

Executive Summary

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 414

[CMS-5522-FC and IFC]

RIN 0938-AT13

Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period and interim final rule with comment period.

SUMMARY: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the Quality Payment Program for eligible clinicians. Under the Quality Payment Program, eligible clinicians can participate via one of two tracks: Advanced Alternative Payment Models (APMs); or the Merit-based Incentive Payment System (MIPS). We began implementing the Quality Payment Program through rulemaking for calendar year (CY) 2017. This final rule with comment period provides updates for the second and future years of the Quality Payment Program.

In addition, we also are issuing an interim final rule with comment period (IFC) that addresses extreme and uncontrollable circumstances MIPS eligible clinicians may face as a result of widespread catastrophic events affecting a region or locale in CY 2017, such as Hurricanes Irma, Harvey and Maria.

DATES: *Effective Date:* These provisions of this final rule with comment period and interim final rule with comment period are effective on January 1, 2018.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. ET on January 2, 2018.

ADDRESSES: In commenting, please refer to file code CMS-5522-FC when commenting on issues in the final rule with comment period, and CMS-5522-IFC when commenting on issues in

the interim final rule with comment period. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.
2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-FC or CMS-5522-IFC (as appropriate)
P.O. Box 8016
Baltimore, MD 21244-8016

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY:


Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5522-FC or CMS-5522-IFC (as appropriate)
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

A. For delivery in Washington, DC
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

B. For delivery in Baltimore, MD:



Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

Executive Summary and Background

A. Overview


This final rule with comment period makes payment and policy changes to the Quality Payment Program. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, enacted April 16, 2015) amended Title XVIII of the Social Security Act (the Act) to repeal the Medicare sustainable growth rate (SGR) formula, to reauthorize the Children's Health Insurance Program (CHIP), and to strengthen Medicare access by improving physician and other clinician payments and making other improvements. The MACRA advances a forward-looking, coordinated framework for clinicians to successfully take part in the Quality Payment Program that rewards value and outcomes in one of two ways:

- Advanced Alternative Payment Models (Advanced APMs).
- Merit-based Incentive Payment System (MIPS).

Our goal is to support patients and clinicians in making their own decisions about health care using data driven insights, increasingly aligned and meaningful quality measures, and innovative technology. To implement this vision, the Quality Payment Program emphasizes high-value care and patient outcomes while minimizing burden on eligible clinicians. The Quality Payment Program is also designed to be flexible, transparent, and structured to improve over time with input from clinicians, patients, and other stakeholders.

In today's health care system, we often pay doctors and other clinicians based on the number of services they perform rather than patient health outcomes. The good work that clinicians do is not limited to conducting tests or writing prescriptions, but also taking the time to have a conversation with a patient about test results, being available to a patient through telehealth or expanded hours, coordinating medicine and treatments to avoid confusion or errors, and developing care plans.

The Quality Payment Program takes a comprehensive approach to payment by basing consideration of quality on a set of evidenced-based measures that were primarily developed by clinicians, thus encouraging improvement in clinical practice and supporting by advances in technology that allow for the easy exchange of information. The Quality Payment Program also



offers special incentives for those participating in certain innovative models of care that provide an alternative to fee-for-service payment.


We have sought and will continue to seek feedback from the health care community through various public avenues such as rulemaking, listening sessions and stakeholder engagement. We understand that technology, infrastructure, physician support systems, and clinical practices will change over the next few years and are committed to refine our policies for the Quality Payment Program with those factors in mind.

We are aware of the diversity among clinician practices in their experience with quality-based payments and expect the Quality Payment Program to evolve over multiple years. The groundwork has been laid for expansion toward an innovative, patient-centered, health system that is both outcome focused and resource effective. A system that leverages health information technology to support clinicians and patients and builds collaboration across care settings. The Quality Payment Program: (1) supports care improvement by focusing on better outcomes for patients, and preserving the independent clinical practice; (2) promotes the adoption of APMs that align incentives for high-quality, low-cost care across healthcare stakeholders; and (3) advances existing delivery system reform efforts, including ensuring a smooth transition to a healthcare system that promotes high-value, efficient care through unification of CMS legacy programs.

In the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models final rule with comment period (81 FR 77008, November 4, 2016), referred to as the “CY 2017 Quality Payment Program final rule,” we established incentives for participation in Advanced APMs, supporting the goals of transitioning from fee-for-service (FFS) payments to payments for quality and value. The CY 2017 Quality Payment Program final rule included definitions and processes to determine Qualifying APM Participants (QPs) in Advanced APMs. The CY 2017 Quality Payment Program final rule also established the criteria for use by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in making comments and recommendations to the Secretary on proposals for physician-focused payment models (PFPMs).

The CY 2017 Quality Payment Program final rule also established policies to implement MIPS, which consolidated certain aspects of the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs) and made CY 2017 the transition year for clinicians under the Quality Payment Program. As prescribed by MACRA, MIPS focuses on the following: (1) quality—including a set of evidence-based, specialty-specific standards; (2) cost; (3) practice-based improvement activities; and (4) use of certified electronic health record (EHR) technology (CEHRT) to support interoperability and advanced quality objectives in a single, cohesive program that avoids redundancies.

This CY 2018 final rule with comment period continues to build and improve upon our transition year policies, as well as, address elements of MACRA that were not included in the first year of the program, including virtual groups, beginning with the CY 2019 performance period facility-



based measurement, and improvement scoring. This final rule with comment period implements policies for “Quality Payment Program Year 2,” some of which will continue into subsequent years of the Quality Payment Program.

We have also included an interim final rule with comment period to establish an automatic extreme and uncontrollable circumstance policy for the 2017 MIPS performance period that recognizes recent hurricanes (Harvey, Irma, and Maria) and other natural disasters can effectively impede a MIPS eligible clinician’s ability to participate in MIPS.


B. Quality Payment Program Strategic Objectives

After extensive outreach with clinicians, patients and other stakeholders, we created 7 strategic objectives to drive continued progress and improvement. These objectives help guide our final policies and future rulemaking in order to design, implement, and advance a Quality Payment Program that aims to improve health outcomes, promote efficiency, minimize burden of participation, and provide fairness and transparency in operations.

