AAFP Response
The AAFP agrees that both individual MIPS-eligible clinicians and groups should be able to submit quality, CPIA, and ACI data via a qualified third party (defined as a qualified registry, QCDR, or EHR submission). We agree that individual MIPS-eligible clinicians should be able to report quality data via Medicare Part B claims and report CPIA and ACI data via attestation, and agree that groups should be able to report CPIA and ACI data via attestation.

We appreciate the fact that eligible clinicians will be allowed to report performance data using different submission methods. If an eligible clinician submits data via multiple mechanisms, we agree that CMS should score all options and use the highest performance score.

However, while we appreciate the fact that ONC points out it may reduce administrative burden to report quality, CPIA and ACI performance data by using the same single third-party submission mechanism, we do not support a requirement in future years for a single submission mechanism for all three of these performance categories. Not only is it likely not possible, as ONC points out, that vendors would be able to become qualified to submit data for each of these performance categories within the first year, but it is also possible that a vendor has no desire to become qualified to submit data for all three of these performance categories. It is also possible that eligible clinicians and groups may prefer to continue to report quality, CPIA, and ACI data via separate submission mechanisms. We continue to support modular qualification of third-party intermediaries, who will become qualified for only those performance categories for which they will submit data on behalf of eligible clinicians. Likewise, we continue to support freedom of choice for eligible clinicians and groups in the submission mechanism to be used for each different performance category. We do, however, recommend that ONC disseminate clear messaging to third-party data submission intermediaries that it could behoove them to become qualified to submit data for the three performance categories of Quality, CPIA, and ACI data, as reporting these three categories via the same submission mechanism may reduce administrative burden for eligible clinicians; thus, there is a strong potential for increased market demand for third-party data submission intermediaries qualified to submit data for all three performance categories. If eligible clinicians prefer to use a single vendor for submission of all categories of data, they could then opt to select a vendor that is qualified to submit data for each performance category. However, if it makes more sense for an eligible clinician to continue to utilize vendors or third parties already in place, each qualified to report on different categories, rather than to purchase new technology or enter into new contractual relationships simply to obtain a single third-party qualified to report all categories of data, they are then able to do so. This would also limit eligible clinicians from having to pay for functionality that the vendor did not need to provide to its clients.

We agree that it makes sense for all eligible clinicians choosing to report within a group (other than a virtual group), rather than individually, that they should report using the same single submission mechanism for a given performance category. Any circumstances that would pose challenges in doing so (that would affect whether to report individually or in a group) could usually be reasonably foreseen before decision-making by the eligible clinician. However, because group practice membership has the potential to change within a reporting period (i.e., eligible clinicians may leave or join another practice), it is recommended that the final rule address terms of reporting for these scenarios, regardless of whether a third-party intermediary is used for data submission or whether the eligible clinician or group is reporting performance scores independently.

The following scenarios should be addressed: