Health Care Delivery System Transformation: Moving from Volume to Value

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Objectives

• CMS Priorities
  – Continuous quality improvement to improve patient safety
  – Shifting from Volume to Value-Based payments
  – Measure alignment and streamlining

• Health System Transformation: MACRA 2015
  – Review of the Medicare Access and CHIP Reauthorization Act
  – The Quality Payment Program
    • MIPS vs APMs

• What’s next?
  – Transforming Clinical Practice Initiative (TCPI)
Complications

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>
</tr>
</thead>
</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.
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>Condition</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator-Associated Pneumonia</td>
<td>62.4% ↓</td>
</tr>
<tr>
<td>Early Elective Delivery</td>
<td>70.4% ↓</td>
</tr>
<tr>
<td>Central Line-Associated Blood Stream Infections</td>
<td>12.3% ↓</td>
</tr>
<tr>
<td>Venous thromboembolic complications</td>
<td>14.2% ↓</td>
</tr>
<tr>
<td>Re-admissions</td>
<td>7.3% ↓</td>
</tr>
</tbody>
</table>
Million Hearts Cardiovascular Disease Risk Reduction Model will reward population-level risk management

- Heart attacks and strokes are a leading cause of death and disability in the United States
  - Prevention of cardiovascular disease can significantly reduce both CVD-related and all-cause mortality

- Participant responsibilities
  - Systematic beneficiary risk calculation* and stratification
  - Shared decision making and evidence-based risk modification
  - Population health management strategies
  - Reporting of risk score through certified data registry

- Eligible applicants
  - General/family practice, internal medicine, geriatric medicine, multi-specialty care, nephrology, cardiology
  - Private practices, community health centers, hospital-owned practices, hospital/physician organizations

*Uses American College of Cardiology/American Heart Association (ACA/AUA) Atherosclerotic Cardiovascular Disease (ASCVD) 10-year pooled cohort risk calculator

Payment Model

- Pay-for-outcomes approach
- Disease risk assessment payment
  - One time payment to risk stratify eligible beneficiary
    - $10 per beneficiary
- Care management payment
  - Monthly payment to support management, monitoring, and care of beneficiaries identified as high-risk
  - Amount varies based upon population-level risk reduction

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Focus on Social Determinants of Health: Addressing Social Needs

- Hospital Readmission Reduction...what’s the problem?
  - High re-admission rates could indicate breakdowns in care delivery systems
    - Payment systems incentivized fragmentation
    - More complicated cases = more “hands in the pot”
    - Expectation of patients to self-manage is great

Clinician-patient interaction
- Episodic treatment
- Unmanaged condition worsening
- Use of suboptimal medication regimens
- Lack of primary care or social support
- Return to ER

No community infrastructure to achieve common care goals
- Lack of standard communication
- Unreliable information transfer
- Unsupported patient/family engagement during transfers
- Lack of follow-up to address prevention
Accountable Health Communities Model addresses health-related social needs

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Testing the **effectiveness of referrals** and **community services navigation** on total cost of care using a rigorous mixed method evaluative approach
- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs

3 Model Tracks

- **Track 1** **Awareness** – Increase beneficiary **awareness** of available community services through information dissemination and referral
- **Track 2** **Assistance** – Provide community service navigation services to **assist** high-risk beneficiaries with accessing services
- **Track 3** **Alignment** – Encourage partner **alignment** to ensure that community services are available and responsive to the needs of beneficiaries

Total Investment > $157 million

Anticipated Award Sites 44

[https://innovation.cms.gov/initiatives/ahcm](https://innovation.cms.gov/initiatives/ahcm)
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
Measure Alignment Efforts

- **CMS Draft 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 1st, final report to be published in May

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

- CMS is already using measures from the each of the core sets
- Commercial health plans are rolling out the core measures as part of their contract cycle

Key CMS 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
What does it mean for you?

THE

MEDICARE ACCESS &
CHIP REAUTHORIZATION ACT

OF 2015
MACRA is part of a broader push towards value and quality.

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and Alternative Payment Models in Medicare.

**Medicare Fee-for-Service**

**GOAL 1:** Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018. 30%

**GOAL 2:** Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018. 85%

**STAKEHOLDERS:**
- Consumers
- Businesses
- Payers
- Providers
- State Partners

Set internal goals for HHS

Invite private sector payers to match or exceed HHS goals
GUIDING QUESTIONS:

1) What is MACRA?
2) What does it address?
3) How will clinicians be affected?
4) Next steps and resources
What is “MACRA”?
What is “MACRA”?