These strategic objectives are as follows: (1) to improve beneficiary outcomes and engage patients through patient-centered Advanced APM and MIPS policies; (2) to enhance clinician experience through flexible and transparent program design and interactions with easy-to-use program tools; (3) to increase the availability and adoption of robust Advanced APMs; (4) to promote program understanding and maximize participation through customized communication, education, outreach and support that meet the needs of the diversity of physician practices and patients, especially the unique needs of small practices; (5) to improve data and information sharing on program performance to provide accurate, timely, and actionable feedback to clinicians and other stakeholders; (6) to deliver IT systems capabilities that meet the needs of users for data submission, reporting, and improvement and are seamless, efficient and valuable on the front and back-end; and (7) to ensure operation excellence in program implementation and ongoing development; and to design the program in a manner that allows smaller independent and rural practices to be successful. More information on these objectives and the Quality Payment Program can be found at qpp.cms.gov.

Stakeholder feedback is the hallmark of the Quality Payment Program. We solicited and reviewed nearly 1,300 comments and had over 100,000 physicians and other stakeholders attend our outreach sessions to help inform our policies for Quality Payment Program Year 2. We have set ambitious yet achievable goals for those clinicians interested in APMs, as they are a vital part of bending the Medicare cost curve by encouraging the delivery of high-quality, low-cost care. To allow this program to work for all stakeholders, we further recognize that we must provide ongoing education, support, and technical assistance so that clinicians can understand program requirements, use available tools to enhance their practices, and improve quality and progress toward participation in APMs if that is the best choice for their practice. Finally, we understand that we must achieve excellence in program management, focusing on customer needs while also promoting problem-solving, teamwork, and leadership to provide continuous improvements in the Quality Payment Program.

C. One Quality Payment Program



Clinicians have told us that they do not separate their patient care into domains, and that the Quality Payment Program needs to reflect typical clinical workflows in order to achieve its goal of better patient care. Advanced APMs, the focus of one pathway of the Quality Payment Program, contribute to better care and smarter spending by allowing physicians and other clinicians to deliver coordinated, customized, high-value care to their patients in a streamlined and cost-effective manner. Within MIPS, the second pathway of the Quality Payment Program, we believe that integration into typical clinical workflows can best be accomplished by making connections across the four statutory pillars of the MIPS incentive structure. Those four pillars are: (1) Quality; (2) Clinical Practice Improvement Activities (referred to as “Improvement Activities”); (3) meaningful use of CEHRT (referred to as “Advancing Care Information”); and (4) Resource Use (referred to as “Cost”).

Although there are two separate pathways within the Quality Payment Program, Advanced APMs and MIPS both contribute toward the goal of seamless integration of the Quality Payment Program into clinical practice workflows. Advanced APMs promote this seamless integration by way of payment methodology and design that incentivize care coordination. The MIPS builds the capacity of eligible clinicians across the four pillars of MIPS to prepare them for participation in APMs in later years of the Quality Payment Program. Indeed, the bedrock of the Quality Payment Program is high-value, patient-centered care, informed by useful feedback, in a continuous cycle of improvement. The principal way that MIPS measures quality of care is through a set of clinical quality measures (CQMs) from which MIPS eligible clinicians can select. The CQMs are evidence-based, and the vast majority are created or supported by clinicians. Over time, the portfolio of quality measures will grow and develop, driving towards outcomes that are of the greatest importance to patients and clinicians and away from process, or “check the box” type measures.

Through MIPS, we have the opportunity to measure clinical and patient outcomes, not only through evidence-based quality measures, but also by accounting for activities that clinicians and patients themselves identify: namely, practice-driven quality improvement. MIPS also requires us to assess whether CEHRT is used in a meaningful way and based on significant feedback, this area was simplified to support the exchange of patient information, engagement of patients in their own care through technology, and the way technology specifically supports the quality goals selected by the practice. And lastly, MIPS requires us to measure the cost of services provided through the cost performance category, which will contribute to a MIPS eligible clinician’s final score beginning in the second year of the MIPS.

We realize the Quality Payment Program is a big change. In this final rule with comment period, we continue the slow ramp-up of the Quality Payment Program by establishing special policies for MIPS Year 2 aimed at encouraging successful participation in the program while reducing burden, reducing the number of clinicians required to participate, and preparing clinicians for the CY 2019 performance period (CY 2021 payment year). Our hope is for the program to evolve to the point where all the clinical activities captured in MIPS across the four performance categories reflect the single, unified goal of quality improvement.

D. Summary of the Major Provisions

1. Quality Payment Program Year 2

We believe the second year of the Quality Payment Program should build upon the foundation that has been established which provides a trajectory for clinicians to value-based care. A second year to ramp-up the program will continue to help build upon the iterative learning and development of year 1 in preparation for a robust program in year 3.

2. Small Practices

The support of small, independent practices remains an important thematic objective for the implementation of the Quality Payment Program and is expected to be carried throughout future rulemaking. Many small practices did not have to participate in MIPS during the transition year due to the low-volume threshold, which was set for the CY 2017 performance period at less than or equal to \$30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare Part B patients. We have heard feedback that many small practices still face challenges in their ability to participate in the program. We are implementing additional flexibilities for Year 2 including: implementing the virtual groups provisions; increasing the low-volume threshold to less than or equal to \$90,000 in Medicare Part B allowed charges or less than or equal to 200 Medicare Part B patients; adding a significant hardship exception from the advancing care information performance category for MIPS eligible clinicians in small practices; providing 3 points even if small practices submit quality measures below data completeness standards; and providing bonus points that are added to the final scores of MIPS eligible clinicians who are in small practices. We believe that these additional flexibilities and reduction in barriers will further enhance the ability of small practices to participate successfully in the Quality Payment Program.

