporting requirements for non-patient facing clinicians

MIPS Performance Categories What Do I Need to Know?

What are the Performance Category Weights?

Weights assigned to each category based on a 1 to 100 point scale

Transition Year Weights

Quality	Cost	Improvement Activities	Advancing Care Information
60%	0%	15%	25%

Note: These are defaults weights; the weights can be adjusted in certain circumstances

MIPS Performance Category: Quality

- 60% of Final Score in 2017
- 270+ measures available
  - You **select 6** individual measures
    - 1 must be an **Outcome** measure

      OR
    - **High-priority** measure
      - Defined as outcome measures, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination.
  - You may also select specialty-specific set of measures
- *Keep in mind:*

Replaces PQRS and Quality portion of the Value Modifier

Provides for an easier transition for those who have reporting experience due to familiarity

MIPS Performance Category: Cost

- No reporting requirement; 0% of Final Score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments.
- *Keep in mind:*

Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)

Only the scoring is different

MIPS Performance Category: Improvement Activities

- **15%** of Final Score in 2017
- Attest to participation in activities that improve clinical practice
  - Examples: Shared decision making, patient safety, coordinating care, increasing access
- *Clinicians choose* from 90+ activities under 9 subcategories:

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

MIPS Performance Category: Advancing Care Information

- 25% of Final Score in 2017
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are *2 measure sets for reporting to choose from based on EHR* edition:

Advancing Care Information Objectives and Measures	2017 Advancing Care Information Transition Objectives and Measures

MIPS Performance Category: Advancing Care Information

For those using EHR Certified to the 2015 Edition:

Advancing Care Information Objectives and Measures:

Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Send a Summary of Care
Health Information Exchange	Request/Accept a Summary of Care

For those using 2014 Certified EHR Technology:

2017 Advancing Care Information Transition Objectives and Measures:

Base Score Required Measures

Objective	Measure
Protect Patient Health Information	Security Risk Analysis
Electronic Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access
Health Information Exchange	Health Information Exchange

Advancing Care Information: Flexibility

1

CMS will automatically **reweight** the Advancing Care Information performance category to zero for Hospital-based MIPS clinicians, clinicians who lack of Face-to-Face Patient Interaction, NP, PA, CRNAs and CNS

- Reporting is optional although if clinicians choose to report, they will be scored.

2

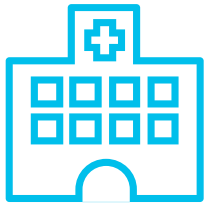
A clinician can **apply** to have their performance category score **weighted to zero** and the **25%** will be **assigned to the Quality category** for the following reasons:

1. Insufficient internet connectivity
2. Extreme and uncontrollable circumstances
3. Lack of control over the availability of CEHRT

MIPS Participation
What Do I Need to Know?

Pick Your Pace for Participation for the Transition Year

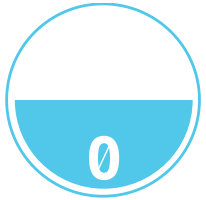
Participate in an Advanced Alternative Payment Model



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

MIPS

Test



Submit Something

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

Partial Year

Submit a Partial Year

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

Full Year

Submit a Full Year

- Fully participate starting January 1, 2017
- Positive payment adjustment

Note: Clinicians do not need to tell CMS which option they intend to pursue.

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

MIPS: Choosing to Test for 2017

Submit Something

- Submit **minimum** amount of 2017 data to Medicare
- **Avoid** a downward adjustment
- Gain familiarity with the program

