AGENDA

• Patients Over Paperwork Initiative
• 2019 IPPS Final Rule
  – Promoting Interoperability
  – New objectives and measures
  – New scoring methodology
  – Reporting
• 2019 QPP Proposed Rule
  – Big Changes mimicking those in IPPS Final Rule
  – Submission Types
  – “Opting In” vs “Voluntarily Reporting”
  – Payment Adjustments
PATIENTS OVER PAPERWORK

PROBLEM
FOR EVERY HOUR A PROVIDER SEES PATIENTS, THEY SPEND NEARLY 2 HOURS ON PAPERWORK.

SOLUTION
Ease burden, focus on patients.

“Through “Patients over Paperwork,” CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience. In carrying out this internal process, CMS is moving the needle and removing regulatory obstacles that get in the way of providers spending time with patients.”
(https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html)

- Documentation Requirements Simplification (DRS) Initiative
  - Changes to DME, Signature Reviews, IRF, Immunosuppressive and Teaching E&M requirements
- E&M Reform
  - Overview: https://youtu.be/W2QBTQNxSY
  - Coding Education Video: https://www.youtube.com/watch?v=B0BZmGYpYFU&feature=youtu.be
- Meaningful Measures Initiative
  - CMS selection of measures that are most vital to providing high-quality care and improving outcomes, while aligning measures across programs.
2019 IPPS FINAL RULE

OVERVIEW of MAJOR CHANGES

• “Meaningful Use/MU” is now “Promoting Interoperability/PI”
  – Also, under QPP, ACI is now PI.
  – Interoperability is an inherent requirement to meet the needs of this new healthcare ecosystem.
• Security Risk Analysis continues to be required.
• Minimum 90-day reporting period for PI and eCQM
• 2015 CEHRT is required.
• New Objectives
• New Measures
• New Performance Score Methodology (much like QPP)
• Removed measures
2019 IPPS FINAL RULE
PROMOTING INTEROPERABILITY

• MINIMUM 90-day reporting period
• Performance Score of a MINIMUM of 50 points is required
• SRA does not contribute to score but is still required

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Maximum Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td>e-Prescribing</td>
<td>10 points</td>
</tr>
<tr>
<td>Bonus: Query of Prescription Drug Monitoring Program (PDMP)</td>
<td>5 points bonus</td>
<td></td>
</tr>
<tr>
<td>Bonus: Verify Opioid Treatment Agreement</td>
<td>5 points bonus</td>
<td></td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic Referral Loops by Sending Health Information</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information</td>
<td>20 points</td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>40 points</td>
</tr>
<tr>
<td>Public Health and Clinical Data Exchange</td>
<td>Choose any two of the following: Syndromic Surveillance Reporting Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting</td>
<td>10 points</td>
</tr>
</tbody>
</table>

Note: Security Risk Analysis is retained, but not included as part of the scoring methodology.
OBJECTIVE: ePrescribing (eRx)

- **NEW!** Query of PDMP (optional in CY2019, required in CY2020) – 5 bonus points in each year
  - Separate exclusions apply in CY2020
  - If EH qualifies for eRx exclusion, they also qualify for Query of PDMP measure exclusion.
- **NEW!** Verify Opioid Treatment (optional in both CY2019 and CY2020) – 5 bonus points in each year
  - Exclusion – if claimed, points will be redistributed equally among the HIE objective.
OBJECTIVE: Health Information Exchange (HIE)

- **CHANGED!** Send Summary of Care now named “Support Electronic Referral Loops by Sending Health Information” (20 points)
  - No exclusions
- **NEW!** Request/Accept Summary of Care + Clinical Info Reconciliation are combining to become a new measure “Support Electronic Referral Loops by Receiving and Incorporating Health Information” (20 points)
  - In the event that an eligible hospital or CAH claims an exclusion for the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure, the 20 points would be redistributed to the Support Electronic Referral Loops by Sending Health Information measure, and that measure would then be worth 40 points.
  - New exclusions for provider unable to implement functionality in CY2019
2019 IPPS FINAL RULE

