The Medicare Access & Chip Reauthorization Act of 2015

QUALITY PAYMENT PROGRAM

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Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

Medicare Reporting Prior to MACRA

Currently there are **multiple quality and value reporting programs** for Medicare clinicians:

Physician Quality Reporting Program (PQRS)	Value-Based Payment Modifier (VM)	Medicare Electronic Health Records (EHR) Incentive Program

PROPOSED RULE

MIPS: Major Provisions

- ✓ Eligibility (participants and non-participants)
- ✓ Performance categories & scoring
- ✓ Data submission
- ✓ Performance period & payment adjustments

Who Will Participate in MIPS?

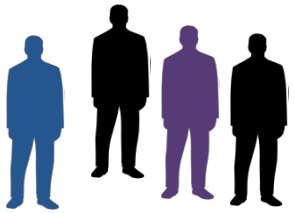
Affected clinicians are called **"MIPS eligible clinicians"** and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Secretary may broaden Eligible Clinicians group to include others such as

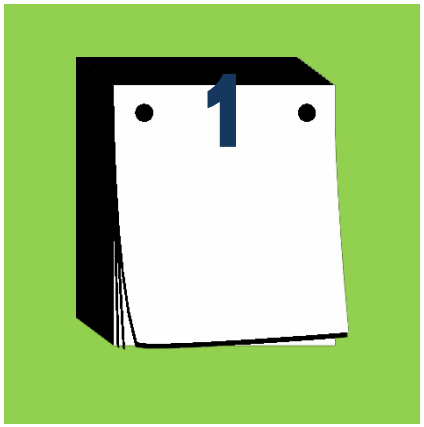
Years 3+



Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

Who will NOT Participate 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

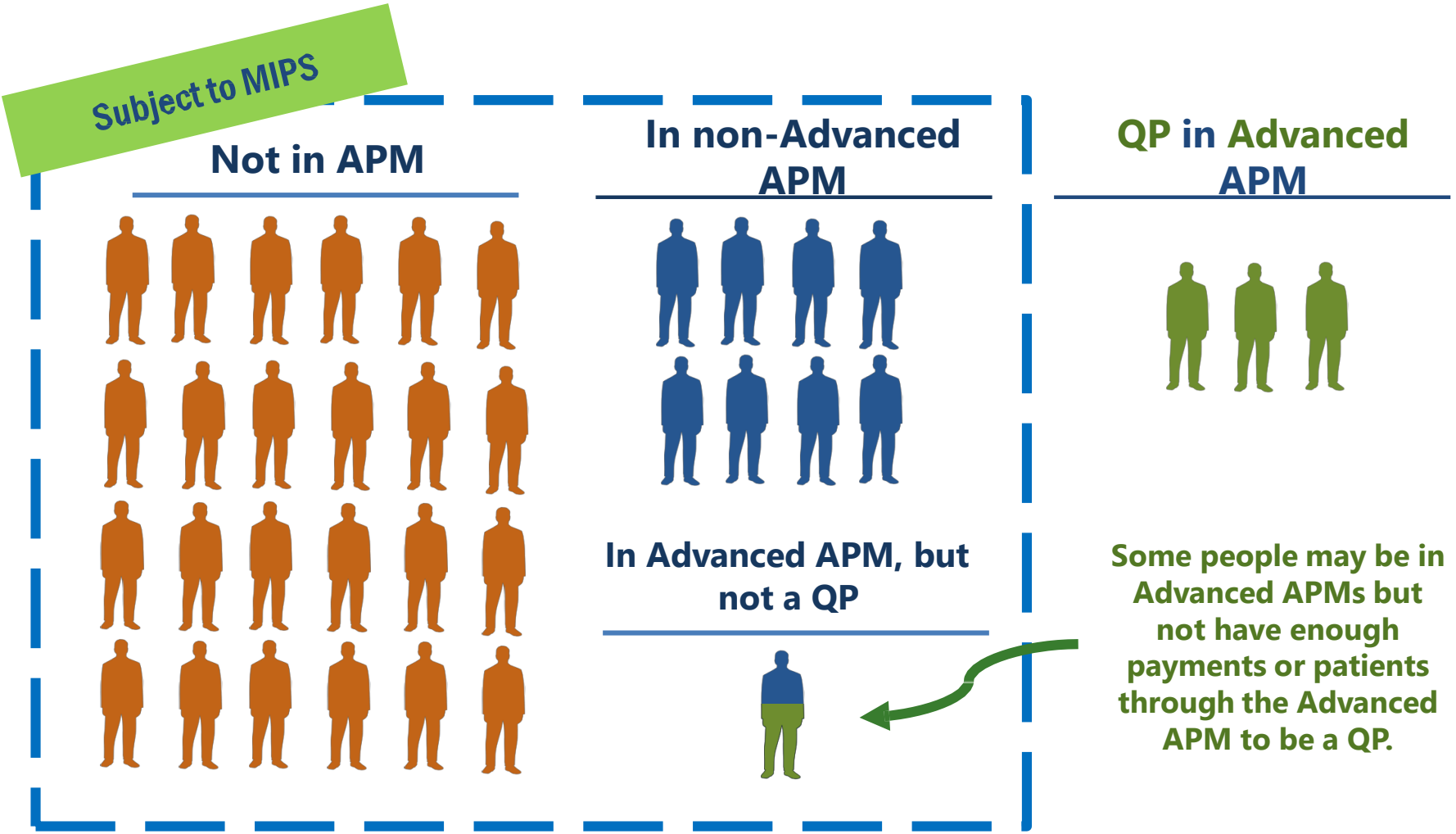
Certain participants in ADVANCED Alternative Payment Models

↓

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

Note: Most clinicians will be subject to MIPS.



Note: Figure not to scale.