Minimum Amount of Data

1
Quality
Measure

OR

1
Improvement
Activity

OR

4 or 5*
Required
Advancing
Care
Information
Measures

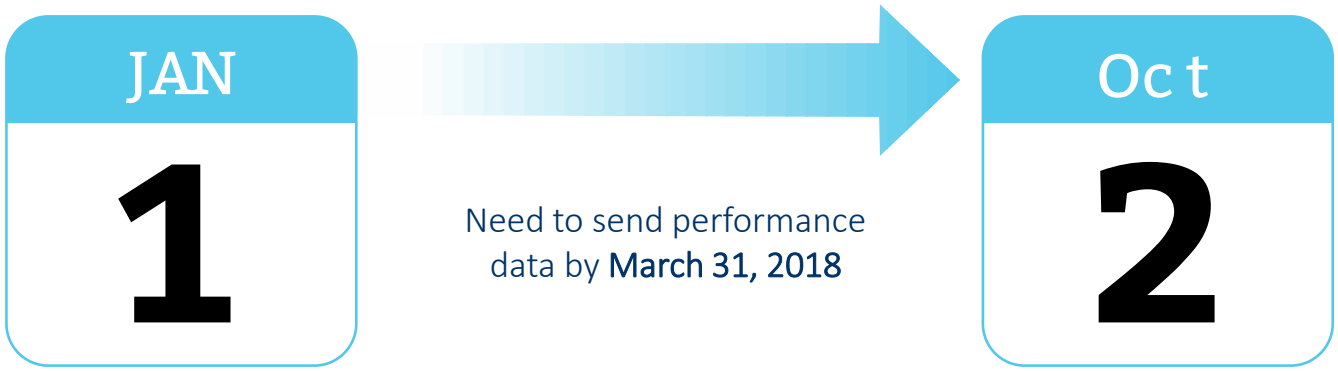
*Depending on CEHRT edition

MIPS: Partial Participation for 2017

Submit a Partial Year

- Submit **90 days** of 2017 data to Medicare
- May earn a positive payment adjustment

"So what?" - If you're not ready on January 1, you can start anytime between January 1 and October 2



MIPS: Full Participation for 2017

Submit a Full Year

- Submit a **full year** of 2017 data to Medicare
- May earn a positive payment adjustment
- Best way to **earn largest payment adjustment** is to submit data on all MIPS performance categories

Key Takeaway:
Positive adjustments are based on the performance data on the performance information submitted, not the **amount** of information or **length of time submitted.**

MIPS Reporting
What Do I Need to Know?

Submission Methods

	Individual	Group
Quality	• Qualified Clinical Data Registry (QCDR) • Qualified Registry • EHR • Claims	• QCDR • Qualified Registry • EHR • Administrative Claims • CMS Web Interface • CAHPS for MIPS Survey
Improvement Activities	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • CMS Web Interface • Attestation
Advancing Care Information	• QCDR • Qualified Registry • EHR • Attestation	• QCDR • Qualified Registry • EHR • Attestation • CMS Web Interface

*Must be reported via a CMS approved survey vendor together with another submission method for all other Quality measures.

Transition Year 2017

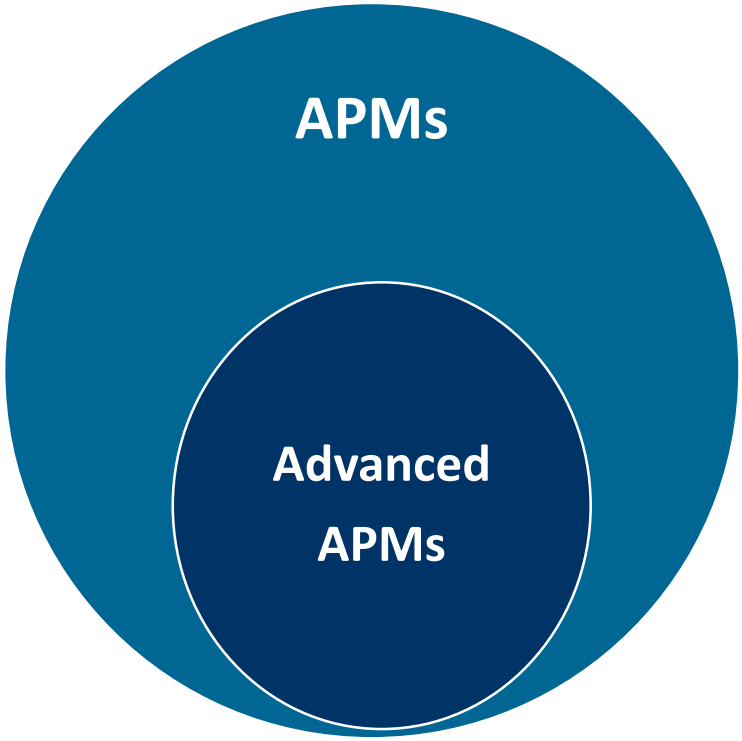
Final Score	Payment Adjustment
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Part II:
APM Basics
What Do I Need to Know?

Alternative Payment Models (APMs)

- A payment approach that provides added incentives to clinicians to provide high-quality and cost-efficient care.
- Can apply to a specific condition, care episode or population.
- May offer significant opportunities for eligible clinicians who are not ready to participate in Advanced APMs.

Advanced APMs are a Subset of APMs



Advanced APMs Must Meet Certain Criteria

To be an Advanced APM, the following three requirements must be met.

The APM:

1. Requires participants to use **certified EHR technology**;
2. Provides payment for covered professional services based on **quality measures** comparable to those used in the MIPS quality performance category; and
3. **Either**: (1) is a **Medical Home Model expanded** under CMS Innovation Center authority OR (2) requires **participants to bear a more than nominal amount of financial risk.**

Advanced APMs in 2017

For the 2017 performance year, the following models are Advanced APMs:

- Comprehensive End Stage Renal Disease Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Shared Savings Program Track 2
- Shared Savings Program Track 3
- Next Generation ACO Model
- Oncology Care Model (Two-Sided Risk Arrangement)

The list of Advanced APMs is posted at QPP.CMS.GOV and will be updated with new announcements as needed.

What is the benefit of participating in an Advanced APM?

Advanced Alternative Payment Models

Clinicians who participate significantly in Advanced APMs can:

- Receive **greater rewards** for taking on some risk related to patient outcomes.

"So what?" - It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates extra incentives for a sufficient degree of participation in Advanced APMs.

Qualifying APM Participant (QP)

Qualifying APM Participants (QPs) are clinicians who have a certain **% of Part B payments for professional services or patients furnished Part B professional services** through an **Advanced APM Entity**.

Beginning in 2021, this threshold % may be reached through a combination of Medicare and other **non-Medicare payer arrangements**, such as private payers and Medicaid.

How do Eligible Clinicians become Qualifying APM Participants?

- ✓ The Threshold Score is compared to the corresponding QP threshold table and CMS takes the better result.

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Part III: Checklist for Preparing and Participating in MIPS

Preparing and Participating in MIPS: A Checklist

- Determine your eligibility and understand the requirements.
- Choose whether you want to submit data as an individual or as a part of a group.
- Choose your submission method and verify its capabilities.
- Verify your EHR vendor or registry's capabilities before your chosen reporting period.
- Prepare to participate by reviewing practice readiness, ability to report, and the Pick Your Pace options.
- Choose your measures. Visit **qpp.cms.gov** for valuable resources on measure selection and remember to review your current billing codes and Quality Resource Use Report to help identify measures that best suit your practice.
- Verify the information you need to report successfully.
- Care for your patients and record the data.
- Submit your data by March 2018.

❑ Determine Your Eligibility

How Do I Do This?

1. Calculate your annual patient count and billing amount for the 2017 transition year.
   - Review your claims for service provided between September 1, 2015 and August 31, 2016, and where CMS processed the claim by November 4, 2016.
   - Did you bill more than $30,000 **AND** provide care for more than 100 Medicare patients a year?
     - Yes: You're eligible.
     - No: You're exempt.
2. CMS will provide additional guidance on eligibility in Winter/Early Spring 2017.

❑ Prepare to Participate

How Do I Do This?

1. Consider your practice readiness.
   - Have you previously participated in a quality reporting program?
2. Evaluate your ability to report.
   - What is your data submission method?
   - Are you prepared to begin reporting data between January 1, 2018 and March 31, 2018?
3. Review the Pick Your Pace options for Transition Year 2017.
   - Test
   - Partial Year
   - Full Year

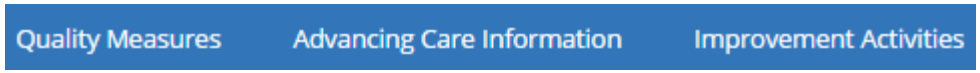
❑ Choose Your Measures/Activities

How Do I Do This?