CHANGED PI OBJECTIVES/MEASURES

OBJECTIVE: Coordination of Care

- REMOVED! View, Download and Transmit
- REMOVED! Secure Electronic Messaging
- REMOVED! Patient Generated Health Data
2019 IPPS FINAL RULE
CHANGED PI OBJECTIVES/MEASURES

OBJECTIVE: Provide Electronic Access

- **CHANGED!** Provide Electronic Access (Objective) now named “Provider to Patient Exchange”
- **CHANGED!** Provide Patient Access (Measure) now named “Provide Patients Electronic Access to Their Health Information” (40 points)
  - No exclusions.
- **REMOVED!** Education (Measure) has been eliminated.
2019 IPPS FINAL RULE

CHANGED PI OBJECTIVES/MEASURES

OBJECTIVE: Public Health

• **CHANGED!** Public Health now named “Clinical Data Registry Reporting” (10 pts)
  - Current exclusions remain
  - EHs/CAHs can choose the 2 measures
    • Must submit y/n or exclusion response for 2 measures. If submits a “no”, it will automatically fail them from PI Program.
    - Can claim an exclusion for 1 measure + “yes” to another measure and the EH/CAH will still earn 10 pts.
    - If claims exclusions for any or both measures, 10 pts will be redistributed to Provide Patients Electronic Access to Their Health Information measure.
OVERVIEW of MAJOR CHANGES

- “Advancing Care Information/ACI” is now “Promoting Interoperability/PI”
- New “Stage 3” Objectives & New Measures (mimics 2019 IPPS PI)
- 2015 CEHRT is required (no bonus)
- Security Risk Analysis continues to be required.
- New Eligible Clinicians (PT, OT, Clinical Social Worker and Clinical Psychologist)
  - Could also include: Speech Language Pathologist, Audiologist, Nurse Midwives, Dieticians/Nutritional Professionals if CMS determines these EC would have 6 MIPS eCQMs available!
- New Category Weights
- New Reporting Periods
- New Submission Methods
- Option to “opt in” or “voluntarily submit”
- Hospital-based ECs - Facility-based Scoring (VBP metrics)

https://www.azaleahealth.com/resources/qpp
## 2019 QPP PROPOSED RULE

### ELIGIBLE CLINICIANS

<table>
<thead>
<tr>
<th>Eligible Clinicians</th>
<th>2018</th>
<th>2019</th>
<th>2019 POSSIBLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td></td>
<td>All clinicians included in 2018 with the addition of 4 new clinician types:</td>
<td></td>
</tr>
<tr>
<td>Physician assistant</td>
<td></td>
<td>Physical therapist</td>
<td><strong>if CMS determines these EC would have 6 MIPS eCQMs available!</strong></td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td></td>
<td>Occupational therapist</td>
<td></td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
<td></td>
<td>Clinical social worker</td>
<td></td>
</tr>
<tr>
<td>Certified registered nurse anesthetist</td>
<td></td>
<td>Clinical psychologist</td>
<td></td>
</tr>
<tr>
<td>A group that includes such professionals (required by statute)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2019 QPP PROPOSED RULE

2019 CATEGORY WEIGHTS

45% QUALITY

- 6 eCQMs
- Full CY Reporting Period
- Facility Based scoring available based on Hospital VBP Program
- Add 10 new eCQMs
- Remove 34
- New Collection and Submission Types

25% PROMOTING INTEROPERABILITY

- 30 Score to Participate
- >80 Score for Exceptional Performance
- Minimum 90-day Reporting Period
- Requires 2015 CEHRT
- New EC Types

15% COST

- Based on Claims data
- Adding 8 new Episode-based measures (each separately weighted)

15% IMPROVEMENT ACTIVITIES

- Minimum 90-day reporting period
2019 QPP PROPOSED RULE
2019 PROPOSED DATA COLLECTION & SUBMISSION MECHANISM CHANGES

1. **Collection Type**: These are eCQMs collection methods: CQMs (EHR), MIPS CQMs (Registry), QCDR measures, CAHPS for MIPS survey, and CMS Web Interface measures.

2. **Submission Types**: the mechanism by which a submitter type submits data to CMS, including:
   - **Direct**: The direct submission type allows users to transmit data through a computer-to-computer interaction (API embedded in the EHR).
   - **Log in and Upload**: Enables users to upload and submit data in the form and manner specified by CMS with a set of authenticated credentials (EIDM account).
   - **Log in and Attest**: Users manually attest that certain measures and activities were performed in the form and manner specified by CMS with a set of authenticated credentials (EIDM account).
   - **CMS Web Interface**: Groups of 25 or more ECs. (proposed to reduce this to 16)
   - **Claims** (proposed to include small group practices)

3. **Submitter Types**: MIPS eligible clinician, group (and virtual group), or via a third-party intermediary acting on behalf of clinician or group that submits data on measures and activities under MIPS.
### 2019 QPP PROPOSED RULE

**INDIVIDUALS ECs**

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Submission Type</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Direct</td>
<td>Individual or Third Party Intermediary&lt;sup&gt;2&lt;/sup&gt;</td>
<td>eCQMs</td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td>Individual</td>
<td>MIPS CQMs</td>
</tr>
<tr>
<td></td>
<td>Medicare Part B claims</td>
<td>Individual</td>
<td>QCDR measures</td>
</tr>
<tr>
<td></td>
<td>(small practices)&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td>Medicare Part B claims measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(small practices)</td>
</tr>
<tr>
<td>Cost</td>
<td>No data submission required&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Individual</td>
<td>-</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>Direct</td>
<td>Individual or Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Log in and attest</td>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Direct</td>
<td>Individual or Third Party Intermediary</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Log in and attest</td>
<td>Individual</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> Third party intermediary does not apply to Medicare Part B claims submission type.

<sup>2</sup> Requires no separate data submission to CMS: measures are calculated based on data available from MIPS eligible clinicians’ billings on Medicare claims. **NOTE:** As used in this proposed rule, the term “Medicare Part B claims” differs from “administrative claims” in that “Medicare Part B claims” require MIPS eligible clinicians to append certain billing codes to denominator-eligible claims to indicate the required quality action or exclusion occurred.
### TABLE 30: Data Submission Types for MIPS Eligible Clinicians Reporting as Groups

<table>
<thead>
<tr>
<th>Performance Category/Submission Combinations Accepted</th>
<th>Submission Types</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Direct</td>
<td>Group or Third Party Intermediary</td>
<td>eCQMs, MIPS CQMs, QCDR measures, CMS Web Interface measures, Medicare Part B claims measures (small practices)</td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CMS Web Interface (groups of 25 or more eligible clinicians)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Part B claims (small practices)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>No data submission required</td>
<td>Group</td>
<td>Administrative claims measures</td>
</tr>
<tr>
<td>Promoting Interoperability</td>
<td>Direct</td>
<td>Group or Third Party Intermediary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Log in and attest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>Direct</td>
<td>Group or Third Party Intermediary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Log in and upload</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Log in and attest</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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2. Requires no separate data submission to CMS: measures are calculated based on data available from MIPS eligible clinicians’ billings on Medicare claims. **NOTE:** As used in this proposed rule, the term “Medicare Part B claims” differs from “administrative claims” in that “Medicare Part B claims” require MIPS eligible clinicians to append certain billing codes to denominator-eligible claims to indicate the required quality action or exclusion occurred.
2019 QPP PROPOSED RULE
PROMOTING INTEROPERABILITY

• REPORTING PERIOD: MINIMUM 90-day reporting period

• SRA does not contribute to score but is still required

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Max Points</th>
<th>Reporting</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td>e-Prescribing</td>
<td>10 pts</td>
<td>Num/Den</td>
<td>Available</td>
</tr>
<tr>
<td><strong>Bonus:</strong> Query of Prescription Drug Monitoring Program (PDMP)</td>
<td>5 pts</td>
<td>Num/Den</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bonus:</strong> Verify Opioid Treatment Agreement</td>
<td>5 pts</td>
<td>Num/Den</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic Referral Loops by Sending Health Information</td>
<td>20 pts</td>
<td>Num/Den</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information</td>
<td>20 pts</td>
<td>Num/Den</td>
<td>Available</td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>40 pts</td>
<td>Num/Den</td>
<td></td>
</tr>
<tr>
<td>Public Health and Clinical Data Exchange</td>
<td>Choose two of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting</td>
<td>10 pts</td>
<td>Yes/No</td>
<td>Available</td>
</tr>
<tr>
<td>Protect Patient Health Information</td>
<td>Security Risk Analysis</td>
<td>0 pts</td>
<td>Yes/No</td>
<td></td>
</tr>
</tbody>
</table>
2019 QPP PROPOSED RULE

