Value-Based Care:
CMS Priorities in Health System Transformation

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Centers for Medicare and Medicaid Services

Presentation to the Industry Collaboration Effort Annual Conference
December 6th, 2016
San Francisco, CA
Disclaimer

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Objectives

• Overview of CMS Priorities
  - Continuous quality improvement to improve patient safety
  - Focus on payment and delivery system transformation
  - Shifting from Volume to Value-Based payments
  - Review of select programs at the CMS Innovation Center

• Policy Updates
  - Calendar Year (CY) 2017 final rules
    • Hospital and Outpatient Perspective Payment System
    • Physician Fee Schedule
  - The Medicare Access and CHIP Reauthorization Act (MACRA)

• Technical assistance and support
Complications

[A Surgeon’s Notes on an Imperfect Science]

The ‘Must Do’ List: Certain Patient Safety Rules Should Not Be Elective
Robert Wachter
August 20, 2015


So we will continue to work across sectors and across the aisle for the goals we share: better care, smarter spending, and healthier people.
Better Care, Smarter Spending, Healthier People

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
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</table>
| 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.
CMS Health Equity Plan for Medicare

**Priority 1:** Expand the Collection, Reporting, and Analysis of Standardized Data

**Priority 2:** Evaluate Disparities Impacts and Integrate Equity Solutions Across CMS Programs

**Priority 3:** Develop and Disseminate Promising Approaches to Reduce Health Disparities

**Priority 4:** Increase the Ability of the Health Care Workforce to Meet the Needs of Vulnerable Populations

**Priority 5:** Improve Communication & Language Access for Individuals with LEP & Persons with Disabilities

**Priority 6:** Increase Physical Accessibility of Health Care Facilities
## Ongoing work of The CMS Innovation Center

### Focus Areas

#### Pay Providers

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<td>- Medicare Shared Savings Program (housed in Center for Medicare)</td>
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<td>- Comprehensive Primary Care Initiative (CPC)</td>
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<td>- Comprehensive Care for Joint Replacement (proposed)</td>
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<td>- Financial Alignment Initiative</td>
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<td>- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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<td>- Medicare Care Choices</td>
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<td>- Medicare Advantage Value-Based Insurance Design model</td>
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#### Deliver Care

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<th>Support providers and states to improve the delivery of care</th>
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<td><strong>Million Hearts Cardiovascular Risk Reduction Model</strong></td>
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#### Distribute Information

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<th>Increase information available for effective informed decision-making by consumers and providers</th>
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<td><strong>Information to providers in CMMI models</strong></td>
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<tr>
<td><strong>Shared decision-making required by many models</strong></td>
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Partnership for Patients contributes to quality improvements

Data shows from 2010 to 2014...

17% ↓ Hospital Acquired Conditions → 87,000 LIVES SAVED → 2.1 million PATIENT HARM EVENTS AVOIDED → $20 billion IN SAVINGS

Leading Indicators, change from 2010 to 2013

<table>
<thead>
<tr>
<th>Ventilator-Associated Pneumonia</th>
<th>Early Elective Delivery</th>
<th>Central Line-Associated Blood Stream Infections</th>
<th>Venous thromboembolic complications</th>
<th>Re-admissions</th>
</tr>
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<tr>
<td>62.4% ↓</td>
<td>70.4% ↓</td>
<td>12.3% ↓</td>
<td>14.2% ↓</td>
<td>7.3% ↓</td>
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ACO Participation

**Accountable Care Organizations (ACOs): General Information**
ACOs are groups of clinicians, hospitals, and other health-care providers that choose to come together to deliver coordinated, high-quality care to the Medicare patients they serve.

**ACO Investment Model**
The ACO Investment Model is testing new pre-payment approaches meant to support Medicare Shared Savings Program ACOs.

**Advance Payment ACO Model**
The Advance Payment ACO Model is providing upfront and monthly payments to 35 ACOs participating in the Medicare Shared Savings Program.