PROPOSED RULE

MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:

Or

Individual

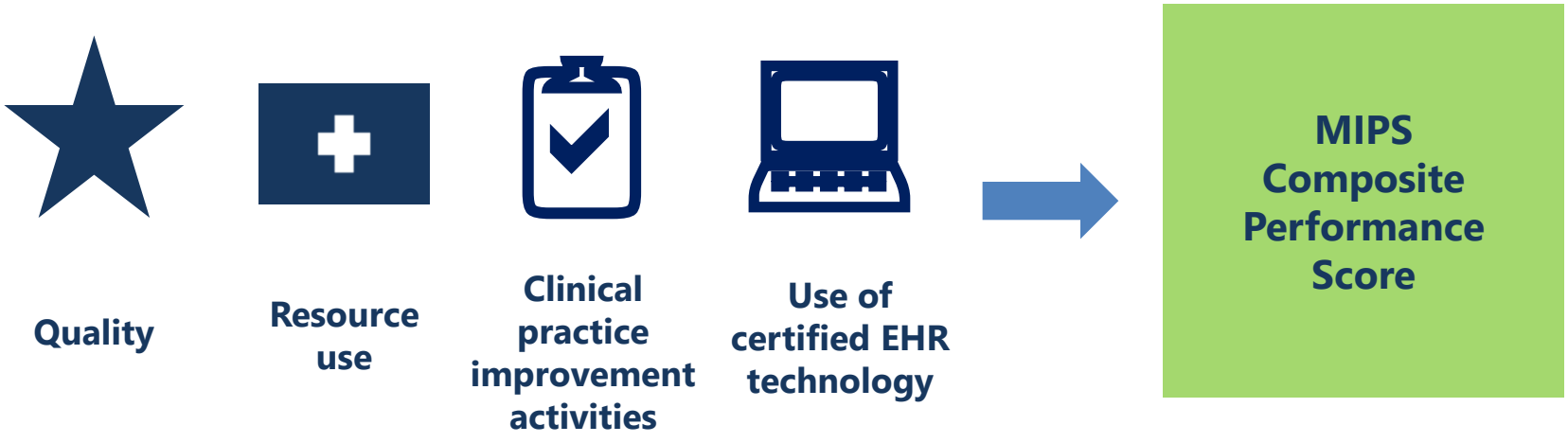
Group

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

MIPS Performance Categories

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



PROPOSED RULE

MIPS: Quality Performance Category

Summary:

- ✓ **Selection of 6 measures**
- ✓ **1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable**
- ✓ **Select from individual measures or a specialty measure set**
- ✓ **Population measures automatically calculated**
- ✓ **Key Changes from Current Program (PQRS):**
  - **Reduced from 9 measures to 6 measures with no domain requirement**
  - **Emphasis on outcome measurement**
  - **Year 1 Weight: 50%**

PROPOSED RULE

MIPS: Resource Use Performance Category

Summary:

- ✓ **Assessment under all available resource use measures, as applicable to the clinician**
- ✓ **CMS calculates based on claims so there are no reporting requirements for clinicians**
- ✓ ***Will compare resources used to treat similar care episodes and clinical condition groups across practice**
- ✓ **Can be risk-adjusted to reflect external factors**
- ✓ **Key Changes from Current Program (Value Modifier):**
  - **Adding 40+ episode specific measures to address specialty concerns**
  - **Year 1 Weight: 10%**

PROPOSED RULE

MIPS: Clinical Practice Improvement Activity Performance Category

Summary:

- ✓ **To not receive a zero score, a minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities**
- ✓ **Full credit for patient-centered medical home**
- ✓ **Minimum of half credit for APM participation**
- ✓ **Examples include care coordination, shared decision-making, safety checklists, expanding practice access**
- ✓ **Key Changes from Current Program:**
  - **Not applicable (new category)**
  - **Year 1 Weight: 15%**

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

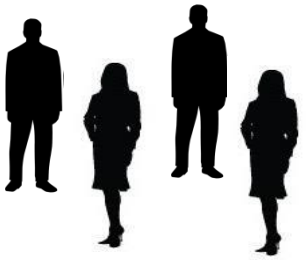
Who can participate?

All MIPS Eligible Clinicians

Participating as an..

Individual

or

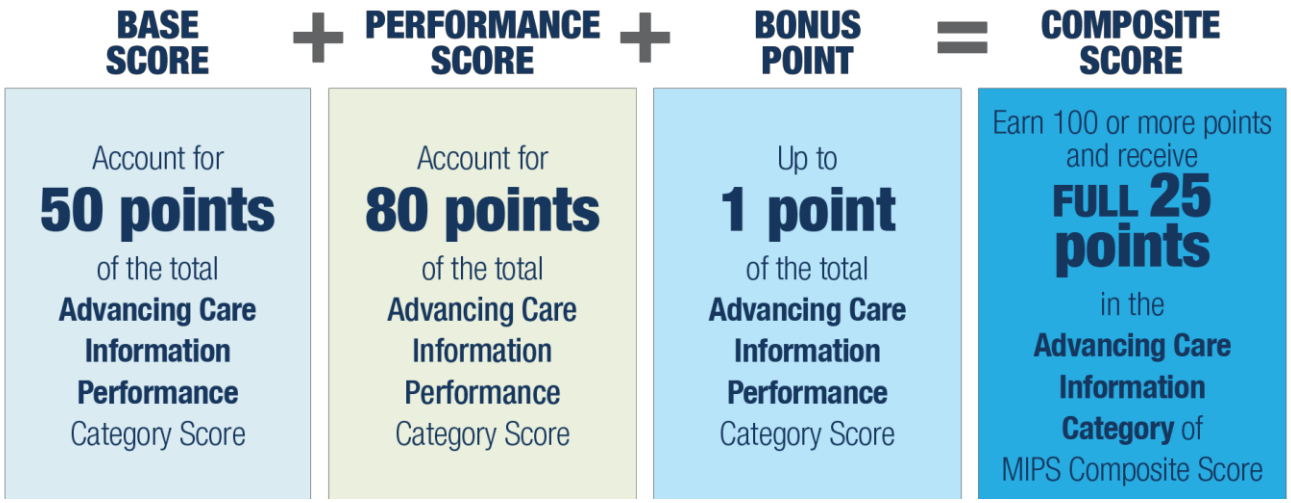


Group

Those Not Eligible

Include: NPs, PAs, Hospitals, Facilities & Medicaid

PROPOSED RULE
MIPS: Advancing Care Information Performance Category



The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Base Score
Accounts for 50 points of the total Advancing Care Information category score.

To receive the base score, physicians must simply provide the numerator/denominator or yes/no for each objective and measure

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:

Protect Patient Health Information (yes required)

Electronic Prescribing (numerator/denominator)

Patient Electronic Access (numerator/denominator)

Coordination of Care Through Patient Engagement (numerator/denominator)

Health Information Exchange (numerator/denominator)

Public Health and Clinical Data Registry Reporting (yes required)

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

THE PERFORMANCE SCORE

The performance score accounts for up to 80 points towards the total Advancing Care Information category score

Physicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

Patient Electronic Access

Coordination of Care Through Patient Engagement

Health Information Exchange

PROPOSED RULE

MIPS: Advancing Care Information Performance Category

Summary:

- ✓ **Scoring based on key measures of health IT interoperability and information exchange.**
- ✓ **Flexible scoring for all measures to promote care coordination for better patient outcomes**
- ✓ **Key Changes from Current Program (EHR Incentive):**
  - **Dropped "all or nothing" threshold for measurement**
  - **Removed redundant measures to alleviate reporting burden.**
  - **Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives**
  - **Reduced the number of required public health registries to which clinicians must report**
  - **Year 1 Weight: 25%**