1. Go to **qpp.cms.gov**.

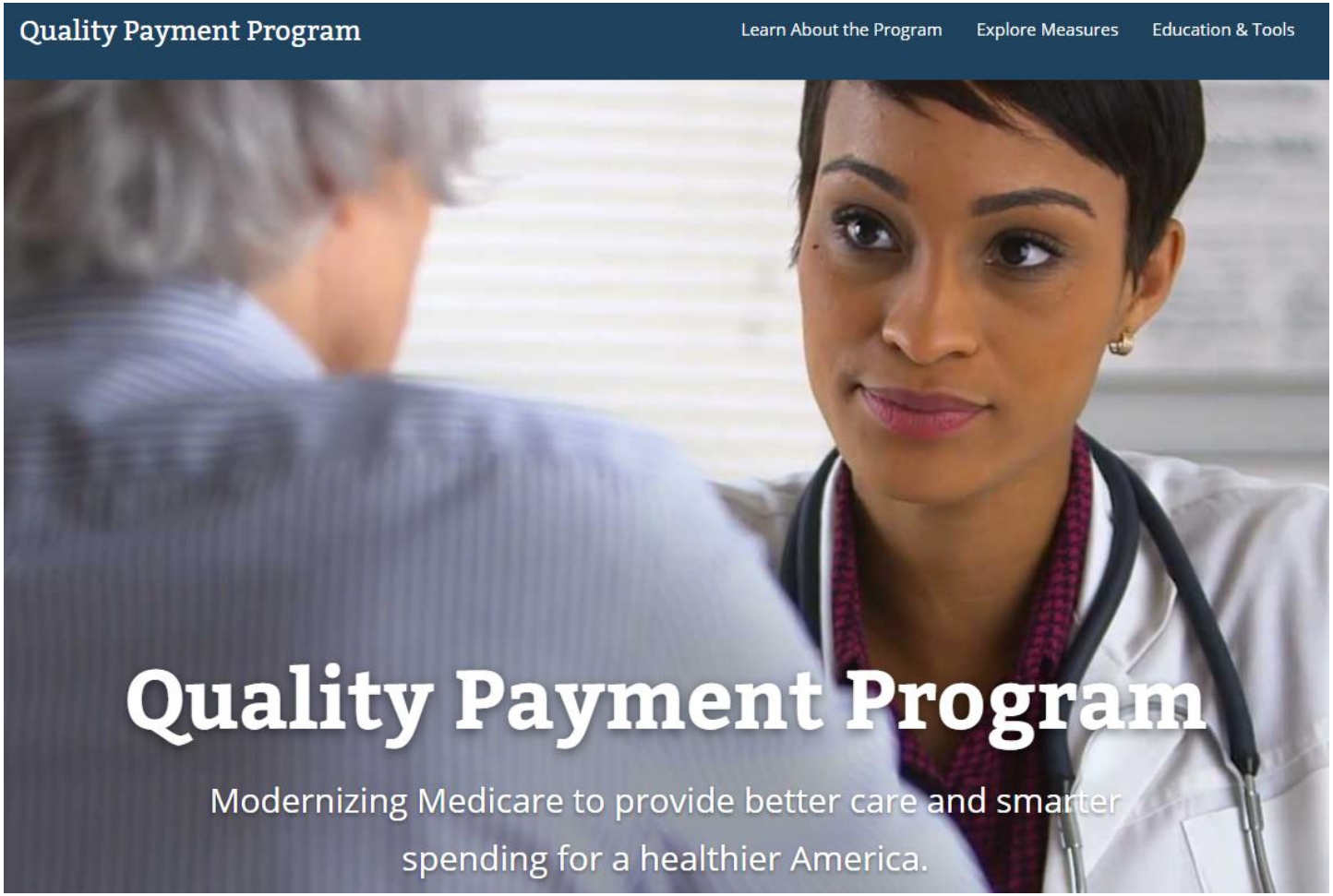
2. Click on the **Explore Measures** tab at the top of the page.

3. Select the performance category of interest.



4. Review the individual Quality and Advancing Care Information measures as well as Improvement Activities.

Website: https://qpp.cms.gov



Quality Payment Program

Program Performance | Quality Measures | Advancing Care Informati

MIPS Overview

Use this tool to browse the different MIPS measures and activities.

Note: This tool is only for informational and estimation purposes. You can't use measures or activities.

Category	What do you need to do?
Quality Replaces the Physician Quality Reporting System (PQRS).	**Most participants:** Report up to 6 qua for a minimum of 90 days. **Groups using the web interface:** Rep **Groups in APMs qualifying for speci Program Track 1 or the Oncology Ca** APM. You do not need to do anything
Improvement Activities New category.	**Most participants:** Attest that you co minimum of 90 days. **Groups with fewer than 15 particip professional shortage area:** Attest th of 90 days. **Participants in certified patient-cen practices, or an APM designated as** earn full credit.