In keeping with the objectives to provide education about the Quality Payment Program and maximize participation, and as mandated by the statute, during a period of 5 years, \$100 million in funding was provided for technical assistance to be available to provide guidance and assistance to MIPS eligible clinicians in small practices through contracts with regional health collaboratives, and others. Guidance and assistance on the MIPS performance categories or the transition to APM participation will be available to MIPS eligible clinicians in practices of 15 or fewer clinicians with priority given to practices located in rural areas or medically underserved areas (MUAs), and practices with low MIPS final scores. More information on the technical assistance support available to small practices can be found at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/SURS-Fact-Sheet.pdf>.

We have also performed an updated regulatory impact analysis, accounting for flexibilities, many of which are continuing into the Quality Payment Program Year 2, that have been created to ease the burden for small and solo practices.

3. Summary of Major Provisions for Advanced Alternative Payment Models (Advanced APMs)

a. Overview

APMs represent an important step forward in our efforts to move our healthcare system from volume-based to value-based care. Our existing APM policies provide opportunities that support state flexibility, local leadership, regulatory relief, and innovative approaches to improve quality, accessibility, and affordability.

APMs that meet the criteria to be Advanced APMs provide the pathway through which eligible clinicians, many of whom who would otherwise fall under the MIPS, can become Qualifying APM Participants (QPs), thereby earning incentives for their Advanced APM participation. In the CY 2017 Quality Payment Program final rule, we estimated that 70,000 to 120,000 eligible clinicians would be QPs for payment year 2019 based on Advanced APM participation in performance year 2017 (81 FR 77516). With new Advanced APMs expected to be available for participation in 2018, including the Medicare ACO Track 1 Plus (1+) Model, and the addition of new participants for some current Advanced APMs, such as the Next Generation ACO Model and Comprehensive Primary Care Plus (CPC+) Model, we anticipate higher numbers of QPs in subsequent years of the program. We currently estimate that approximately 185,000 to 250,000 eligible clinicians may become QPs for payment year 2020 based on Advanced APM participation in performance year 2018.


b. Advanced APMs

In the CY 2017 Quality Payment Program final rule, to be considered an Advanced APM, we finalized that an APM must meet all three of the following criteria, as required under section 1833(z)(3)(D) of the Act: (1) The APM must require participants to use CEHRT; (2) The APM must provide for payment for covered professional services based on quality measures comparable to those in the quality performance category under MIPS; and (3) The APM must either require that participating APM Entities bear risk for monetary losses of a more than nominal amount under the APM, or be a Medical Home Model expanded under section 1115A(c) of the Act (81 FR 77408).

We are maintaining the generally applicable revenue-based nominal amount standard at 8 percent for QP Performance Periods 2019 and 2020. We are exempting participants in Round 1 of the CPC+ Model as of January 1, 2017 from the 50 eligible clinician limit as proposed. We are also finalizing a more gradual ramp-up in percentages of revenue for the Medical Home Model nominal amount standard over the next several years.

c. Qualifying APM Participant (QP) and Partial QP Determinations

QPs are eligible clinicians in an Advanced APM who have met a threshold percentage of their patients or payments through an Advanced APM or, beginning in performance year 2019, attain QP status through the All-Payer Combination Option. Eligible clinicians who are QPs for a year are excluded from the MIPS reporting requirements and payment adjustment for the year, and receive a 5 percent APM Incentive Payment for the year in years from 2019 through 2024. The



statute sets thresholds for the level of participation in Advanced APMs required for an eligible clinician to become a QP for a year.

We are finalizing that for Advanced APMs that start or end during the QP Performance Period and operate continuously for a minimum of 60 days during the QP Performance Period for the year, we are making QP determinations using payment or patient data only for the dates that APM Entities were able to participate in the Advanced APM per the terms of the Advanced APM, not for the full QP Performance Period.

Eligible clinicians who participate in Advanced APMs but do not meet the QP or Partial QP thresholds are subject to MIPS reporting requirements and payment adjustments unless they are otherwise excluded from MIPS.

d. All-Payer Combination Option

The All-Payer Combination Option, which uses a calculation based on an eligible clinician's participation in both Advanced APMs and Other Payer Advanced APMs to make QP determinations, is applicable beginning in performance year 2019. To become a QP through the All-Payer Combination Option, an eligible clinician must participate in an Advanced APM with CMS as well as an Other Payer Advanced APM. We determine whether other payer arrangements are Other Payer Advanced APMs based on information submitted to us by eligible clinicians, APM Entities, and in some cases by payers, including states and Medicare Advantage Organizations. In addition, the eligible clinician or the APM Entity must submit information to CMS so that we can determine whether the eligible clinician meets the requisite QP threshold of participation.

To be an Other Payer Advanced APM, as set forth in section 1833(z)(2)(B)(ii) and (C)(ii) of the Act and implemented in the CY 2017 Quality Payment Program final rule, a payment arrangement with a payer (for example, payment arrangements authorized under Title XIX, Medicare Health Plan payment arrangements, and payment arrangements in CMS Multi-Payer Models) must meet all three of the following criteria: (1) CEHRT is used; (2) the payment arrangement must require the use of quality measures comparable to those in the quality performance category under MIPS; and (3) the payment arrangement must either require the APM Entities to bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures, or be a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models expanded under section 1115A(c) of the Act.

In this final rule with comment period, we are finalizing policies that provide more detail about how the All-Payer Combination Option will operate. We are finalizing that an other payer arrangement would meet the generally applicable revenue-based nominal amount standard we proposed if, under the terms of the other payer arrangement, the total amount that an APM Entity potentially owes the payer or foregoes is equal to at least: for the 2019 and 2020 QP Performance Periods, 8 percent of the total combined revenues from the payer of providers and suppliers in participating APM Entities only for arrangements that are expressly defined in terms of revenue. We are also finalizing a more gradual ramp-up in percentages of revenue for the Medicaid Medical Home Model nominal amount standard over the next several years.

We are finalizing the Payer Initiated and Eligible Clinician Other Payer Advanced APM determination processes to allow payers, APM Entities, or eligible clinicians to request that we determine whether other payer arrangements meet the Other Payer Advanced APM criteria. We have also finalized requirements pertaining to the submission of information.