**Comprehensive ESRD Care Model**
The Comprehensive ESRD Care Model is designed to improve care for beneficiaries with ESRD while lowering Medicare costs.
Comprehensive Primary Care Plus (CPC+)

*CMS’s largest-ever initiative to transform how primary care is delivered and paid for in America*

**GOALS**


2. Empower practices to provide comprehensive care that meets the needs of all patients.

3. Improve quality of care, improve patients’ health, and spend health care dollars more wisely.

**CARE TRANSFORMATION FUNCTIONS**

- Access and continuity
- Care management
- Comprehensiveness and coordination
- Patient and caregiver engagement
- Planned care and population health

**PARTICIPANTS AND PARTNERS**

- 5 year model: 2017-2021
- Up to 5,000 practices in up to 20 regions
- Two tracks depending on practice readiness for transformation and commitment to advanced care delivery for patients with complex needs
- Public and private payers in CPC+ regions
- HIT vendors (official partners for Track 2 only)

**PAYMENT REDESIGN COMPONENTS**

- PBPM risk-adjusted care management fees
- Performance-based incentive payments for quality, experience, and utilization measures that drive total cost of care

For Track 2, hybrid of reduced fee-for-service payments and up-front “Comprehensive Primary Care Payment” to offer flexibility in delivering care outside traditional office visits
Critical focus on Post-Acute Care

- Important part of the health system
- 42% of Medicare fee for service beneficiaries discharged from hospitals go to PAC
  - Sicker and quicker discharges
- Large numbers of Medicare enrollees served in these settings (over 5.5 million beneficiaries)
- Recovery, support and rehabilitation
  - Transition to lowest safe level of care
Transitional Care Management Service Requirements

- Services are required **during the beneficiary’s transition to the community setting** following particular kinds of discharges;
- The health care professional **accepts care of the beneficiary post-discharge** from the facility setting without a gap;
- The beneficiary has **medical and/or psychosocial problems** that require moderate or high complexity medical decision making.

  **CPT codes 99495 and 99496**

- The 30-day **TCM period begins on the date the beneficiary is discharged** from the inpatient hospital setting and continues for the next 29 days.
Final Rule for CY2017 Outpatient Prospective Payment System  
Released November 1, 2016

• Estimated to increase OPPS payments by 1.7 percent and ASC rates by 1.9 percent in 2017

• Adds new quality measures to the Hospital OPPS and the ASC Quality Reporting Program  
  - Focused on improving patient outcomes and experience of care  
  - Aligns with the Quality Payment Program

• Addressing Physicians’ Concerns Regarding Pain Management  
  - Finalizes the removal of the pain management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey for purposes of the Hospital Value-Based Purchasing Program
Final Rule for CY2017 Outpatient Prospective Payment System Released November 1, 2016

- **Streamlines EHR Incentive reporting requirements**
  - Eliminates the Clinical Decision Support (CDS) and Computerized Order Entry (CPOE) objectives and measures beginning in 2017

- Allows all returning participants in the EHR Incentive Programs to report on a 90-day EHR reporting period in 2016 and 2017

- Finalizes an application process for a one-time significant hardship exception for certain eligible professionals in 2017 who are transitioning to the Quality Payment Program
Final Rule for CY2017 Outpatient Prospective Payment System Released November 1, 2016

• **Revises OPPS and ASC payment system** for CY 2017
  - Issuing an interim final rule with comment period to establish the Medicare Physician Fee Schedule payment rates for the non-excepted items and services billed by a non-excepted off-campus provider-based department of a hospital

• **Excepted Items and Services**—certain off-campus Provider-Based Departments would be permitted to continue to bill the OPPS, including those items and services furnished after January 1, 2017:
  - By a dedicated emergency department;
  - By an off-campus department that was billing for covered services furnished prior to November 2, 2015, that has not impermissibly relocated or changed ownership; or
  - In a department that is “on campus,” or within 250 yards, of the hospital or a remote location of the hospital.
Expands the Diabetes Prevention Program model starting Jan 2018