QUALITY

- REPORTING PERIOD: Full Calendar Year
- Multiple data collection options for single category
- Considering a tiered scoring process based on measure “value”
- Small Practice bonus will be 3 points added to Quality numerator while calculating Category Score (down from 5 in 2018)
- 60% Data Completeness Required
- Facility-Based scoring will be available to the facility-based MIPS ECs and Groups for both Quality and Cost performance categories. The 2019 measure set for Hospital Value-Based Purchasing (VBP) program will be used.
  - \( \geq 75 \) services furnished in POS 21, 22 or 23
- CMS Web Interface for groups of 16 or more ECs
- Adding 10 new MIPS Measures
- Removing 34 Measures
• Proposing to add 8 new episode-based measures

• 2 measures considered today are MSPB and TPCC

• The Episode-based measures are developed to inform the attributed clinicians about the cost of the care they deliver. The cost for only the items and services that are related to an episode of care for a clinical condition or procedure are accounted using Medicare Parts A and B fee-for-service claims data. These costs are based on Episode groups which:
  – Represent a clinically cohesive set of medical services rendered to treat a given medical condition
  – Aggregate all items and services provided for a defined patient cohort to assess the total cost of care.
  – Are defined around treatment for a condition (acute or chronic) or performance of a procedure.
**2019 QPP PROPOSED RULE**

**2019 PROPOSED COST MEASURES**

**Cost Achievement Points**

<table>
<thead>
<tr>
<th>Total Available Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>= Cost Performance Score</td>
</tr>
</tbody>
</table>

2017 Cost information is available to non-ACO participants now on the QPP Website!

**EPISODE-BASED MEASURES PROPOSED FOR MIPS 2019**

<table>
<thead>
<tr>
<th>Measure Topic</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Outpatient Percutaneous Coronary Intervention (PCI)</td>
<td>Procedural</td>
</tr>
<tr>
<td>Knee Arthroplasty</td>
<td>Procedural</td>
</tr>
<tr>
<td>Revascularization for Lower Extremity Chronic Critical Limb Ischemia</td>
<td>Procedural</td>
</tr>
<tr>
<td>Routine Cataract Removal with Intraocular Lens (IOL) Implantation</td>
<td>Procedural</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>Procedural</td>
</tr>
<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
<td>Acute inpatient medical condition</td>
</tr>
<tr>
<td>Simple Pneumonia with Hospitalization</td>
<td>Acute inpatient medical condition</td>
</tr>
<tr>
<td>ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)</td>
<td>Acute inpatient medical condition</td>
</tr>
</tbody>
</table>
2019 QPP PROPOSED RULE

2017 COST CATEGORY REVIEW

MIPS – Merit-based Incentive Payment System
APMs – Alternative Payment Models

Medicare Spending Per Beneficiary (MSPB)
Measure ID: MSPB_1

BENCHMARK DATA
Lowest Benchmark: $20,676
Highest Benchmark: $21,215

MEASURE INFO
The data is based on claims information from all beneficiaries that were billed under Medicare in 2017. This is an inverse measure, where less spending indicates better performance.

Measure Score: 7.2

Total Per Capita Costs (TPCC)
Measure ID: TPCC_1

BENCHMARK DATA
Lowest Benchmark: $16,658.6
Highest Benchmark: $20,071.5

MEASURE INFO

Measure Score: 3.0
2019 QPP PROPOSED RULE
LOW VOLUME EC/GROUP PARTICIPATION OPTIONS

• **Opting In**
  – Formal declaration required on QPP website that is irrevocable
  – Can be done if EP or TIN exceeds at least one of the low-volume threshold requirements
    • $90,000
    • Beneficiaries <= 200
    • Covered Professional services <= 200
  – MIPS adjustment factor applies

• **Voluntary Submission**
  – MIPS adjustment factor does not apply
2019 QPP PROPOSED RULE
PAYMENT ADJUSTMENTS