We are finalizing certain modifications to how we calculate Threshold Scores and make QP determinations under the All-Payer Combination Option. We are retaining the QP Performance Period for the All-Payer Combination Option from January 1 through August 31 of each year as finalized in the CY 2017 Quality Payment Program final rule.

e. Physician-Focused Payment Models (PFPMs)

The PTAC is an 11-member federal advisory committee that is an important avenue for the creation of innovative payment models. The PTAC is charged with reviewing stakeholders' proposed PFPMs, and making comments and recommendations to the Secretary regarding whether they meet the PFPM criteria established by the Secretary through rulemaking in the CY 2017 Quality Payment Program final rule. The Secretary is required to review the comments and recommendations submitted by the PTAC and post a detailed response to these recommendations on the CMS Website.


We sought comments on broadening the definition of PFPM to include payment arrangements that involve Medicaid or the Children's Health Insurance Program (CHIP) as a payer even if Medicare is not included as a payer. We are maintaining the current definition of a PFPM to include only payment arrangements with Medicare as a payer. We believe this definition retains focus on APMs and Advanced APMs, which would be proposals that the Secretary has more direct authority to implement, while maintaining consistency for PTAC's review while they are still refining their processes. In addition, we sought comment on the Secretary's criteria and stakeholders' needs in developing PFPM proposals aimed at meeting the criteria.

4. Summary of Major Provisions for the Merit-based Incentive Payment System (MIPS)

For Quality Payment Program Year 2, which is the second year of the MIPS and includes the 2018 performance period and the 2020 MIPS payment year, as well as the following:

a. Quality

We previously finalized that the quality performance category would comprise 60 percent of the final score for the transition year and 50 percent of the final score for the 2020 MIPS payment year (81 FR 77100). While we proposed to maintain a 60 percent weight for the quality performance category for the 2020 MIPS payment year, we are not finalizing this proposal and will be keeping our previously finalized policy to weight the quality performance category at 50 percent for the 2020 MIPS payment year. We are also finalizing that for purposes of the 2021 MIPS payment year, the performance period for the quality and cost performance categories is CY 2019 (January 1, 2019 through December 31, 2019). We note that we had previously finalized that for the purposes of the 2020 MIPS payment year the performance period for the



quality and cost performance categories is CY 2018 (January 1, 2018 through December 31, 2018). We did not make proposals to modify this time frame in the CY 2018 Quality Payment Program proposed rule and are therefore unable to modify this performance period.


Quality measures are selected annually through a call for quality measures under consideration, with a final list of quality measures being published in the Federal Register by November 1 of each year. We are finalizing for the CAHPS for MIPS survey for the Quality Payment Program Year 2 and future years that the survey administration period will, at a minimum, span over 8 weeks and, at a maximum, 17 weeks and will end no later than February 28th following the applicable performance period. In addition, we are finalizing for the Quality Payment Program Year 2 and future years to remove two Summary Survey Modules (SSMs), specifically, “Helping You to Take Medication as Directed” and “Between Visit Communication” from the CAHPS for MIPS survey.

For the 2018 MIPS performance period, we previously finalized that the data completeness threshold would increase to 60 percent for data submitted on quality measures using QCDRs, qualified registries, via EHR, or Medicare Part B claims. While we proposed to maintain a 50 percent data completeness threshold for the 2018 MIPS performance period, we are not finalizing this proposal and will be keeping our previously finalized data completeness threshold of 60 percent for data submitted on quality measures using QCDRs, qualified registries, EHR, or Medicare Part B claims for the 2018 MIPS performance period. We also proposed to have the data completeness threshold for the 2021 MIPS payment year (2019 performance period) to 60 percent for data submitted on quality measures using QCDRs, qualified registries, EHR, or Medicare Part B claims. We are also finalizing this proposal. We anticipate that as MIPS eligible clinicians gain experience with the MIPS we will propose to further increase these thresholds over time.

b. Improvement Activities

Improvement activities are those that improve clinical practice or care delivery and that, when effectively executed, are likely to result in improved outcomes. We believe improvement activities support broad aims within healthcare delivery, including care coordination, beneficiary engagement, population management, and health equity. For the 2020 MIPS payment year, we previously finalized that the improvement activities performance category would comprise 15 percent of the final score (81 FR 77179). There are no changes in improvement activities scoring for Quality Payment Program Year 2 (2018 MIPS performance period) as discussed in section II.C.7.a.(5) of this final rule with comment period. However, in this final rule, we are finalizing our proposal to no longer require self-identifications for non-patient facing MIPS eligible clinicians, small practices, practices located in rural areas or geographic HPSAs, or any combination thereof, beginning with the 2018 MIPS performance period and for future years.

We are finalizing that for Quality Payment Program Year 2 and future years (2018 MIPS performance period and future years), MIPS eligible clinicians or groups must submit data on improvement activities in one of the following manners: via qualified registries, EHR submission mechanisms, QCDR, CMS Web Interface, or attestation; and that for activities that are




performed for at least a continuous 90 days during the performance period, MIPS eligible clinicians must submit a yes response for activities within the Improvement Activities Inventory.

In this final rule with comment period, we are finalizing updates to the Improvement Activities Inventory. Specifically, as discussed in the appendices (Tables F and G) of this final rule with comment period, we are finalizing 21 new improvement activities (some with modification) and changes to 27 previously adopted improvement activities (some with modification and including 1 removal) for the Quality Payment Program Year 2 and future years (2018 MIPS performance period and future years) Improvement Activities Inventory. These activities were recommended by clinicians, patients and other stakeholders interested in advancing quality improvement and innovations in healthcare. We will continue to seek new improvement activities as the program evolves. Additionally, we are finalizing several policies related to submission of improvement activities. In particular, we are formalizing the annual call for activities process for Quality Payment Program Year 3 and future years. We are finalizing with modification, for the Quality Payment Program Year 3 and future years, that stakeholders should apply one or more of the criteria when submitting improvement activities in response to the Annual Call for Activities. In addition to the criteria listed in the proposed rule for nominating new improvement activities for the Annual Call for Activities policy, we are modifying and expanding the proposed criteria list to also include: (1) improvement activities that focus on meaningful actions from the person and family's point of view, and (2) improvement activities that support the patient's family or personal caregiver. In addition, we are finalizing to: (1) accept submissions for prospective improvement activities at any time during the performance period for the Annual Call for Activities and create an Improvement Activities Under Review (IAUR) list; (2) only consider prospective activities submitted by March 1 for inclusion in the Improvement Activities Inventory for the performance periods occurring in the following calendar year; and (3) add new improvement activities and subcategories through notice-and-comment rulemaking in future years of the Quality Payment Program.