PROPOSED RULE

MIPS: Calculating the Composite Performance Score (CPS) for MIPS

- ✓ **MIPS composite performance scoring method that accounts for:**
  - **Weights of each performance category**
  - **Exceptional performance factors**
  - **Availability and applicability of measures for different categories of clinicians**
  - **Group performance**
  - **The special circumstances of small practices, practices located in rural areas, and non-patient- facing MIPS eligible clinicians**

Calculating the Composite Performance Score (CPS) for MIPS

Category	Weight	Scoring
Quality	50%	• Each measure 1-10 points compared to historical benchmark (if avail.) • 0 points for a measure that is not reported • Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting • Measures are averaged to get a score for the category
Advancing care information	25%	• Base score of 50 points is achieved by reporting at least one use case for each available measure • Up to 10 additional performance points available per measure • Total cap of 100 percentage points available
CPIA	15%	• Each activity worth 10 points; double weight for "high" value activities; sum of activity points compared to a target
Resource Use	10%	• Similar to quality

✓ Unified scoring system:
1. Converts measures/activities to points
2. Eligible Clinicians wil know in advance what they need to do to achieve top performance
3. Partial credit available

PROPOSED RULE

MIPS Data Submission Options
Quality and Resource Use

	Individual Reporting	Group Reporting
		
Quality	✓ Claims ✓ QCDR ✓ Qualified Registry ✓ EHR Vendors ✓ Administrative Claims (No submission required)	✓ QCDR ✓ Qualified Registry ✓ EHR Vendors ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey ✓ Administrative Claims (No submission required)
Resource use	✓ Administrative Claims (No submission required)	✓ Administrative Claims (No submission required)

PROPOSED RULE

MIPS Data Submission Options
Advancing Care Information and CPIA

	Individual Reporting 	Group Reporting 
Advancing care information	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)
2 CPIA	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ Administrative Claims (No submission required)	✓ Attestation ✓ QCDR ✓ Qualified Registry ✓ EHR Vendor ✓ CMS Web Interface (groups of 25 or more)

PROPOSED RULE

MIPS Performance Period

MIPS Performance Period (Begins 2017)

- ✓ **All MIPS performance categories are aligned to a performance period of one full calendar year.**
- ✓ **Goes into effect in first year (2017 performance period, 2019 payment year).**

2017	2018	2019	2020	2021	2022	2023	2024	2025
Performance Period		Payment Year						

PROPOSED RULE

MIPS: Payment Adjustment

- ✓ **A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.**
- ✓ **An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an "additional performance threshold," defined as the 25th percentile of possible values above the CPS performance threshold.**

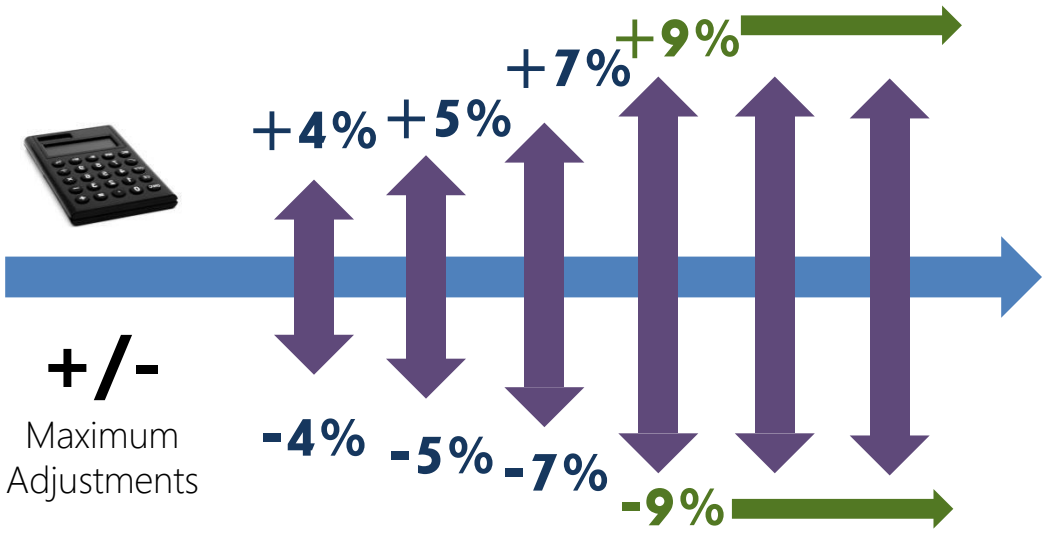
PROPOSED RULE

MIPS: Payment Adjustment

- ✓ A MIPS eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.
- ✓ A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.
- ✓ A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.

How much can MIPS adjust payments?