What does it 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 1 new system (MIPS)
- **Provides bonus payments** for participation in **eligible alternative payment models** (APMs)
What does MACRA address?
Medicare Payment Prior to MACRA

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

The Sustainable Growth Rate (SGR)

• Established in 1997 to control the cost of Medicare payments to physicians

IF

Overall physician costs > Target Medicare expenditures

As calculated by the SGR
Medicare Payment Prior to MACRA

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

**The Sustainable Growth Rate (SGR)**

- Established in 1997 to **control the cost of Medicare payments** to physicians

**IF**

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<th>Overall physician costs</th>
<th>Target Medicare expenditures</th>
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**Physician payments cut across the board**
Medicare Payment Prior to MACRA

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

The Sustainable Growth Rate (SGR)

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians)

MACRA replaces the SGR with a more predictable payment method that incentivizes value.
Currently there are multiple quality and value reporting programs for Medicare clinicians:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare Electronic Health Records (EHR) Incentive Program
MACRA streamlines these programs into MIPS.
Which clinicians does MACRA affect? (Will it affect me?)
Short answer:
MACRA affects clinicians who participate in Medicare Part B.
MACRA affects Medicare Part B clinicians.

Affected clinicians are called “eligible professionals” (EPs) and will participate in MIPS. The types of Medicare Part B health care clinicians affected by MIPS may expand in the first 3 years of implementation.

**Years 1 and 2**
- Physicians, PAs, NPs, Clinical nurse specialists, Nurse anesthetists

**Years 3+**
- Secretary may broaden EP group to include others such as:
  - Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals
Are there any exceptions to participation in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

1. **FIRST year of Medicare Part B participation**
2. **Below low patient volume threshold**
3. **Certain participants in ELIGIBLE Alternative Payment Models**

Note: MIPS does not apply to hospitals or facilities
How will MACRA affect Medicare clinicians?
MACRA changes how Medicare pays clinicians.

The current system:

1. Services provided
2. Medicare Fee Schedule
3. Adjustments
4. Final payment to clinician

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare EHR Incentive Program
MACRA changes how Medicare pays clinicians.

The system after **MACRA**:

- **Services provided**
- **Medicare Fee Schedule**
- **Adjustments**
- **Final payment to clinician**

**Merit-Based Incentive Payment System (MIPS)**

*Or special lump sum bonuses through participation in eligible Alternative Payment Models*
Based on a composite performance score, clinicians will receive +/- or neutral adjustments up to the percentages below.

<table>
<thead>
<tr>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022 onward</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4%</td>
<td>+5%</td>
<td>+7%</td>
<td>+9%</td>
</tr>
<tr>
<td>-4%</td>
<td>-5%</td>
<td>-7%</td>
<td>-9%</td>
</tr>
</tbody>
</table>

The potential maximum adjustment % will increase each year from 2019 to 2022.

Merit-Based Incentive Payment System (MIPS)
How much can MIPS adjust payments?

**Note:** MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.

<table>
<thead>
<tr>
<th>Year</th>
<th>Minimum Adjustments</th>
<th>Maximum Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-9%</td>
<td>+9%</td>
</tr>
<tr>
<td>2020</td>
<td>-7%</td>
<td>+7%</td>
</tr>
<tr>
<td>2021</td>
<td>-5%</td>
<td>+5%</td>
</tr>
<tr>
<td>2022</td>
<td>-4%</td>
<td>+4%</td>
</tr>
<tr>
<td>Onward</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Potential for 3X adjustment*
The MIPS composite performance score will factor in performance in 4 weighted categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Use of certified EHR technology

What will determine my MIPS score?
The MIPS composite performance score will factor in performance in 4 weighted categories:

- Quality measures will be published in an annual list.
- Clinicians will be able to choose the measures on which they’ll be evaluated.

**Quality**

- Resource use
- Clinical practice improvement activities
- Use of certified EHR technology

**MIPS Composite Performance Score**
What will determine my MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted categories**:

- **Quality**
- **Resource use**
- **Clinical practice improvement activities**
- **Use of certified EHR technology**

*Will compare resources used to treat similar care episodes and clinical condition groups across practices*

*Can be risk-adjusted to reflect external factors*
What will determine my MIPS score?