Additionally, we are finalizing that for purposes of the 2021 MIPS payment year, the performance period for the improvement activities performance category is a minimum of a continuous 90-day period within CY 2019, up to and including the full CY 2019 (January 1, 2019 through December 31, 2019).

In this final rule with comment period, we are also expanding our definition of how we will recognize an individual MIPS eligible clinician or group as being a certified patient-centered medical home or comparable specialty practice. We are finalizing our proposal, with clarification, that at least 50 percent of the practice sites within the TIN must be recognized as a patient-centered medical home or comparable specialty practice to receive full credit as a certified or recognized patient-centered medical home or comparable specialty practice for the 2020 MIPS payment year and future years. We are clarifying that a practice site as is the physical location where services are delivered. We proposed in section II.C.6.e.(3)(b) of the proposed rule (82 FR 30054) that eligible clinicians in practices that have been randomized to the control group in the CPC+ model would also receive full credit as a Medical Home Model. We are not finalizing this proposal, however, because CMMI has not randomized any practices into a control group in CPC+ Round 2.



We are also finalizing changes to the study, including modifying the name to the “CMS Study on Burdens Associated with Reporting Quality Measures,” increasing the sample size for 2018, and updating requirements.

Furthermore, in recognition of improvement activities as supporting the central mission of a unified Quality Payment Program, we are finalizing in section II.C.6.e.(3)(a) of this final rule with comment period to continue to designate activities in the Improvement Activities Inventory that will also qualify for the advancing care information bonus score. This is consistent with our desire to recognize that CEHRT is often deployed to improve care in ways that our programs should recognize.


c. Advancing Care Information

For the Quality Payment Program Year 2, the advancing care information performance category is 25 percent of the final score. However, if a MIPS eligible clinician is participating in a MIPS APM the advancing care information performance category may be 30 percent or 75 percent of the final score depending on the availability of APM quality data for reporting. We are finalizing that for purposes of the 2021 MIPS payment year, the performance period for advancing care information performance category is a minimum of a continuous 90-day period within CY 2019, up to and including the full CY 2019 (January 1, 2019 through December 31, 2019).

Objectives and measures in the advancing care information performance category focus on the secure exchange of health information and the use of CEHRT to support patient engagement and improved healthcare quality. While we continue to recommend that physicians and clinicians migrate to the implementation and use of EHR technology certified to the 2015 Edition so they may take advantage of improved functionalities, including care coordination and technical advancements such as application programming interfaces, or APIs, we recognize that some practices may have challenges in adopting new certified health IT. Therefore, we are finalizing that MIPS eligible clinicians may continue to use EHR technology certified to the 2014 Edition for the performance period in CY 2018. Clinicians may also choose to use the 2015 Edition CEHRT or a combination of the two. Clinicians will earn a bonus for using only 2015 CEHRT in 2018.

For the 2018 performance period, MIPS eligible clinicians will have the option to report the Advancing Care Information Transition Objectives and Measures using 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of 2014 and 2015 Edition CEHRT, as long as the EHR technology they possess can support the objectives and measures to which they plan to attest. Similarly, MIPS eligible clinicians will have the option to attest to the Advancing Care Information Objectives and Measures using 2015 Edition CEHRT or a combination of 2014 and 2015 Edition CEHRT, as long as their EHR technology can support the objectives and measures to which they plan to attest.

We are finalizing exclusions for the e-Prescribing and Health Information Exchange Objectives beginning with the 2017 performance period. We are also finalizing that eligible clinicians can earn 10 percentage points in their performance score for reporting to any single public health agency or clinical data registry to meet any of the measures associated with the Public Health and Clinical Data Registry Reporting objective (or any of the measures associated with the




Public Health Reporting Objective of the 2018 Advancing Care Information Transition Objectives and Measures, for clinicians who choose to report on those measures) and, and will award an additional 5 percentage point bonus for reporting to more than one. We are implementing several provisions of the 21st Century Cures Act (Pub. L. 114-255, enacted on December 13, 2016) pertaining to hospital-based MIPS eligible clinicians, ambulatory surgical center-based MIPS eligible clinicians, MIPS eligible clinicians using decertified EHR technology, and significant hardship exceptions under the MIPS. We are also finalizing a significant hardship exception for MIPS eligible clinicians in small practices. For clinicians requesting a reweighting of the advancing care information performance category, we are changing the deadline for submission of this application to December 31 of the performance period. Lastly, we are finalizing additional improvement activities that are eligible for a 10 percent bonus under the advancing care information performance category if they are completed using CEHRT.

d. Cost

We previously finalized that the cost performance category would comprise zero percent of the final score for the transition year and 10 percent of the final score for the 2020 MIPS payment year (81 FR 77165). For the 2020 MIPS payment year, we proposed to change the weight of the cost performance category from 10 percent to zero percent (82 FR 30047). For the 2020 MIPS payment year, we are finalizing a 10 percent weight for the cost performance category in the final score in order to ease the transition to a 30 percent weight for the cost performance category in the 2021 MIPS payment year. For the 2018 MIPS performance period, we are adopting the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure that were adopted for the 2017 MIPS performance period, and we will not use the 10 episode-based measures that were adopted for the 2017 MIPS performance period. Although data on the episode-based measures has been made available to clinicians in the past, we are in the process of developing new episode-based measures with significant clinician input and believe it would be more prudent to introduce these new measures over time. We will continue to offer performance feedback on episode-based measures prior to potential inclusion of these measures in MIPS to increase clinician familiarity with the concept as well as specific episode-based measures. Specifically, we are providing feedback on these new episode-based cost measures for informational purposes only. We intend to provide performance feedback on the MSPB and total per capita cost measures by July 1, 2018, consistent with section 1848(q)(12) of the Act. In addition, we intend to offer feedback on newly developed episode-based cost measures in 2018 as well.