• FY2019 (PROGRAM YEAR 2017)
  – CMS exceeded the MIPS participation goal in 2017
  – MIPS was designed to be budget neutral = the penalties pay for incentives
  – Result: Fewer penalties accessed and more incentive payouts issued
  – Exceptional Performers (those with >70 Score) saw an average of .68%-2.02%

• FY2020 (PROGRAM YEAR 2018)
  – Adjustments +/- 5%

• FY2021 (PROGRAM YEAR 2019)
  – Budget neutrality must consider the proposed changes:
    • Opting In
    • Scaling Factor (page 811 of PR)
    • Minimum participation Performance Score is increasing to 30
    • Cost could bring scores down
    • Adjustments +/- 7%
ORGANIZATIONAL EFFORT

*It MUST start at the top.*

Submitting regulatory data to CMS requires a lot of important decisions. Decisions that impact . . .

YOUR SCORES,

YOUR REIMBURSEMENT,

AND YOUR REPUTATION.

That is why it is critical that decisions around regulatory program compliance start at the top. It is essential that leadership recognizes and supports reporting efforts, and that the value and importance of the programs are imprinted throughout an organization.
TEAM

T - Technical
E - Educational
A - Administrative
M - Medical
T.E.A.M.

T = Technical Staff
- EHR Superuser
- IT Director
- Security Official
- Interface Manager
- Staff responsible for updating to SNOMED, RxNorm, LOINC and other EHR tables

E = Educational Staff
- EHR Superuser
- Clinical Staff Lead
- Financial Impact Advisor

A = Administrative
- Administrative Representation
- Data Collection
- Data Reporting and/or Authorized Official

M = Medical
- Medical/Clinical Staff Lead
LEARNING is KEY.

• **Breadth** = full span of knowledge of a subject
• **Depth** = extent to which specific topics are focused upon, amplified and explored

KNOWLEDGE TRANSFER is ESSENTIAL.

PLANNING FOR THE UNEXPECTED is CRUCIAL.

• Time off
• Staff turn over
• Moving program targets
• Audits
PREPARATION STEPS
PLAN/REVIEW YOUR PARTICIPATION STRATEGY

• Which programs can you/should you participate in?
  – If you’ve been eligible for Medicaid EHR Incentives in the past, are you still eligible? Remember, you can participate in both Medicaid PI and QPP!
  – Consider the consequences (penalties) for non-participation.

• If eligible for QPP, will you submit as a group or individually?

• Which “stage” will you submit this year?
  – Do you need a system upgrade?

• If you’re a hospital, which attestation “method” will you choose?

• Engage your TEAM
PROGRAM DATA COLLECTION
GETTING WHAT YOU NEED TO REPORT

WORKFLOWS =
- Preferred documentation processes
- Communicated during training and in education materials

TRIGGERS =
- Data elements that when selected result in a specific outcome
- A single trigger result can result in multiple outcomes
The industry suggests that system retraining occurs every 2-3 years:
- ONC certification updates
- Regulatory Program changes
- Staff turnover and knowledge transfer

Joint effort between you and your EHR vendor:
- Workflow analysis
- Remediation plans
- Specific training to optimize EHR use to create efficiencies
- Updating your training materials library
PREPARATION STEPS
TEST YOUR ACCESS TO SUBMISSION SITES

**QualityNet**
Symantic VIP is required

**QPP**
Requires EIDM credentials
RESOURCES

Program Education
RESOURCES

Go Learn.

HOSPITAL-SPECIFIC:

• MU/PI - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligible_Hospital_Information.html

• IQR - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

• OQR - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalOutpatientQualityReportingProgram.html

• QUALITYNET - https://www.qualitynet.org

EVERYONE:

• eCQI - https://ecqi.healthit.gov

• QUALITY PAYMENT PROGRAM (QPP) - https://qpp.cms.gov


• Your local QIO/QIN

FAVORITE 3rd PARTY RESOURCES:

• SA Ignite - https://www.saignite.com

• HIMSS Learning Center - http://www.himsslearn.org
Contact Information

Email: MBowes@AzaleaHealth.com
Phone: 402.770.9875

www.AzaleaHealth.com
Thank you!