MACRA and the CMS Quality Payment Program (QPP)

Howard Pitluk, MD, MPH, FACS
Vice President, Medical Affairs & Chief Medical Officer
Health Services Advisory Group (HSAG)

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Disclosure

I have nothing to report nor are there any real or perceived conflicts of interest, implied or expressed, in the following presentation.

Howard Pitluk, MD, MPH, FACS
HSAG: Your Partner in Healthcare Quality

- HSAG is the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
- HSAG is and has been committed to improving healthcare quality for more than 35 years.
- QIN-QIOs in every state/territory are united in a network under the Centers for Medicare & Medicaid Services (CMS).
- The Medicare QIO Program is the largest federal program dedicated to improving healthcare quality at the community level.

HSAG’s QIN-QIO Territory

Nearly 25 percent of the nation’s Medicare beneficiaries

HSAG is the Medicare QIN-QIO for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
What Is MACRA?


* Children’s Health Insurance Program

What Does MACRA Do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula.
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for value over volume.
- **Streamlines** multiple quality reporting programs into one new system: MIPS.
- **Provides** bonus payments for participation in eligible APMs.
What Does Value-Based Payment Mean to CMS?

- Transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient healthcare
- Value = Quality/Cost or Health Outcomes Achieved/Dollars Spent
- Tools and initiatives for promoting better quality, while avoiding unnecessary costs
  - Tools: Measurement, payment incentives, public reporting, conditions of participation, coverage policy, and regulatory change
  - Initiatives: Pay for reporting, pay for performance, gain sharing, competitive bidding, bundled payment, coverage decisions, and direct provider support (i.e., electronic health record [EHR] incentives, etc.)
- Five principles:
  - Define the end goal, not just the process for achieving it.
  - All providers’ incentives must be aligned (includes hospitals and physicians).
  - The right measures must be developed and implemented in rapid cycle.
  - CMS must actively support quality improvement.
  - The clinical community and patients must be actively engaged.

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The Quality Payment Program (QPP)

Clinicians have two tracks from which to choose:

- **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.
- **Advanced APMs**
  - Advanced Alternative Payment Models (APMs)
  - If you decide to participate in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.
Part 1: MIPS Basics
What Do I Need To Know?

What Is the MIPS?

- Combines legacy programs into a single, improved reporting program

PQRS ➔ VM ➔ EHR ➔ MIPS

 Legacy Program Phase Out

<table>
<thead>
<tr>
<th>Last Performance Period</th>
<th>PQRS Payment End</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>2018</td>
</tr>
</tbody>
</table>

Source: The Centers for Medicare & Medicaid Services

PQRS = Physician Quality Reporting System
VM = Value-Based Modifier
EHR = Electronic Health Record
MIPS Visualization

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

<table>
<thead>
<tr>
<th>Participating in...</th>
<th>Is similar to reporting on...</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>Quality</td>
</tr>
<tr>
<td>VM</td>
<td>Cost</td>
</tr>
<tr>
<td>EHR</td>
<td>Advancing care Information</td>
</tr>
</tbody>
</table>

Source: The Centers for Medicare & Medicaid Services

What Will Determine My MIPS Score?

The MIPS composite performance score will factor in four weighted categories:

- Quality
- Cost
- Improvement activities
- Advancing care Information

Source: The Centers for Medicare & Medicaid Services
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 MIPS Officially Begin?

- **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 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 beginning on January 1, 2019.

Source: The Centers for Medicare & Medicaid Services
MIPS Eligibility
What Do I Need to Know?

Eligible Clinicians

Clinicians billing more than $30,000 a year in Medicare Part B allowed charges OR 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

Source: The Centers for Medicare & Medicaid Services
Determine Your Eligibility

How do I do this?
https://qpp.cms.gov/participation-lookup

• 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 OR provide care for more than 100 Medicare patients a year?
    • Yes: You are eligible.
    • No: You are exempt.

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 AND
  • See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  • Receive 25% of your Medicare payments OR
  • See 20% of your Medicare patients through an Advanced APM

Source: The Centers for Medicare & Medicaid Services
If You Are Exempt

- You may choose to voluntarily submit quality data to CMS to prepare for future participation, but you will not qualify for a payment adjustment based on your 2017 performance.
- This will help you hit the ground running when you are eligible for payment adjustments in future years.