e. Submission Mechanisms

We are finalizing additional flexibility for submitting data through multiple submission mechanisms. Due to operational reasons and to allow additional time to communicate how this policy intersects with our measure applicability policies, this policy will not be implemented for the 2018 performance period but will be implemented instead for the 2019 performance period of the Quality Payment Program. Individual MIPS eligible clinicians or groups will be able to submit measures and activities, as available and applicable, via as many mechanisms as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories for the 2019 performance period. This option will provide



clinicians the ability to select the measures most meaningful to them, regardless of the submission mechanism.

Also, given stakeholder concerns regarding CMS' multiple submissions mechanism policy, we want to clarify that under the validation process for Year 3, MIPS eligible clinicians who submit via claims or registry submission only or a combination of claims and registry submissions would not be required to submit measures through other mechanisms to meet the quality performance category criteria; rather, it is an option available to MIPS eligible clinicians which may increase their quality performance category score. We expect that MIPS eligible clinicians would choose the submission mechanism that would give them 6 measures to report. Our intention is to offer multiple submission mechanisms to increase flexibility for MIPS individual clinicians and groups. We are not requiring that MIPS individual clinicians and groups submit via additional submission mechanisms; however, through this policy the option would be available for those that have applicable measures and/or activities available to them.


f. Virtual Groups

Virtual groups are a new way to participate in MIPS starting with the 2018 MIPS performance period. For the 2018 performance period, clinicians can participate in MIPS as an individual, as a group, as an APM Entity in a MIPS APM, or as a virtual group.

For the implementation of virtual groups as a participation option under MIPS, we are establishing the following policies. We are defining a virtual group as a combination of two or more TINs assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians that elect to form a virtual group for a performance period for a year. In order for solo practitioners or such groups to be eligible to join a virtual group, the solo practitioners and the groups would need to exceed the low-volume threshold. A solo practitioner or a group that does not exceed the low-volume threshold could not participate in a virtual group, and it is not permissible under the statute to apply the low-volume threshold at the virtual group level. Also, we are finalizing our virtual group policies to clearly delineate those group-related policies that apply to virtual groups versus policies that only apply to virtual groups.

Virtual groups are required to make an election to participate in MIPS as a virtual group prior to the start of an applicable performance period. We are also finalizing a two-stage virtual group election process for the applicable 2018 and 2019 performance periods. The first stage is the optional eligibility stage, but for practices that do not choose to participate in stage 1 of the election process, we will make an eligibility determination during stage 2 of the election process. The second stage is the virtual group formation stage. We are also finalizing that virtual groups must have a formal written agreement among each party of a virtual group. The election deadline will be December 31.

To provide support and reduce burden, we intend to make technical assistance (TA) available, to the extent feasible and appropriate, to support clinicians who choose to come together as a virtual group for the first 2 years of virtual group implementation applicable to the 2018 and 2019 performance years. Clinicians already receiving technical assistance may continue to do so for virtual groups support; otherwise, the Quality Payment Service Center is available to assist and connect virtual groups with a technical assistance representative. For year 2, we believe that we



have created an election process that is simple and straightforward. For Quality Payment Program Year 3, we intend to provide an electronic election process, if technically feasible.

Virtual groups are required to meet the requirements for each performance category and responsible for aggregating data for their measures and activities across the virtual group, for example, across their TINs. In future years, we intend to examine how we define “group” under MIPS with respect to flexibility in composition and reporting.

g. MIPS APMs

MIPS eligible clinicians who participate in MIPS APMs are scored using the APM scoring standard instead of the generally applicable MIPS scoring standard. For the 2018 performance period, we are finalizing modifications to the quality performance category reporting requirements and scoring for MIPS eligible clinicians in MIPS APMs, and other modifications to the APM scoring standard. For purposes of the APM scoring standard, we are adding a fourth snapshot date that would be used only to identify eligible clinicians in APM Entity groups participating in those MIPS APMs that require full TIN participation. This snapshot date will not be used to make QP determinations. Along with the other APM Entity groups, these APM Entity groups would be used for the purposes of reporting and scoring under the APM scoring standard described in the CY 2017 Quality Payment Program final rule (81 FR 77246).

h. Facility-based Measurement


We solicited comments on implementing facility-based measurement for the 2018 MIPS performance period and future performance periods to add more flexibility for clinicians to be assessed in the context of the facilities at which they work. We described facility-based measures policies related to applicable measures, applicability to facility-based measurement, group participation, and facility attribution. For clinicians whose primary professional responsibilities are in a healthcare facility we presented a method to assess performance in the quality and cost performance categories of MIPS based on the performance of that facility in another value-based purchasing program.

After much consideration, we are finalizing our proposal to allow clinicians to use facility-based measurement in year 3 (2019) of the Quality Payment Program. We will use the 2018 year to ensure that clinicians better understand the opportunity and ensure operational readiness to offer facility-based measurement.

i. Scoring

In the transition year of the Quality Payment Program, we finalized a unified scoring system to determine a final score across the 4 performance categories (81 FR 77273 through 77276). For the 2018 MIPS performance period, we will build on the scoring methodology we finalized for the transition year, focusing on encouraging MIPS eligible clinicians to meet data completeness requirements.

For quality performance category scoring, we are finalizing to extend some of the transition year policies to the 2018 MIPS performance period and also finalizing several modifications to existing policy. Quality measures that can be scored against a benchmark that meet data



completeness standards, and meet the minimum case size requirements will continue to receive between 3 and 10 points as measure achievement points. Measures that do not have a benchmark or meet the case minimum requirement will continue to receive 3 points.