Quality Payment Program

Learn About the Program | Explore Measures | Education & Tools

Program Performance | Quality Measures | Advancing Care Information | Improvement Activities

Quality Measures

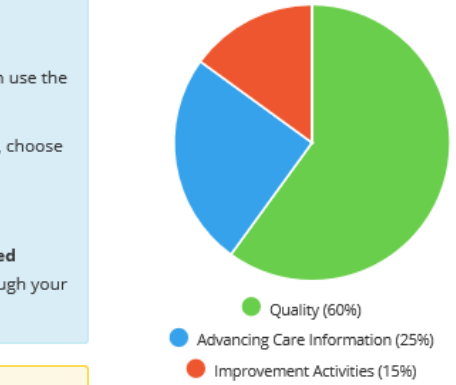
Instructions

1. Review and select measures that best fit your practice.
2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.
3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.
4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

Note: This tool is only for informational and estimation purposes. You can't use it to submit or attest to measures or activities.

2017 MIPS Performance



Select Measures

Search All by Keyword: All | Search for... | SEARCH

Filter By: High Priority Measure | Data Submission Method | Specialty Measure Set

Showing **271** Measures

- Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use — ADD
- Acute Otitis Externa (AOE): Topical Therapy — ADD
- ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication — ADD

Selected Measures

0 Measures Added

Once you select measures they will appear here

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES

https://qpp.cms.gov

NEXT STEPS

Where can I go to get help?

Technical Support Available to Clinicians

Integrated Technical Assistance Program

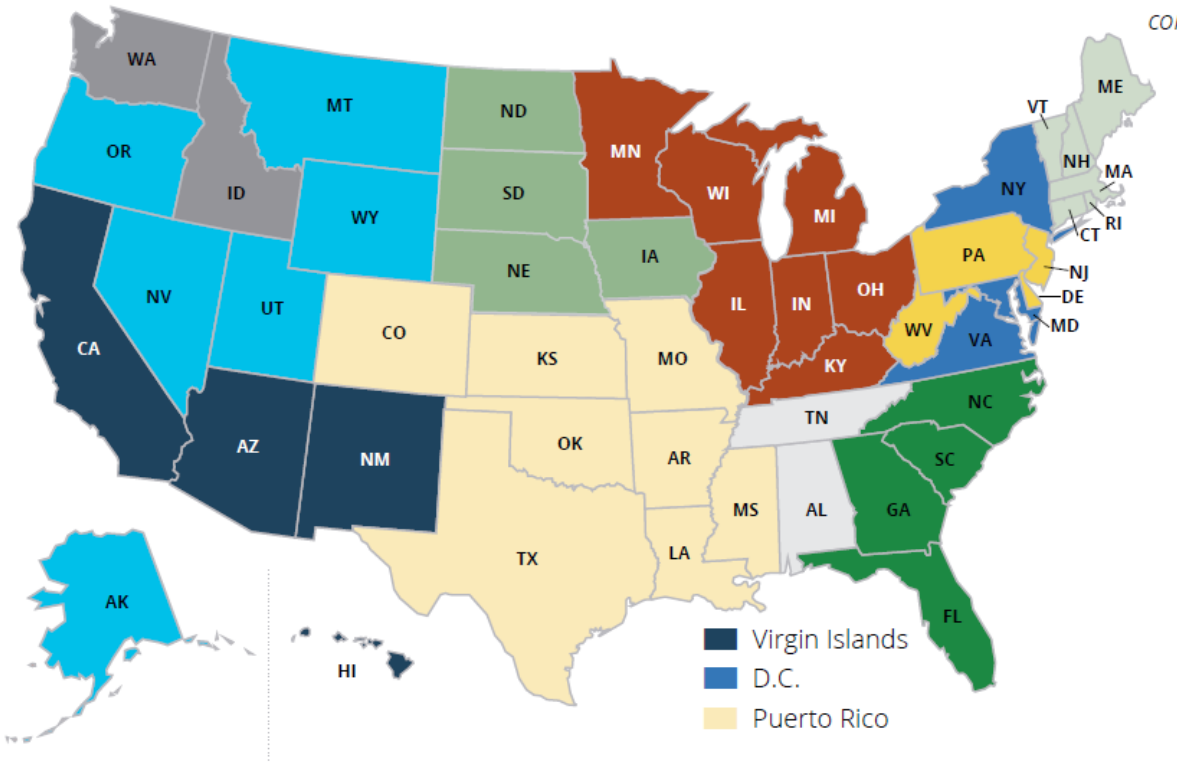
- **Full-service, expert help**
  - Quality Payment Program Service Center
  - Quality Innovation Network/Quality Improvement Organizations
  - Quality Payment Program — Small, Underserved, and Rural Support
  - Transforming Clinical Practice Initiative
  - APM Learning Networks