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.

Source: The Centers for Medicare & Medicaid Services
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 percent of National Provider identifiers (NPIs) billing under the group’s Taxpayer Identification Number (TIN) during a performance period are labeled as non-patient facing.
- There are more flexible reporting requirements for non-patient facing clinicians.

Source: The Centers for Medicare & Medicaid Services
Pick Your Pace for Participation for the Transition Year

**Participate in an Advanced APM**

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

**MIPS**

- **Test Pace**
  - Submit Nothing
  - Submit a Partial Year: 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 2017
  - Positive payment adjustment

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

Not participating in the QPP for the Transition Year will result in a negative 4 percent payment adjustment.

Source: The Centers for Medicare & Medicaid Services

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MIPS: Choosing to Test for 2017

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

**Submit Something**

**Minimum Amount of Data**

- 1 Quality Measure
- 1 Improvement Activity
- 4 or 5 Required Advancing Care Information Measures*

Source: The Centers for Medicare & Medicaid Services

* Depending on certified electronic health record technology (CEHRT) edition

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### MIPS: Partial Participation for 2017

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

**Submit a Partial Year**

“So what?” — If you are not ready on January 1, you can start anytime between January 1 and October 2.

- Need to send performance data by March 31, 2018

Source: The Centers for Medicare & Medicaid Services

### MIPS: Full Participation for 2017

- 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

**Submit a Full Year**

**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.

Source: The Centers for Medicare & Medicaid Services
Bonus Payments and Reporting Periods

MIPS payment adjustment is based on data submitted. Clinicians should pick what’s best for their practice.

Submit a Full Year

Full year participation
• Is the best way to get the maximum adjustment
• Gives you the most measures to choose from
• Prepares you the most for the future of the program

Submit a Partial Year

Partial participation (report for 90 days)
• You can still achieve the maximum adjustment

Source: The Centers for Medicare & Medicaid Services
Patient Safety and Quality Improvement: A Moral and Financial Imperative

Individual vs. Group Reporting

Options

Individual

1. Individual — under a NPI number and TIN where they reassign benefits

Group

2. As a Group
   a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*
   b) As an APM Entity

* If clinicians participate as a group, they are assessed as a group across all four MIPS performance categories.

Submission Methods

<table>
<thead>
<tr>
<th>Quality</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>QCDR</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
<td>QCDR</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>QCDR</td>
<td></td>
</tr>
<tr>
<td>EHR</td>
<td>Qualified Registry</td>
<td></td>
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<tr>
<td>Claims</td>
<td>EHR</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
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<tr>
<td>EHR</td>
<td>EHR</td>
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<tr>
<td>Attestation</td>
<td>Administrative Claims</td>
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<td>EHR</td>
<td>EHR</td>
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<tr>
<td>Attestation</td>
<td>CMS Web Interface</td>
<td></td>
</tr>
</tbody>
</table>

CAHPS = Consumer Assessment of Healthcare Providers and Systems
Source: The Centers for Medicare & Medicaid Services

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Submission Methods: Helpful Information

<table>
<thead>
<tr>
<th>Submission Mechanism</th>
<th>How Does It Work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Clinical Data Registry (QCDR)</td>
<td>A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. Each QCDR typically provides tailored instructions on data submission for eligible clinicians. e.g. ASIPP’S National Interventional Pain Management (NIPM) QCDR</td>
</tr>
<tr>
<td>Qualified Registry</td>
<td>A Qualified Registry collects clinical data from an eligible clinician or group of eligible clinicians and submits it to CMS on their behalf.</td>
</tr>
<tr>
<td>Electronic Health Record (EHR)</td>
<td>Eligible clinicians submit data directly through the use of an EHR system that is considered certified EHR technology (CEHRT). Alternatively, clinicians may work with a qualified EHR data submission vendor (DSV) who submits on behalf of the clinician or group.</td>
</tr>
<tr>
<td>Attestation</td>
<td>Eligible clinicians prove (attest) that they have completed measures or activities.</td>
</tr>
<tr>
<td>CMS Web Interface</td>
<td>A secure internet-based application available to pre-registered groups of clinicians. CMS loads the Web Interface with the group’s patients. The group then completes data for the pre-populated patients.</td>
</tr>
<tr>
<td>Claims</td>
<td>Clinicians select measures and begin reporting through the routine billing processes.</td>
</tr>
</tbody>
</table>