For quality data submitted via EHR, QCDR, or qualified registry, we are lowering the number of points available for measures that do not meet the data completeness criteria to 1 point, except for a measure submitted by a small practice, which we will continue to assign 3 points.

We are finalizing a timeline to identify and propose to remove topped out quality measures through future rulemaking. We are evaluating additional considerations needed to maintain measures for important aspects of care, such as patient safety and high reliability, and will address this in future rulemaking. We are finalizing a policy of applying a scoring cap to identified topped out measures with measure benchmarks that have been topped out for at least 2 consecutive years; however, based on feedback, we will award up to 7 points for topped out measures rather than the 6 points originally proposed. We are finalizing the special scoring policy for the 6 measures identified for the 2018 performance period with a 7-point scoring cap.

We are also excluding CMS Web Interface measures from topped out scoring, but we will continue to monitor differences between CMS Web Interface and other submission options. We intend to address CAHPS through future rulemaking.

Beginning with the 2018 MIPS performance period, we are finalizing measuring improvement scoring at the performance category level for the quality performance category, but we will monitor this approach and revisit as needed through future rule making. We are finalizing measuring improvement scoring at the measure level for the cost performance category.

For the 2018 MIPS performance period, the quality, improvement activities, cost and advancing care information performance category scores will be given weight in the final score, or be reweighted if a performance category score is not available.

We are also finalizing small practice and complex patient bonuses only for the 2020 MIPS payment year. The small practice bonus of 5 points will be applied to the final score for MIPS eligible clinicians in groups, virtual groups, or APM Entities that have 15 or fewer clinicians and that submit data on at least one performance category in the 2018 performance period. We will also apply a complex patient bonus capped at 5 points using the dual eligibility ratio and average HCC risk score. We increased the complex patients bonus from 3 points as proposed in part to align with the small practice bonus. The final score will be compared against the MIPS performance threshold of 15 points for the 2020 MIPS payment year, a modest increase from 3 points in the transition year. A 15-point final score equal to the performance threshold can be achieved via multiple pathways and continues the gradual transition into MIPS. The additional performance threshold for exceptional performance will remain at 70 points, the same as for the transition year.

We are finalizing a policy of applying the MIPS payment adjustment to the Medicare paid amount.

j. Performance Feedback

We proposed and are finalizing the policy to provide Quality Payment Program performance feedback to eligible clinicians and groups. Initially, we will provide performance feedback on an annual basis. In future years, we aim to provide performance feedback on a more frequent basis, which is in line with clinician requests for timely, actionable feedback that they can use to improve care.

k. Third Party Intermediaries

In the CY 2017 Quality Payment Program final rule (81 FR 77362), we finalized that qualified registries, QCDRs, health IT vendors, and CMS-approved survey vendors will have the ability to act as intermediaries on behalf of individual MIPS eligible clinicians and groups for submission of data to CMS across the quality, improvement activities, and advancing care information performance categories.

Regarding QCDRs and qualified registries, we are finalizing our proposal to eliminate the self-nomination submission method of email and require that QCDRs and qualified registries submit their self-nomination applications via a web-based tool for future program years beginning with the 2018 performance period. Beginning with the 2019 performance period, we are finalizing the use of a simplified self-nomination process for previously approved QCDRs and qualified registries in good standing.

In addition, regarding information a QCDR specifically must provide to us at the time of self-nomination, we are making a number of clarifications, finalized that the term “QCDR measures” will replace the existing term of “non-MIPS measures”, and sought public input on requiring full development and testing of QCDR measures by submission. We have also made a few clarifications to existing criteria as they pertain to qualified registries.

We are not making any changes to the health IT vendors that obtain data from CEHRT requirements. Regarding CMS-approved survey vendors, we are finalizing that for the Quality Payment Program year 2, and for future years, that the vendor application deadline be January 31st of the applicable performance year or a later date specified by CMS. Lastly, based on comments we received on the 10-year record retention period and our interest in reducing financial and time burdens under this program and having consistent policies across this program, we are aligning our record retention period across the program by modifying our proposal for third parties from 10 years to finalize a 6-year retention period. Therefore, we are finalizing that entities must retain all data submitted to us for purposes of MIPS for a 6 years from the end of the MIPS performance period.

l. Public Reporting

As discussed in section II.C.11. of this final rule with comment period, we proposed and are finalizing public reporting of certain eligible clinician and group Quality Payment Program information, including MIPS and APM data in an easily understandable format as required under the MACRA.

m. Eligibility and Exclusion Provisions of the MIPS Program

We are modifying the definition of a non-patient facing MIPS eligible clinician to apply to virtual groups. In addition, we are finalizing our proposal to specify that groups considered to be non-patient facing (more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician) during the non-patient facing determination period would automatically have their advancing care information performance category reweighted to zero.


Additionally, we are finalizing our proposal to increase the low-volume threshold to less than or equal to \$90,000 in Medicare Part B allowed charges or 200 or fewer Part-B enrolled Medicare beneficiaries to further decrease burden on MIPS eligible clinicians that practice in rural areas or are part of a small practice or are solo practitioners. We are not finalizing our proposal to provide clinicians the ability to opt-in to MIPS if they meet or exceed one, but not all, of the low-volume threshold determinations, including as defined by dollar amount, beneficiary count or, if established, items and services. We intend to revisit this policy in future rulemaking and are seeking comment on methods to implement this policy in a low burden manner.

E. Payment Adjustments

For the 2020 payment year based on Advanced APM participation in 2018 performance period, we estimated that approximately 185,000 to 250,000 clinicians will become QPs, and therefore, be excluded from the MIPS reporting requirements and payment adjustment, and qualify for a lump sum APM incentive payment equal to 5 percent of their estimated aggregate payment amounts for covered professional services in the preceding year. We estimate that the total lump sum APM incentive payments will be between approximately \$675 million and \$900 million for the 2020 Quality Payment Program payment year. This expected growth in QPs between the first and second year of the program is due in part to reopening of CPC+ and Next Generation ACO for 2018, and the Medicare ACO Track 1+ Model which is projected to have a large number of participants, with a large majority reaching QP status.