The MIPS composite performance score will factor in performance in 4 weighted categories:

- Quality
- Resource use
- Clinical practice improvement activities
- Use of certified EHR technology

*Examples include care coordination, shared decision-making, safety checklists, expanding practice access.*
What will determine my MIPS score?

The MIPS composite performance score will factor in performance in 4 weighted categories:

- **Quality**: This category includes clinical practice improvement activities.
- **Resource use**: This category involves the use of certified EHR technology.

* % weight of this may decrease as more users adopt EHR.
The MIPS composite performance **score** will factor in performance in **4 weighted categories**:

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Clinical practice improvement activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Use of certified EHR technology</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

% weights for quality and resource use are scheduled to adjust each year until 2021.
RECALL: Exceptions to Participation in MIPS

There are 3 groups of clinicians who will NOT be subject to MIPS:

1. **FIRST year of Medicare Part B participation**
2. **Below low patient volume threshold**
3. Certain participants in **ELIGIBLE Alternative Payment Models**

Note: MIPS **does not** apply to hospitals or facilities.
RECALL: Exceptions to Participation in MIPS

There are 3 groups of clinicians who will NOT be subject to MIPS:

- **FIRST year of Medicare Part B participation**
- **Below low patient volume threshold**
- **Certain participants in ELIGIBLE Alternative Payment Models**
What is a Medicare Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

As defined by MACRA, APMs include:

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by federal law
“Eligible” APMs are the most advanced APMs.

As defined by MACRA, eligible APMs must meet the following criteria:

- Base payment on quality measures comparable to those in MIPS
- Require use of certified EHR technology
- Either (1) bear more than nominal financial risk for monetary losses OR (2) be a medical home model expanded under CMMI authority
Note: MACRA does NOT change how any particular APM rewards value. Instead, it creates extra incentives for APM participation.
MACRA provides additional rewards for participating in APMs.
MACRA provides additional rewards for participating in APMs.
MACRA provides **additional** rewards for participating in **APMs**.

**Potential financial rewards**

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In eligible APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td>APM-specific rewards</td>
</tr>
</tbody>
</table>

APM participation = **favorable scoring** in certain MIPS categories
MACRA provides additional rewards for participating in APMs.

Potential financial rewards

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In eligible APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments + APM-specific rewards</td>
<td>APM-specific rewards + 5% lump sum bonus</td>
</tr>
</tbody>
</table>

If you are a qualifying APM participant (QP)
How do I become a qualifying APM participant (QP)?

You must have a certain % of your patients or payments through an eligible APM.

QPs will:
- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in 2019-2024; then will receive higher fee schedule update starting in 2026

25% in 2019 and 2020

Eligible APM  QP
What about private payer or Medicaid APMs? Can they help me qualify to be a QP?

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

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

- Certified EHR use
- Quality Measures
- Financial Risk
Note: Most practitioners will be subject to MIPS.

Subject to MIPS

Not in APM

In non-eligible APM

In eligible APM, but not a QP

QP in eligible APM

Some people may be in eligible APMs and but not have enough payments or patients through the eligible APM to be a QP.

Note: Figure not to scale.
What if I’m in an eligible APM but don’t quite meet the threshold to be a QP?

If you meet a slightly reduced threshold (% of patients or payments in an eligible APM), you are considered a “partially qualified professional” (partial QP) and can:

- Opt out of MIPS
- Participate in MIPS
- Receive favorable weights in MIPS

Ex: 20% in 2019 (Criteria defined in law)
What about private payer or Medicaid APMs? Can they help me qualify to be a QP?

Recall:

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

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

- Certified EHR use
- Quality Measures
- Financial Risk

“Combination all-payer & Medicare threshold option”
When will these MACRA provisions take effect?
MIPS adjustments will begin in 2019.

<table>
<thead>
<tr>
<th>Year</th>
<th>MIPS Payment Adjustment (+/-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>+4%</td>
</tr>
<tr>
<td>2020</td>
<td>-4%</td>
</tr>
<tr>
<td>2021</td>
<td>+5%</td>
</tr>
<tr>
<td>2022</td>
<td>-5%</td>
</tr>
<tr>
<td>2023</td>
<td>+7%</td>
</tr>
<tr>
<td>2024</td>
<td>-7%</td>
</tr>
<tr>
<td>2025</td>
<td>+9%</td>
</tr>
<tr>
<td>2026</td>
<td>-9%</td>
</tr>
</tbody>
</table>

**NOTE:** Similar to prior quality programs, adjustments for MIPS will be based on performance in a prior year. The exact time (e.g. 1 yr. prior) will be determined in upcoming rule-making.
Qualifying APM bonuses will also begin in 2019.