Source: The Centers for Medicare & Medicaid Services

MIPS Scoring
What Do I Need to Know?
### MIPS Scoring for Quality (60 Percent of Final Score in Transition Year)

**Select 6 of the approximately 300 available quality measures (minimum of 90 days)**
- Or a specialty set
- Or CMS Web Interface measures

**Quick Tip:**
Easier for a clinician who participates longer to meet case volume criteria needed to receive more than 3 points.

**Clinicians receive 3 to 10 points** on each quality measure based on performance against benchmarks.

**Bonus points are available**
- 2 points for submitting an additional outcome measure
- 1 point for submitting an additional high-priority measure
- 1 point for using CEHRT to submit measures electronically end-to-end

**Failure to submit performance data** for a measure = 0 points.

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### Choose Your Measures/Activities

**How do I do this?**

- Go to qpp.cms.gov.
- Click on the **Explore Measures** at the top of the page.
- Select the performance category of interest.

**Quality Measures**
**Advancing Care Information**
**Improvement Activities**

- Review the individual Quality and Advancing Care Information measures as well as Improvement Activities.
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MIPS Performance Category: Cost

- No reporting requirement; 0 percent 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

Source: The Centers for Medicare & Medicaid Services

MIPS Performance Category: Improvement Activities

- 15 percent 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

Source: The Centers for Medicare & Medicaid Services
Basic QPP Rules for Improvement Activities Submissions

- Rewards practice improvement activities
- Choose from over 90 activities that suit practice’s scope.
- Full credit for PCMH* accreditation; partial credit for APM participation
- Activities are weighted; earn up to 40 points.

Sample Practice Improvement Activities

- Implementation of at least one additional recommended activity from the Quality Innovation Network-Quality Improvement Organization after technical assistance has been provided related to improving care coordination.
- Implementing programs that improve quality & outcomes (e.g., telehealth, population health management)
- Collaborating with key partners to improve community health
- Participating in CMS’ TCPI** initiative

*MPCN Medical Care Home
**Transforming Clinical Practice Initiative
Source: The Centers for Medicare & Medicaid Services

MIPS Scoring for Improvement Activities (15 Percent of Final Score in Transition Year)

Total points = 40

Activity Weights
- Medium = 10 points
- High = 20 points

Alternate Activity Weights*
- Medium = 20 points
- High = 40 points

*For clinicians in small, rural, and underserved practices or with non-patient facing clinician groups

Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice

Source: The Centers for Medicare & Medicaid Services

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Improvement Activity: Requirements for the Transition Year

- **Test Means:**
  - Attesting to 1 Improvement Activity
  - Activity can be high or medium weight
  - In most cases, to attest you need to indicate that you have done the activity for 90 days.

Submit a Partial Year

- **Partial and Full Means:**
  - Attesting to 1 of the following combinations:
    - 2 high-weighted activities
    - 1 high-weighted activity and 2 medium-weighted activities
    - At least 4 medium-weighted activities
  - Clinicians with special considerations
    - 1 high-weighted activity
    - 2 medium-weighted activities

Submit a Full Year

For a full list of measures, please visit QPP.CMS.GOV

MIPS Performance Category: Advancing Care Information (ACI)

- **25** percent of the 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 based on EHR edition:**
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures
ACI: Requirements for the Transition Year

Submit Something
- Test Means:
  - Submitting 4 or 5 base score measures
  - Depends on use of 2014 or 2015 Edition
  - Reporting all required measures in the base score to earn any credit in the Advancing Care Information performance category

Submit a Partial Year
- Partial and Full Means:
  - Submitting more than the base score in the Transition Year

Submit a Full Year

For a full list of measures, please visit QPP.CMS.GOV.