Finalizes the list of services eligible to be furnished via telehealth, including:
- End-stage renal disease (ESRD)-related services for dialysis;
- Advance care planning services;

Finalizes payment policies related to the use of a new place of service code specifically designed to report services furnished via telehealth

Finalizes values for the new CPT moderate sedation codes
- Uniform methodology for valuation of the procedural codes that currently include moderate sedation
- Adds CPT codes including an endoscopy-specific moderate sedation code

Finalizes revisions to payment for care management
- Payment for new codes for complex chronic care management
- Payment for extra care management following the initiating visit for patients with multiple chronic conditions
2017 Medicare Physician Fee Schedule Final Rule Released November 2, 2016

• Finalizes a number of changes to identify and value primary care, care management, and cognitive services:
  - Separate payments for certain CPT codes describing non-face-to-face prolonged evaluation and management services
  - Revalues existing CPT codes describing face-to-face prolonged services.
  - Separate payments using a new code to describe the comprehensive assessment and care planning for patients with cognitive impairment
  - Separate payments using new codes to pay primary care practices that use inter-professional care management resources to treat patients with behavioral health conditions.
    • Emphasis on behavioral health integration models of care
  - Make separate payments for codes describing chronic care management for patients with greater complexity.
Collaboration with National Partners Measure Alignment Efforts

- CMS Quality Measure Development Plan
  - Highlight known measurement gaps and develop strategy to address these
  - Promote harmonization and alignment across programs, care settings, and payers
  - Assist in prioritizing development and refinement of measures
  - Public Comment period closed March 1\textsuperscript{st}, final report published May 2\textsuperscript{nd}

- Core Measures Sets released February 16\textsuperscript{th}
  - ACOs, Patient Centered Medical Homes (PCMH), and Primary Care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Obstetrics and Gynecology
  - Orthopedics

https://www.cms.gov/Medicare/Quality-Initiatives-
Patient-Assessment-Instruments/QualityMeasures/Core-
Measures.html
Quality Payment Program

Key priorities in health system transformation

3 goals for our health care system:

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on 3 areas

Incentives
Care Delivery
Information Sharing

Affordable Care Act  MACRA
Origins of the Quality Payment Program: MACRA


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

The Quality Payment Program

Medicare Fee Schedule

Adjustments

Final payment to clinician

The Quality Payment Program

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)
FINAL RULE RELEASED 10/14/16

Quality Payment Program
Modernizing Medicare to provide better care and smarter spending for a healthier America.

https://qpp.cms.gov
Which clinicians does MACRA affect? (Will it affect me?)
Who participates in the Quality Payment Program?

- Medicare Part B eligible clinicians who:
  - Bill more $30,000 a year in Medicare charges AND
  - Provide care for more than 100 Medicare Part B patients in a given year

- Eligible clinicians:
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Certified Registered Nurse Anesthetists
How Do Clinicians Participate in MIPS?

OPTIONS

Individual  Group

1. **Individual**: under an NPI number & TIN where they reassign benefits
2. **As a Group**:
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As a MIPS APM entity

* If clinicians participate as a group, they are assessed as group across all 4 MIPS categories
Who is excluded from MIPS?

- **Newly-enrolled Medicare clinicians**
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year.

- **Clinicians below the low-volume threshold**
  - Medicare Part B allowed charges less than or equal to $30,000 **OR** 100 or fewer Medicare Part B patients

- **Clinicians significantly participating in Advanced APMs**
The Quality Payment Program has two tracks you can choose from:

**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 Merit-based Incentive Payment System (MIPS)**
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.
One Path to Quality:

The Merit-based Incentive Payment System (MIPS)
What Is MIPS?
Combines legacy programs into single, improved reporting program

Legacy Program Phase Out

2016
Last Performance Period under Legacy Programs

2018
End of Payment Adjustments under Legacy Programs
What Is MIPS?

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
Performance Score Category Weighting

2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)

NOTE: These are defaults weights; the weights can adjust in certain circumstances
Take note:

- Changes under MACRA related to the Quality Payment Program do not affect the Medicaid OR Hospital EHR Incentive program.