- **Self-service**
  - QPP Online Portal

All support is FREE to clinicians

https://qpp.cms.gov/education

For general information or for help getting connected, contact QPPSURS@IMPAQINT.COM



Coverage by Organization

- Healthcentric Advisors
- IPRO
- Quality Insights (WVMI)
- Alliant GMCF
- QSource
- Altarum
- TMF
- HSAG
- Telligen
- NRHI
- Qualis

Additional Resources

Quality Payment Program:
qpp.cms.gov
1-866-288-8292
TTY: 1-877-715-6222
QPP@cms.hhs.gov

APM Learning Model Support List:
http://innovation.cms.gov

Transforming Clinical Practice Initiative (TCPI):
PTN Map: https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices
To enroll in TCPI, contact:
TCPI.ISC@Truvenhealth.com

Quality Improvement Organizations:
QIN-QIO Map:
http://qioprogram.org/

Quality Payment Program: How to get help

Need Help

The Quality Payment Program Service Center is available to help.

1-866-288-8912

TTY: 1-877-715-6222

Available Monday-Friday; 8:00AM – 8:00PM Eastern Time

Questions

Send us your questions about the Quality Payment Program to

QPP@cms.hhs.gov

Ashby Wolfe, MD, MPP, MPH

Chief Medical Officer, Region IX

Centers for Medicare and Medicaid Services

ashby.wolfe1@cms.hhs.gov


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

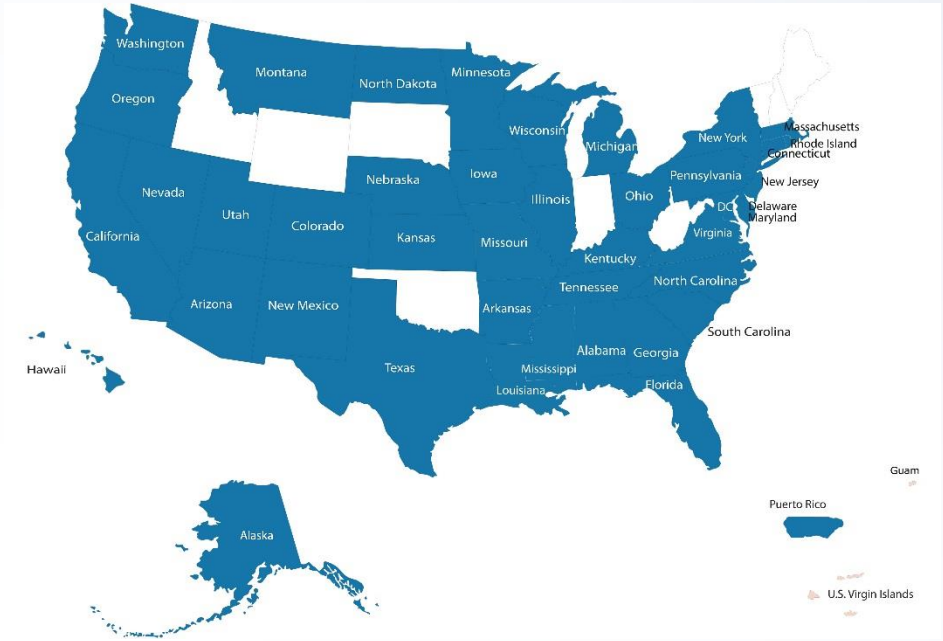

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CAPG

The Voice of Accountable Physician Groups

CAPG

- National professional association for accountable physician organizations
- 250+ medical groups and IPAs
- 42 states, DC, Puerto Rico



CAPG
The Voice of Accountable Physician Groups

CAPG

Mission

- To assist accountable physician groups to improve the quality and value of healthcare provided to patients
- To represent and support physician groups that assume responsibility for clinically integrated, comprehensive, and coordinated healthcare

Support

- Advocacy
- Education
- Leadership

CAPG Annual Conference

- Hot Topics (CME credits available for some sessions)
  - –MACRA
  - –Medicare ACOs
  - –Social Determinants of Health
  - –Risk Management
  - –Quality Improvement

Registration is open! www.capg.org

CAPG
The Voice of Accountable Physician Groups