MIPS Performance Category: ACI (25 Percent of Final Score in Transition Year)

- Earn up to 155 percent maximum score, which will be capped at 100 percent.

ACI category score includes:

- 50% Required Base score (50%)
- 90% Performance score (up to 90%)
- 15% Bonus score (up to 15%)

Keep in mind: You need to fulfill the Base score or you will get a zero in the Advancing Care Information Performance Category.

Source: The Centers for Medicare & Medicaid Services
Calculating the Final Score Under MIPS

\[
\text{Final Score} = \text{Clinician Quality performance category score} \times \text{actual Quality performance category weight} + \text{Clinician Cost performance category score} \times \text{actual Cost performance category weight} + \text{Clinician Improvement Activities performance category score} \times \text{actual Improvement Activities performance category weight} + \text{Clinician Advancing Care Information performance category score} \times \text{actual Advancing Care Information performance category weight}
\]

\[\times 100\]

Source: The Centers for Medicare & Medicaid Services

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Transition Year 2017

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Payment Adjustment</th>
</tr>
</thead>
</table>
| ≥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 |

Source: The Centers for Medicare & Medicaid Services
Summary

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.

Source: The Centers for Medicare & Medicaid Services
Choose a Submission Method and Verify Its Capabilities

How do I do this?

- Review the available submission options for 2017.
  - Speak with your specialty society about your options.
  - Consider using a Technical Assistance program (TCPI, QIN-QIOs, QPP-SURS) for decision support.
  - Visit qpp.cms.gov for information on submission options.
- Choose a submission option.
  - For Qualified Registries, QCDRs, and CAHPS for MIPS Survey:
    - Check that each of the submission options are approved by CMS.
  - For EHR reporting:
    - Check that your EHR is certified by the Office of the National Coordinator for Health Information Technology.

Source: The Centers for Medicare & Medicaid Services

TCPI = Transforming Clinical Practice Initiative;
QPP-SURS = Quality Payment Program - Small, Underserved & Rural Support

No-Cost QPP Support

- Visit https://www.hsag.com/QPP
- Call 1.844.472.4227
- Email HSAGQPPsupport@hsag.com
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Technical Assistance for Clinicians

CMS has free resources and organizations on the ground to provide help to clinicians who are eligible for the QPP:

**PRIMARY CARE & SPECIALIST PHYSICIANS**
Transforming Clinical Practice Initiative
- Supports more than 140,000 clinicians through active, collaborative and peer-based learning, networks, etc.
- Prevention Transformation Networks (PTNs) and Support Agreement 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.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 PTNs providing support to rural, underserved, and rural-urban communities.
- Can learn more about the PTNs and SANs by visiting [CMS's website](https://www.cms.gov).

**SMALL & SOLO PRACTICES**
Small, Underserved, and Rural Support (SURS)
- Provide essential guidance and clear pathway development to clinicians in rural or remote areas, particularly those in rural and underserved areas, to promote consumer health IT adoption, implementation, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to rural, underserved, and rural-urban settings.
- For more information or for assistance getting connected, contact [SURShelp@hsag.com](mailto:SURShelp@hsag.com).

**LARGE PRACTICES**
Quality Innovation Network (QIN) - QPP
- Supports clinicians in large practices (more than 15 clinicians) in meeting CMS's Quality Improvement Payment System requirements through customized technical assistance.
- There are 14 QINs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

**TECHNICAL SUPPORT**
All Eligible Clinicians Are Supported By:
- Quality Payment Program Website: [qpp.cms.gov](http://qpp.cms.gov)
- Serves as a standing point for information on the Quality Payment Program.
- Quality Payment Program Service Center
  - Helpline: 1-844-QPP-1001
  - TTY: 1-877-715-6774

**Source:** The Centers for Medicare & Medicaid Services

Thank You

Howard Pitluk, MD, MPH, FACS
HSAG Vice President for Medical Affairs, Chief Medical Officer
602.801.6950 | hpitluk@hsag.com

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HSAG is an open, objective, and collaborative partner working across organizational, cultural, and geographic boundaries to share knowledge and resources with all stakeholders.

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