Based on a CPS, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



Adjusted Medicare Part B **payment** to clinician

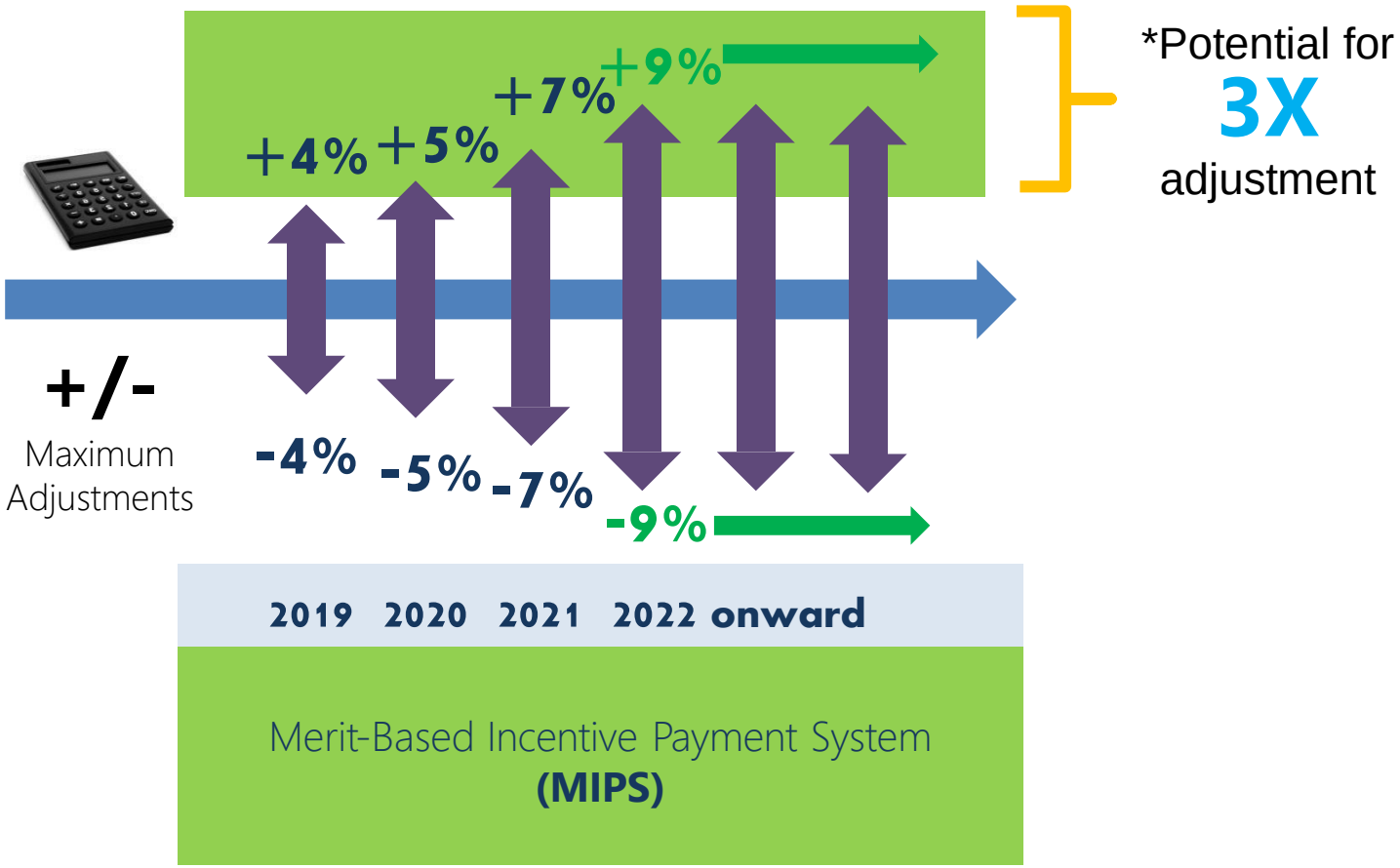
2019 2020 2021 2022 **onward**

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

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

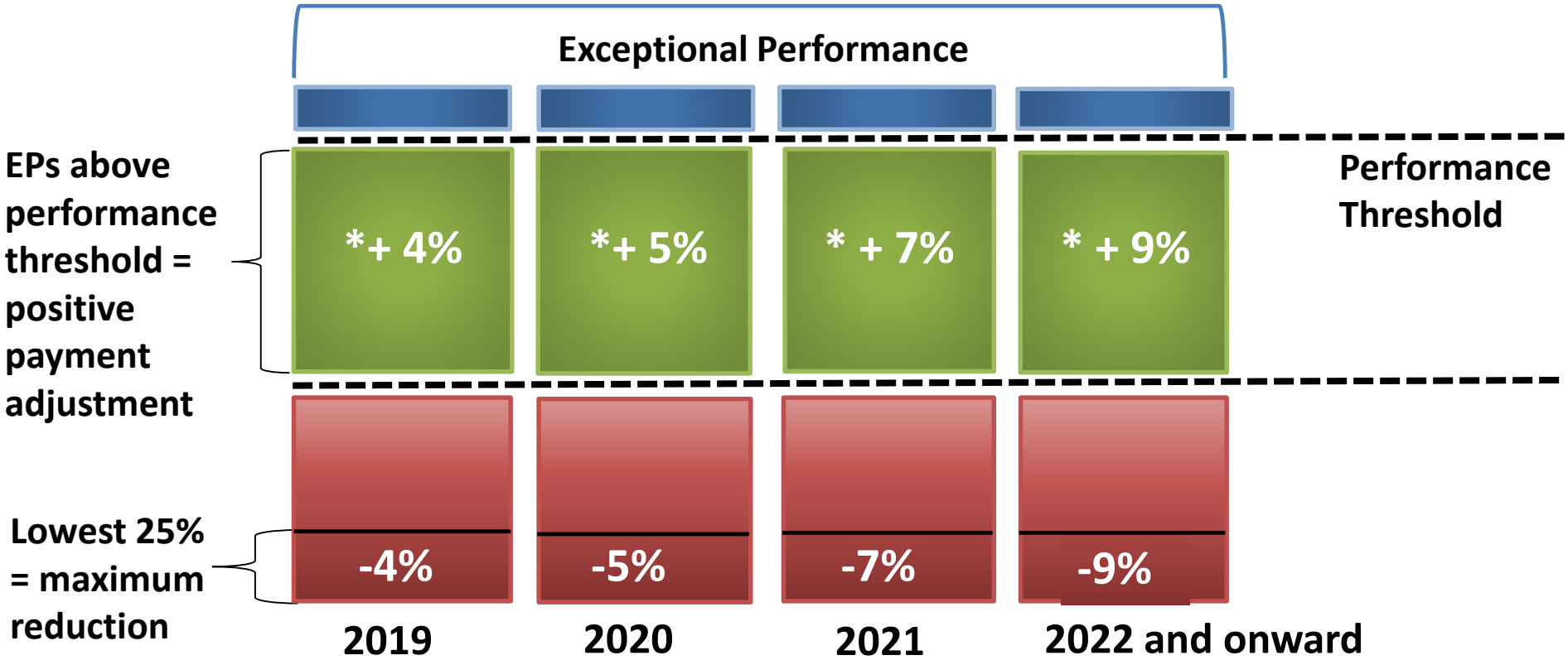
How much can MIPS adjust payments?

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



Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024

MIPS Incentive Payment Formula



**MACRA allows potential 3x upward adjustment BUT unlikely*

What is an 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

Advanced APMs meet certain criteria.

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

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

PROPOSED RULE
Medical Home Models

Medical Home Models:

- ✓ Have a **unique financial risk criterion** for becoming an Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category.**

A **Medical Home Model is an APM** that has the following features:

- ✓ Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- ✓ **Empanelment of each patient** to a primary clinician; and
- ✓ **At least four** of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

PROPOSED RULE

Advanced APM Criterion 1:

Requires use of CEHRT

Certified EHR use

Example: An Advanced APM has a provision in its participation agreement that at least 50% of an APM Entity's eligible clinicians must use CEHRT.

- ✓ An Advanced APM must **require at least 50% of the eligible clinicians in each APM Entity to use CEHRT** to document and communicate clinical care. The threshold will **increase to 75%** after the first year.
- ✓ For the **Shared Savings Program only**, the APM may apply a **penalty or reward** to APM entities based on the degree of CEHRT use among its eligible clinicians.