*NOTE: Bonus payment for APM will be based on estimated aggregate payment for the prior year. E.g. bonus in 2019 will be based on payment for services in 2018.
Fee schedule updates begin in 2016.

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+0.5% each year</td>
</tr>
<tr>
<td>2017</td>
<td>No change</td>
</tr>
<tr>
<td>2018</td>
<td>No change</td>
</tr>
<tr>
<td>2019</td>
<td>No change</td>
</tr>
<tr>
<td>2020</td>
<td>No change</td>
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<tr>
<td>2021</td>
<td>No change</td>
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<tr>
<td>2022</td>
<td>No change</td>
</tr>
<tr>
<td>2023</td>
<td>No change</td>
</tr>
<tr>
<td>2024</td>
<td>No change</td>
</tr>
<tr>
<td>2025</td>
<td>+0.25% or 0.75%</td>
</tr>
<tr>
<td>2026 &amp; on</td>
<td>+0.25% or 0.75%</td>
</tr>
</tbody>
</table>

QPs will also get a +0.75% update to the fee schedule conversion factor each year.

Everyone else will get a +0.25% update.
Putting it all together:

- **Fee Schedule**:
  - 2016: +0.5% each year
  - 2017: No change
  - 2018: +0.25% or 0.75%

- **MIPS**:
  - Max Adjustment (+/-):
    - 2016: +5%
    - 2017: +5%
    - 2018: +5%
    - 2019: 9
    - 2020: 9
    - 2021: 9
    - 2022: 9
    - 2023: 9
    - 2024: 9
    - 2025: 9
    - 2026 & on: +0.25% or 0.75%

- **Participation in Qualifying APM**:
  - +5% bonus (excluded from MIPS)
TAKE-AWAY POINTS

1) MACRA changes the way Medicare pays clinicians and offers financial incentives for providing high value care.

2) Medicare Part B clinicians will participate in the MIPS program, unless they are in their 1st year of Part B participation, meet criteria for participation in certain APMs, or have a low volume of patients.

3) Payment adjustments and bonuses will begin in 2019.

4) A proposed rule is targeted for spring 2016, with the final rule targeted for fall 2016.
What should I do to prepare for MACRA?

• Look for future educational activities

• Please review and provide input on our first proposed rule now available at: http://go.cms.gov/QualityPaymentProgram
  Comment period open April 27 to June 26

• Final rule targeted for early fall 2016

• Consider collaborating with one of the TCPI Practice Transformation Networks or Support and Alignment Networks.
Transforming Clinical Practice Initiative

- Support more than 140,000 clinicians in their practice transformation work
- Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
- Reduce unnecessary hospitalizations for 5 million patients
- Generate $1 to $4 billion in savings to the federal government and commercial payers
- Sustain efficient care delivery by reducing unnecessary testing and procedures
- Build the evidence base on practice transformation so that effective solutions can be scaled
Practice Transformation Networks (PTNs)
In Region 9

- Arizona Health-e Connection
- Children's Hospital of Orange County
- Local Initiative Health Authority of Los Angeles County
- National Rural Accountable Care Consortium
- Pacific Business Group on Health
- VHA/UHC Alliance Newco, Inc.
Support and Alignment Networks (SANs)

- American College of Emergency Physicians
- American College of Physicians
- HCD International, Inc.
- Patient Centered Primary Care Foundation
- The American Board of Family Medicine, Inc.
- Network for Regional Healthcare Improvement
- American College of Radiology
- American Psychiatric Association
- American Medical Association
- National Nursing Centers Consortium
6 Key Benefits to Participating Clinicians

1. Optimize health outcomes for your patients
2. Promote connectedness of care for your patients
3. Learn from high performers how to effectively engage patients and families in care planning
4. More time spent caring for your patients
5. Stronger alignment with new and emerging federal policies
6. Opportunity to be a part of the national leadership in practice transformation efforts

http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx
CMS Proposed Rule regarding the QUALITY PAYMENT PROGRAM (MIPS/APMs)
http://go.cms.gov/QualityPaymentProgram
Taking comments April 27 to June 26

MACRA: Medicare Access and CHIP Reauthorization Act of 2015

CMS Health Equity Plan

Contact information for the Transforming Clinical Practice Initiative
http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx
Questions?

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