- Clinicians attesting under these programs should continue to do so based on that program time frame and schedule.
Based on a composite performance score, clinicians will receive +/- or neutral adjustments up to the percentages below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Adjustment %</th>
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<tbody>
<tr>
<td>2017</td>
<td>+4%</td>
</tr>
<tr>
<td>2018</td>
<td>+5%</td>
</tr>
<tr>
<td>2019</td>
<td>+7%</td>
</tr>
<tr>
<td>2020</td>
<td>+9%</td>
</tr>
<tr>
<td>2021</td>
<td>+9%</td>
</tr>
<tr>
<td>2022</td>
<td>+9%</td>
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</tbody>
</table>

The potential maximum adjustment % will increase each year from 2019 to 2022.
The Timeline for the Quality Payment Program

When does the Quality Payment Program start?

You get to pick your pace for the Quality Payment Program. If you’re ready, you can begin January 1, 2017 and start collecting your performance data. If you’re not ready on January 1, you can choose to start anytime between January 1 and October 2, 2017. Whenever you choose to start, you’ll need to send in your performance data by March 31, 2018.

The first payment adjustments based on performance go into effect on January 1, 2019.

https://qpp.cms.gov
Pick Your Pace during the Transitional Year

Participate in an Advanced Alternative Payment Model

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017
- Submit some data after January 1, 2017
- Neutral or small payment adjustment

MIPS

Test Pace
- Submit Something

Partial Year
- Report for 90-day period after January 1, 2017
- Small positive payment adjustment

Full Year
- Fully participate starting January 1, 2017
- Modest positive payment adjustment

Not participating in the Quality Payment Program for the transition year will result in a negative 4% payment adjustment.
Another Path to Quality:

Advanced Alternative Payment Models (APMs)
Alternative Payment Models (APMs)

- A payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care.

APMs can apply to a specific clinical condition, a care episode, or a population.
Advanced Alternative Payment Models

- Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients’ outcomes.

**Advanced APMs are a Subset of APMs**

**Advanced APMs**

- Advanced APM-specific rewards
- 5% lump sum incentive
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 HTTPS://QPP.CMS.GOV and will be updated with new announcements on an ad hoc basis.
Future Advanced APM Opportunities

- MACRA established the **Physician-Focused Payment Model Technical Advisory Committee (PTAC)** to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee.

- **In future performance years**, we anticipate that the following models will be Advanced APMs:
  - Comprehensive Care for Joint Replacement (CJR) Payment Model (CEHRT)
  - New Voluntary Bundled Payment Model
  - Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT)
  - Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
  - ACO Track 1+
Participation in “MIPS APMs”

- Shared Savings Program Tracks 1, 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC) Model (all arrangements)
- Oncology Care Model (OCM) (all arrangements)
- Comprehensive Primary Care Plus (CPC+) Model
Will Participation in APMs with other Payers count?

Yes, starting in 2021, participation in some of these APMs with other non-Medicare payers can count toward criteria to be a QP.

"Combination all-payer & Medicare threshold option"

IF the APMs meet criteria similar to those for advanced APMs run by CMS:

Certified EHR use
Quality Measures
Financial Risk
The Quality Payment Program has two tracks you can choose from:

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 Merit-based Incentive Payment System (MIPS)
If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.
NEXT STEPS

What do I need to do now?
When Will Clinicians Learn If They Are Eligible for MIPS?