PROPOSED RULE

Advanced APM Criterion 2:

Requires MIPS-Comparable Quality Measures

Quality Measures

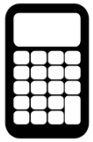
- ✓ An Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;
- ✓ **No minimum** number of measures or domain requirements, **except** that an Advanced APM must have at least one **outcome measure** unless there is not an appropriate outcome measure available under MIPS.

- ✓ **Comparable** means any actual MIPS measures or other measures that are **evidence-based, reliable, and valid**. For example:
  - Quality measures that are endorsed by a consensus-based entity; or
  - Quality measures submitted in response to the MIPS Call for Quality Measures; or
  - **Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.**

PROPOSED RULE

Advanced APM Criterion 3:

Requires APM Entities to Bear More than Nominal Financial Risk



Financial Risk

An Advanced APM must meet **two standards**:

Financial Risk Standard		**Nominal Amount Standard**
APM Entities must bear risk for monetary losses.	**&**	The risk APM Entities bear must be of a certain magnitude.

- ✓ The Advanced APM financial risk criterion is **completely met** if the APM is a **Medical Home Model** that is **expanded under CMS Innovation Center Authority**
- ✓ Medical Home Models that **have not been expanded** will have **different financial risk and nominal amount standards** than those for other APMs.

PROPOSED RULE

Advanced APM Criterion 3: Financial Risk Criterion

The Advanced APM **requires** one or more of the following **if actual expenditures exceed expected expenditures**:

Financial Risk Standard

✓ **Direct payment** from the APM Entity

OR

✓ **Reduction in payment rates** to the APM Entity or eligible clinicians

OR

✓ **Withhold of payment** to the APM Entity or eligible clinicians

PROPOSED RULE

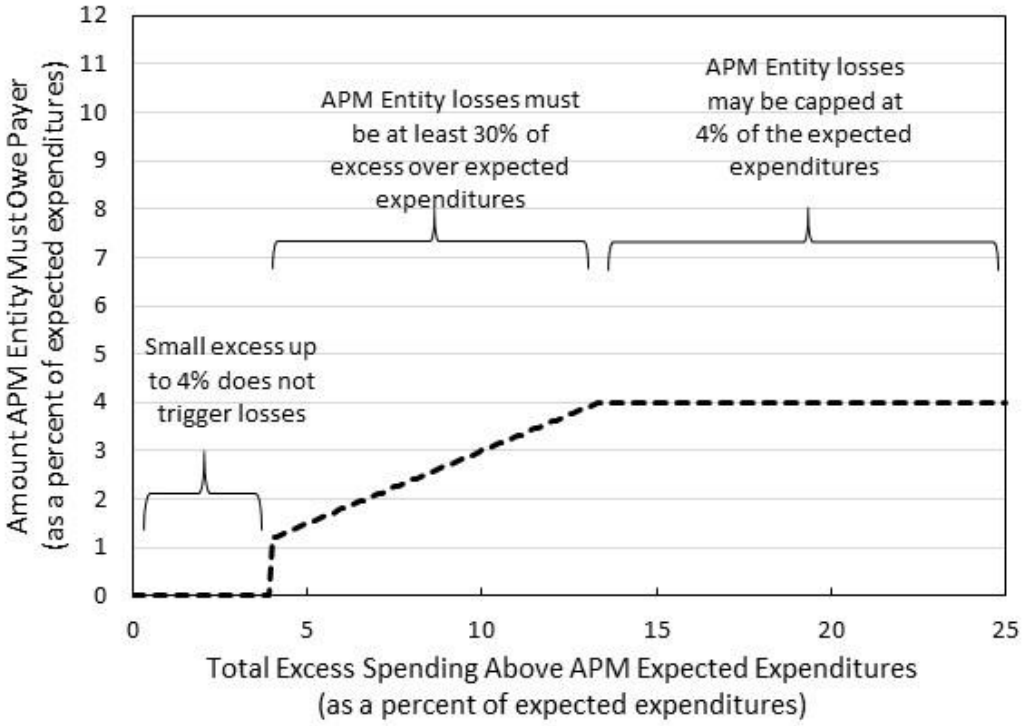
Advanced APM Criterion 3: Financial Risk Criterion

Nominal Amount Standard

The **amount of risk** under an Advanced APM must at least meet the following components:

- ✓ **Total risk** of at least 4% of expected expenditures
- ✓ **Marginal risk** of at least 30%
- ✓ **Minimum loss ratio** (MLR) of no more than 4%.

Illustration of the amount of risk an APM Entity must bear in an Advanced APM:



PROPOSED RULE

Advanced APM Criterion 3: Medical Home Model Financial Risk Criterion

The Medical Home Model **requires** one or more of the following **if the APM Entity fails to meet a specified performance standard**:

Medical Home Model Financial Risk Standard

✓**Direct payment** from the APM Entity

OR

✓**Reduction in payment rates** to the APM Entity or eligible clinicians

OR

✓**Withhold of payment** to the APM Entity or eligible clinicians

OR

✓**Reduces** an **otherwise guaranteed** payment or payments

PROPOSED RULE

Advanced APM Criterion 3: Example

The following is an example of a risk arrangement that would **meet the Advanced APM financial risk criterion**:

An APM consists of a **two-sided** shared savings arrangement:

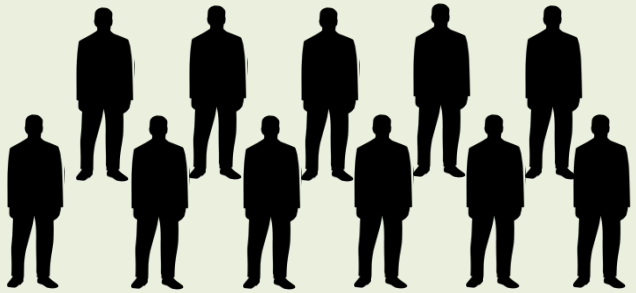
- ✓ If the APM Entity's actual expenditures exceed expected expenditures (the "benchmark"), then the APM Entity **must pay CMS 60% of the amount that expenditures that exceed the benchmark**.
- ✓ The APM Entity **does not have to make any payments** if actual expenditures exceed the benchmark by **less than 2%** of the benchmark amount.
- ✓ There is a **stop-loss provision** so that the APM Entity could pay up to but no more than a **total amount equal to 10%** of the benchmark.