Under the policies in this final rule with comment period, and for purposes of the Regulatory Impact Analysis, we estimate that approximately 622,000 eligible clinicians will be subject to MIPS reporting requirements and payment adjustments in the 2018 MIPS performance period. However, this number may vary depending on the number of eligible clinicians excluded from MIPS based on their status as QPs or Partial QPs. After restricting the population to eligible clinician types who are not newly enrolled, we believe the increase in the low-volume threshold is expected to exclude 540,000 clinicians who do not exceed the low-volume threshold. In the 2020 MIPS payment year, MIPS payment adjustments will be applied based on MIPS eligible clinicians' performance on specified measures and activities within four integrated performance categories.

Assuming that 90 percent of MIPS eligible clinicians of all practice sizes participate in MIPS, we estimate that MIPS payment adjustments will be approximately equally distributed between negative MIPS payment adjustments of \$118 million and positive MIPS payment adjustments of \$118 million to MIPS eligible clinicians, as required by the statute to ensure budget neutrality. Positive MIPS payment adjustments will also include up to an additional \$500 million for




exceptional performance to MIPS eligible clinicians whose final score meets or exceeds the additional performance threshold of 70 points. These MIPS payment adjustments are expected to drive quality improvement in the provision of MIPS eligible clinicians' care to Medicare beneficiaries and to all patients in the health care system. However, the distribution will change based on the final population of MIPS eligible clinicians for CY 2020 and the distribution of scores under the program. We believe that starting with these modest initial MIPS payment adjustments is in the long-term best interest of maximizing participation and starting the Quality Payment Program off on the right foot, even if it limits the magnitude of MIPS positive adjustments during the 2018 MIPS performance period. The increased availability of Advanced APM opportunities, including through Medical Home models, also provides earlier avenues to earn APM incentive payments for those eligible clinicians who choose to participate.

F. Benefits and Costs of the Final Rule with Comment Period

We quantify several costs associated with this rule. We estimate that this final rule with comment period will result in approximately \$694 million in collection of information-related burden. We estimate that the incremental collection of information-related burden associated with this final rule with comment period is a reduction of approximately \$13.9 million relative to the estimated burden of continuing the policies the CY 2017 Quality Payment Program final rule, which is \$708 million. We also estimate regulatory review costs of \$2.2 million for this final rule with comment period. We estimate that federal expenditures will include \$118 million in revenue neutral payment adjustments and \$500 million for exceptional performance payments. Additional federal expenditures include approximately \$675-\$900 million in APM incentive payments to QPs.

G. Automatic Extreme and Uncontrollable Circumstance Policy Interim Final Rule with Comment Period

In order to account for Hurricanes Harvey, Irma, and Maria and other disasters that have occurred or might occur during the 2017 MIPS performance period, we are establishing in an interim final rule with comment period an automatic extreme and uncontrollable circumstance policy for the quality, improvement activities, and advancing care information performance categories for the 2017 MIPS performance period. We believe the automatic extreme and uncontrollable circumstance policy will reduce clinician burden during a catastrophic time and will also align with Medicare policies in other programs such as the Hospital IQR Program. Under this policy, we will apply the extreme and uncontrollable circumstance policies for the MIPS performance categories to individual MIPS eligible clinicians for the 2017 MIPS performance period without requiring a MIPS eligible clinician to submit an application when we determine a triggering event, such as a hurricane, has occurred and the clinician is in an affected area. We will automatically weight the quality, improvement activities, and advancing care information performance categories at zero percent of the final score, resulting in a final score equal to the performance threshold, unless the MIPS eligible clinician submits MIPS data which we would then score on a performance-category-by-performance-category-basis, like all other MIPS eligible clinicians. We are not making any changes to the APM scoring standard policies that apply in 2017 for participants in MIPS APMs. We are waiving notice and comment



and adopting this policy on an interim final basis due to the urgency of providing relief for MIPS eligible clinicians impacted by recent natural disasters during the 2017 MIPS performance period.

H. Stakeholder Input

In developing this final rule with comment period, we sought feedback from stakeholders and the public throughout the process, including in the CY 2018 Quality Payment Program proposed rule, CY 2017 Quality Payment Program final rule with comment period, listening sessions, webinars, and other listening venues. We received a high degree of interest from a broad spectrum of stakeholders. We thank our many commenters and acknowledge their valued input throughout the rulemaking process. We summarize and respond to comments on our proposals in the appropriate sections of this final rule with comment period, though we are not able to address all comments or all issues that all commenters raised due to the volume of comments and feedback. Specifically, due to the volume of comments we have not summarized feedback from commenters on items we solicited feedback on for future rulemaking purposes. However, in general, commenters continue to be supportive as we continue implementation of the Quality Payment Program and maintain optimism as we move from FFS Medicare payment towards a payment structure focused on the quality and value of care. Public support for our proposed approach and policies in the proposed rule, which many were finalized, focused on the potential for improving the quality of care delivered to beneficiaries and increasing value to the public—while rewarding eligible clinicians for their efforts. Additionally we note that we received a number of comments from stakeholders in regards to the application of MIPS to certain Part B drugs. Additional guidance on the applicability of MIPS to Part B drugs can be found on our website at qpp.cms.gov.

We thank stakeholders again for their responses throughout our process, in various venues, including comments on the Request for Information Regarding Implementation of the Merit-based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models (herein referred to as the MIPS and APMs RFI) (80 FR 59102 through 59113) and the CY 2017 Quality Payment Program final rule (81 FR 77008 through 77831). We intend to continue open communication with stakeholders, including consultation with tribes and tribal officials, on an ongoing basis as we develop the Quality Payment Program in future years.

We will continue to offer help so clinicians can be successful in the program and make informed decisions about how to participate. You can find out more about the help that's available at qpp.cms.gov, which has many free and customized resources, or by calling 1-866-288-8292. As with the policy decisions, stakeholder feedback is essential to the development of educational resources as well. We look forward to your feedback on existing or the need for new resources.