December 2016

CMS begins to contact clinicians

January 2017

NPI Lookup Tool available on Quality Payment Program Online Portal

In the meantime:

- Review your Quality and Resource Use Report (QRUR)
- Update your Provider Information (NPI, PECOS, etc.)
Quality Payment Program

Website: https://qpp.cms.gov

Quality Payment Program

Modernizing Medicare to provide better care and smarter spending for a healthier America.
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.

Select Measures

Search All by Keyword:

Filter By:

Showing 271 Measures

- **Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use**

- **Acute Otitis Externa (AOE): Topical Therapy**

- **ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication**
Quality Payment Program

Downloadable Resources

- Quality Payment Program Fact Sheet
  UPDATED OCTOBER 14TH, 2016
- MIPS Fact Sheet
  UPDATED OCTOBER 14TH, 2016
- Advanced APM Fact Sheet
  UPDATED OCTOBER 14TH, 2016
- Small Practice Fact Sheet
  UPDATED OCTOBER 14TH, 2016
- Where to Find Help
  UPDATED OCTOBER 14TH, 2016

Video Library

- Delivery System Reform: Paying for What Works
- Upcoming webinars about the MACRA proposed rule

Official Rule & Legislation

Read the Executive Summary
UPDATED OCTOBER 14TH, 2016

Learn more about Improving and APMs
UPDATED OCTOBER 14TH, 2016

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

Subscribe to Updates
Receive the latest Quality Payment Program updates.

https://qpp.cms.gov
NEXT STEPS

Where can I go to learn more?
What Support Is 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
Do you need technical assistance to help you participate in the Quality Payment Program? The Centers for Medicare & Medicaid Services has specialized programs and resources for eligible clinicians across the country.

**PRIMARY CARE & SPECIALIST PHYSICIANS**
Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs) are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.

[Locate the PTN(s) and SAN(s) in your state]

**LARGE PRACTICES**
Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) Education and Support

- Supports clinicians in large practices (more than 15 clinicians) in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

[Locate the QIN-QIO that serves your state]

**SMALL & SOLO PRACTICES**
Small, Underserved Rural Support Technical Assistance

- Provides outreach, guidance, and direct technical assistance to clinicians in solo or small practices (15 or fewer), particularly those in rural and underserved areas, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- Organizations selected to provide this technical assistance will be available in late 2016.

[Locate the PTN(s) and SAN(s) in your state]

**TECHNICAL SUPPORT**
All Eligible Clinicians Are Supported By:

- **Quality Payment Program Website**: qpp.cms.gov
  Serves as a starting point for information on the Quality Payment Program.

- **Quality Payment Program Service Center**
  Assists with all Quality Payment Program questions.
  1-866-288-8292  TTY: 1-877-715-6222  OPP@cms.hhs.gov

- **Advanced Alternative Payment Model (APM) Learning Networks**
  Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs.
Medicare Access and CHIP Reauthorization Act of 2015 Final Rule

Wednesday, October 26, 2016
2:00 - 3:00 PM Eastern Time

Quality Payment Program Final Rule MLN Connects

Tuesday, November 15, 2016
1:30 - 3:00 PM Eastern Time

Additional webinars recorded and available for download!

https://qpp.cms.gov/education
CMS wants your feedback!

Education & Tools
Welcome to the Quality Payment Program Education & Tools resource library. Enhance your success in the Quality Payment Program.

Read the Official Rule
Learn more about the Quality Payment Program through the final rule with commentary.

Forward Together
We’re working together towards a big goal, so we’re starting slow. We are listening and want your input on how to improve the Quality Payment Program.

As the program grows, so does the possibility to be rewarded for providing better care. These kinds of smarter payments give you more time to spend with your patients and to care for them in the way you think is best.

Public Inspection: October 19, 2016
Publication: November 4, 2016.
Effective Date: January 1, 2017.
Comment Period Closes: December 19, 2016.

Subscribe to Updates
Receive the latest Quality Payment Program email updates.

https://qpp.cms.gov
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

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

[link to QPP website]