PROPOSED RULE

Advanced APM Criterion 3: Medical Home Model Nominal Amount Standard

Medical Home Model Nominal Amount Standard:

Subject to Size Limit



The Medical Home Model standards only apply to APM Entities with ≤ 50 eligible clinicians in the APM Entity's parent organization

To be an Advanced APM, the **amount of risk** under a Medical Home Model must be at least the following amounts:

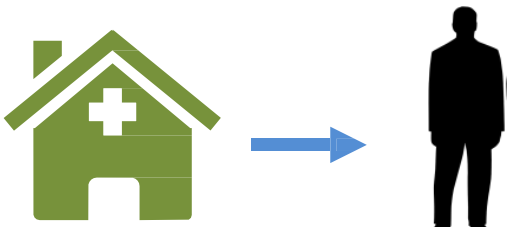
- ✓ **2.5% of Medicare Parts A and B revenue (2017)**
- ✓ **3% of Medicare Parts A and B revenue (2018)**
- ✓ **4% of Medicare Parts A and B revenue (2019)**
- ✓ **5% of Medicare Parts A and B revenue (2020 and later)**

Proposed Rule
Advanced APMs

Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- ✓ **Shared Savings Program** (Tracks 2 and 3)
- ✓ **Next Generation ACO Model**
- ✓ **Comprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Oncology Care Model (OCM)** (two-sided risk track available in 2018)

How do I become a Qualifying APM Participant (QP)?



Advanced APM → QP

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

QPs will:

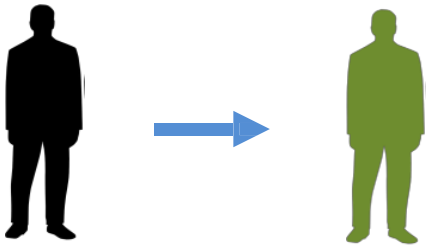
- **Be excluded from MIPS**
- **Receive a 5% lump sum bonus**

Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

PROPOSED RULE

How do Eligible Clinicians become QPs?

Eligible Clinicians to QP in 4 STEPS



Eligible Clinicians **QP**

1. QP determinations are made at the **Advanced APM Entity level**.
2. CMS calculates a **"Threshold Score"** for each Advanced APM Entity.
3. The Threshold Score for each method is compared to the corresponding **QP threshold**.
4. All the eligible clinicians in the Advanced APM Entity **become QPs** for the payment year.

- ✓ The period of assessment (QP Performance Period) for each payment year will be **the full calendar year that is two years prior to the payment year** (e.g., 2017 performance for 2019 payment).
- ✓ Aligns with the MIPS performance period.

PROPOSED RULE

How do Eligible Clinicians become QPs?

STEP 2

- ✓ **CMS will calculate a percentage "Threshold Score" for each Advanced APM Entity using two methods (payment amount and patient count).**
- ✓ **Methods are based on Medicare Part B professional services and beneficiaries attributed to Advanced APM Entities.**
- ✓ **CMS will use the method that results in a more favorable QP determination for each Advanced APM Entity.**

These definitions are used for calculating Threshold Scores under both methods.

Attributed (beneficiaries for whose cost and quality of care the APM Entity is responsible)

Attribution-eligible (all beneficiaries who could potentially be attributed)

PROPOSED RULE

How do Eligible Clinicians become QPs?

STEP 2

- ✓ **The two methods for calculation are Payment Amount Method and Patient Count Method.**

Payment Amount Method

$$$ for Part B professional services to **attributed beneficiaries**

$$$ for Part B professional services to **attribution-eligible beneficiaries**

= **Threshold Score %**

Payments

Patient Count Method

of **attributed beneficiaries** given Part B professional services

---

of **attribution-eligible beneficiaries** given Part B professional services

= **Threshold Score %**

Patients

PROPOSED RULE

How do Eligible Clinicians become QPs?

STEP 3

✓ **The Threshold Score for each method is compared to the corresponding QP threshold table and CMS takes the better result.**

Medicare Option – Payment Amount Method

Payment Year	2019	2020	2021	2022	2023	2024+
QP Payment Amount Threshold	25%	25%	50%	50%	75%	75%
Partial QP Payment Amount Threshold	20%	20%	40%	40%	50%	50%

Medicare Option – Patient Count Method

Payment Year	2019	2020	2021	2022	2023	2024+
QP Patient Count Threshold	20%	20%	35%	35%	50%	50%
Partial QP Patient Count Threshold	10%	10%	25%	25%	35%	35%

Payments

Patients

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

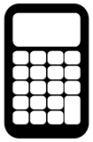
Starting in **2021**, **some** arrangements with other non-Medicare payers can **count toward** becoming a QP

"All-Payer Combination Option"

IF the "Other Payer APMs" meet criteria similar to those for Advanced APMs, CMS will consider them "Other Payer Advanced APMs":

Certified EHR use

Quality Measures



Financial Risk

PROPOSED RULE

APM Incentive Payment

QPs will:

- **Be excluded from MIPS**
- **Receive a 5% lump sum bonus**

Bonus applies in payment years 2019-2024; then QPs receive higher fee schedule updates starting in 2026

- ✓ The "APM Incentive Payment" will be based on the estimated aggregate payments for professional services furnished the year prior to the payment year.
- ✓ E.g., the 2019 APM Incentive Payment will be based on 2018 services.

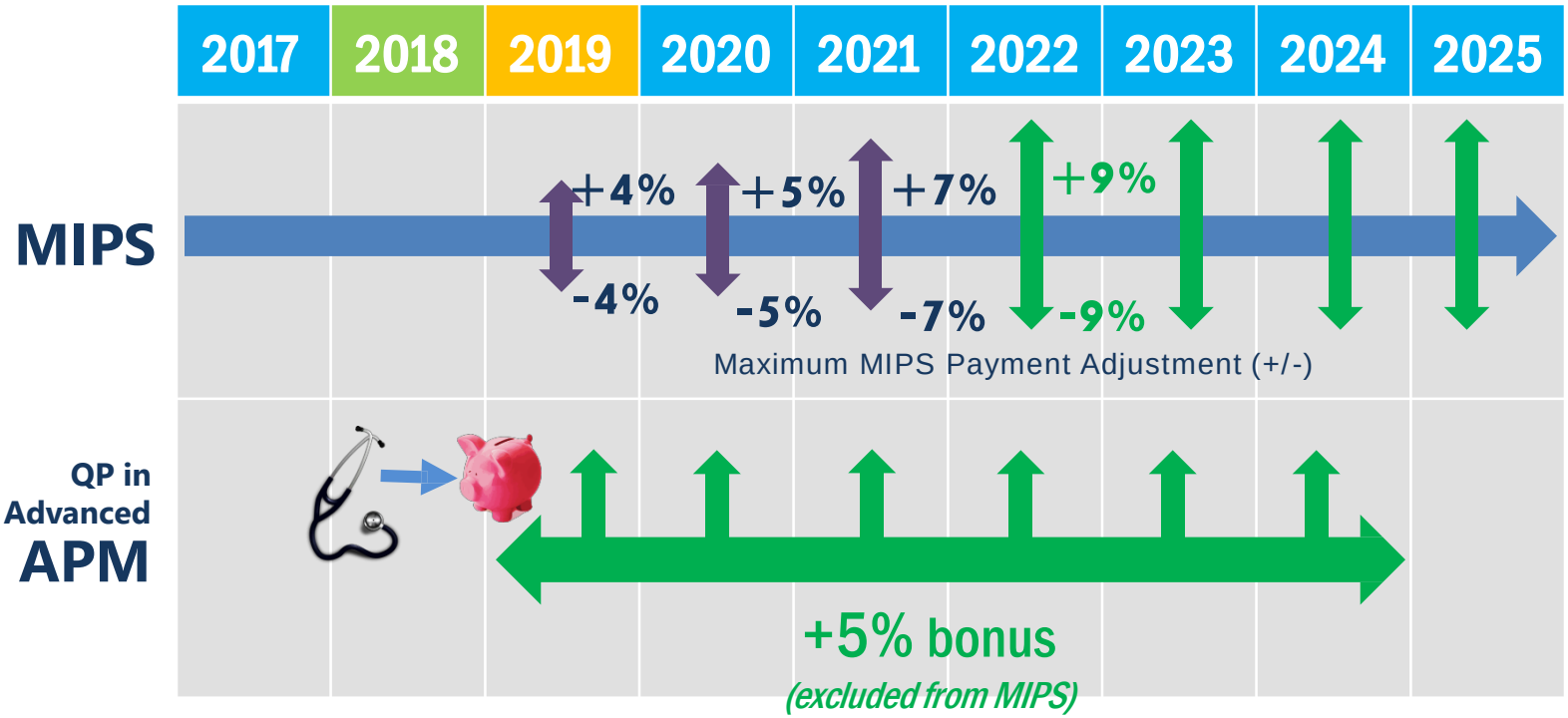
PROPOSED RULE

QP Determination and APM Incentive Payment Timeline

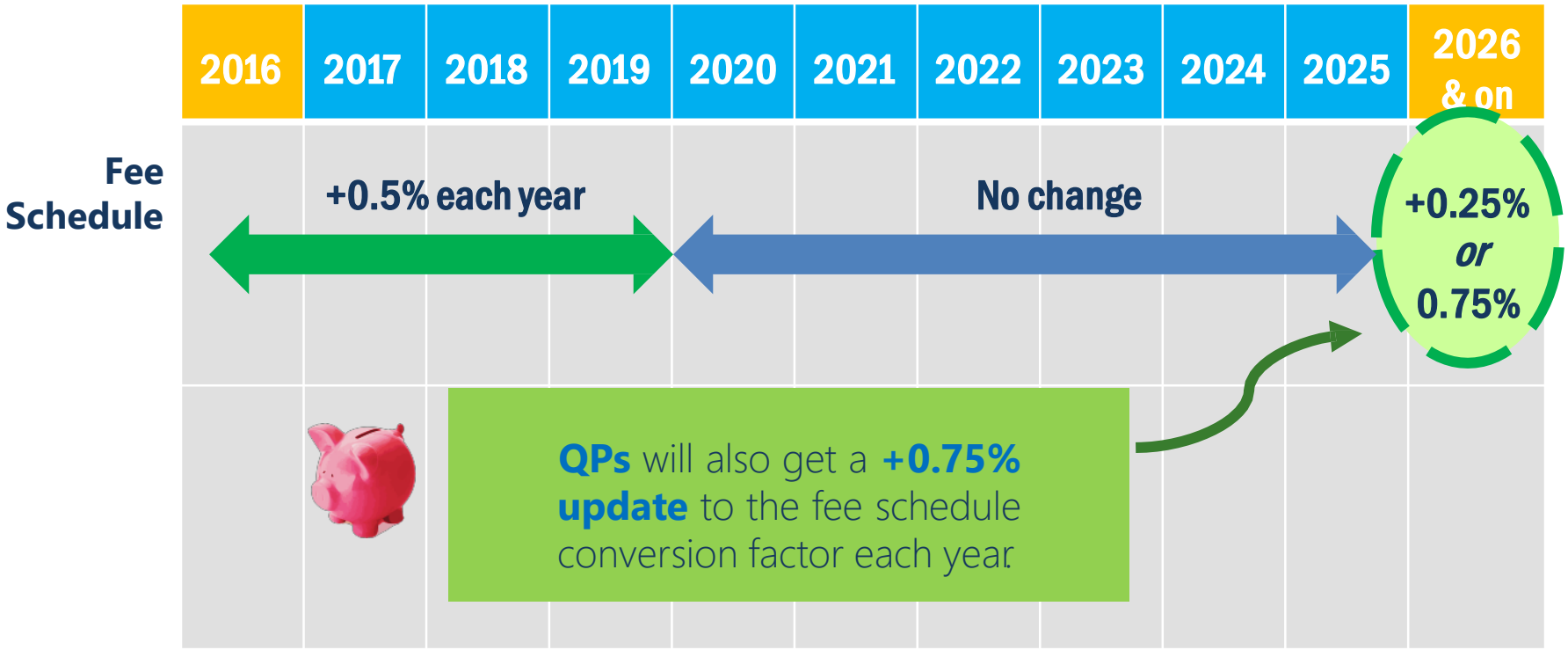
2017	2018	2019
QP Performance Period	**Incentive Payment Base Period**	**Payment Year**
QP status based on Advanced APM participation here.	Add up payments for a QP's services here.	+5% lump sum payment made here. (and excluded from MIPS adjustments)

2018	2019	2020
QP Performance Period	**Incentive Payment Base Period**	**Payment Year**
Repeat the cycle each year…		

MIPS adjustments and APM Incentive Payment will begin in 2019.

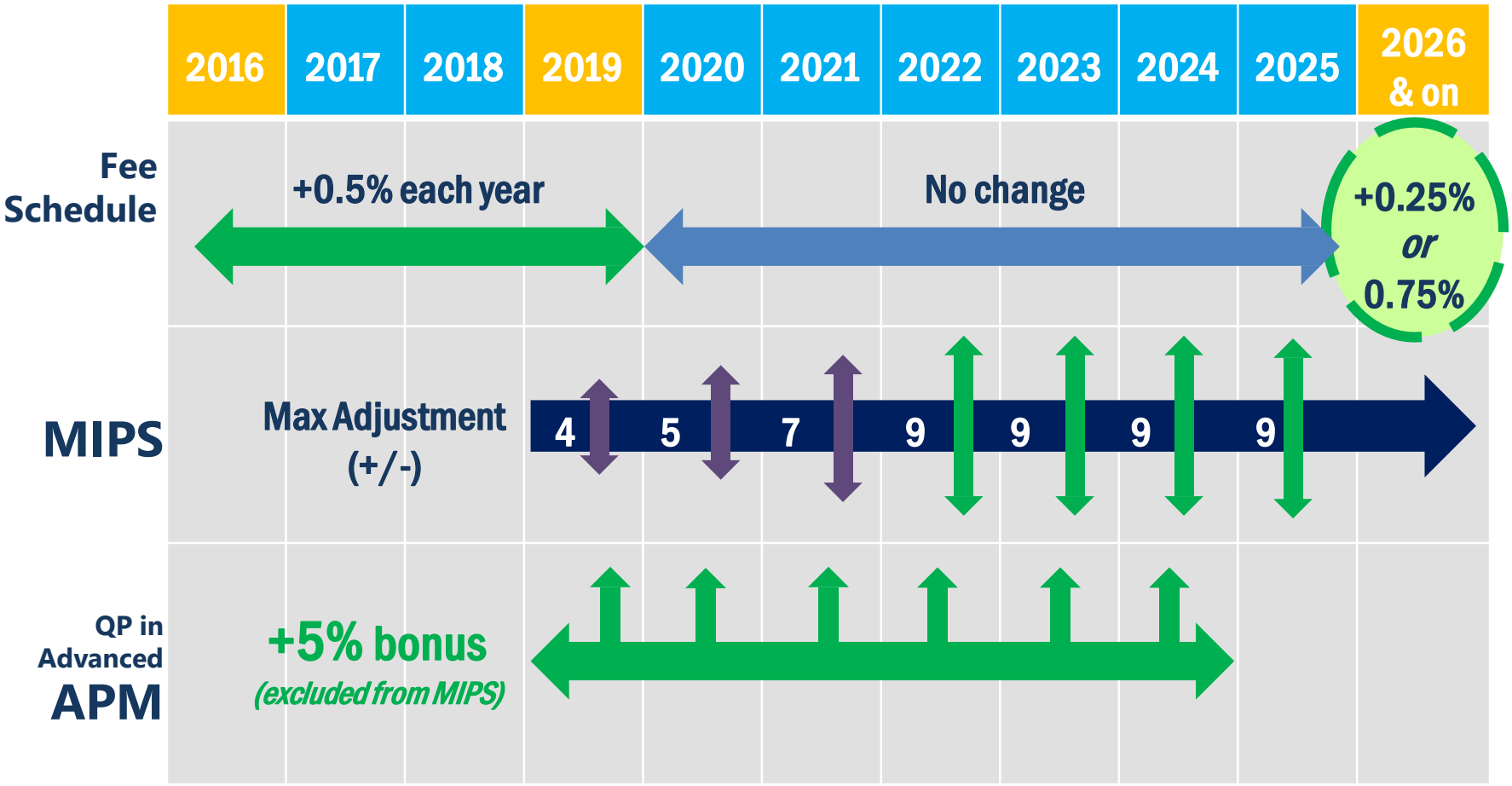


Fee schedule updates begin in 2016.



Everyone else will get a +0.25% update.

Putting it all together:



The Quality Payment Program provides additional rewards for participating in APMs.

Potential financial rewards

Not in APM	In APM	In Advanced APM
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
		5% lump sum bonus

If you are a **Qualifying APM Participant (QP)**

MACRA supports care delivery and promotes innovation.

Such as:

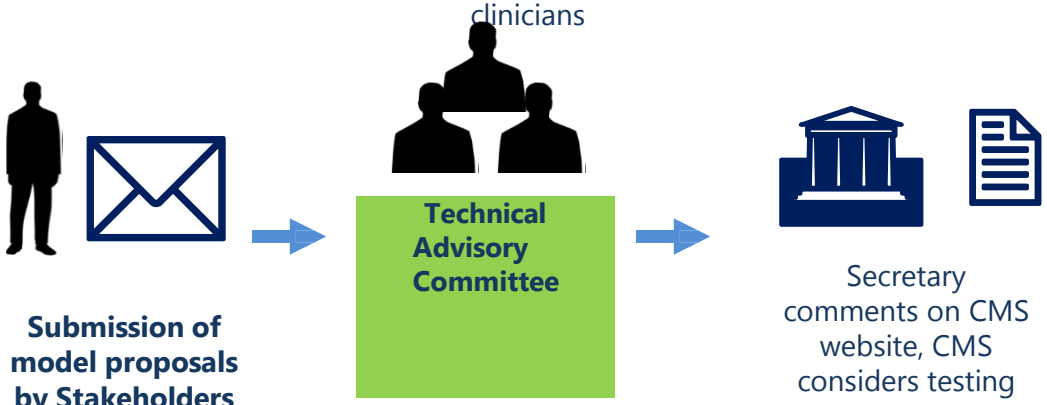
Allocates **$20 million / yr.** from 2016-2020 to **small practices** to provide **technical assistance** regarding MIPS performance criteria or transitioning to an APM.

Creates an advisory committee to help promote development of **Physician-Focused Payment Models**

Independent PFPM Technical Advisory Committee

PFPM = Physician-Focused Payment Model

Goal to encourage new **APM options** for Medicare clinicians



[For more information on the PTAC, go to: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee](https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee)

PROPOSED RULE

Physician-focused Payment Model (PFPM)

Proposed definition: An Alternative Payment Model wherein Medicare is a payer, which includes physician group practices (PGPs) or individual physicians as APM Entities and targets the quality and costs of physician services.

Any PFPM that is selected for testing by CMS and meets the criteria for an Advanced APM would be an Advanced APM.

Practice Transformation in Action

*Transforming Clinical Practice would employ a **three-prong approach** to national technical assistance.*

Aligned federal and state programs with support contractor resources

Practice Transformation Networks to provide on the ground support to practices

Support and Alignment Networks to achieve alignment with medical education, maintenance of certification, more

*This technical assistance would enable large-scale transformation of more than **140,000 clinicians' and** their practices to deliver **better care and result in better health outcomes at lower costs**.*

Communities

Ambulatory and Post-Acute Care

Public Health Services

Hospitals and Healthcare Systems

Primary and Specialty Care Clinicians and Practices

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

Practice Transformation Networks (PTNs) In Region 3

- VHA/UHC Alliance Newco, Inc.
- Health Partners Delmarva, LLC
- HCD International, Inc.
- VHS Valley Health Systems, LLC
- VHQC
- Consortium for Southeastern Hypertension Control
- New Jersey Innovation Institute

When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.