submission mechanism should be eight weeks starting after January 1 and ending no later than March 31.

AAFP Response
We call for the period for data submission to be at least 90 days. The AAFP believes that a shorter time frame and submission deadline earlier than March 31st could be difficult for many eligible clinicians. Given that clinicians employed by health systems may not receive or have access to December data until February and cumulative year-to-date data following that, establishing an earlier submission deadline could result in clinicians being unable to meet the requirements. This could be extremely detrimental to clinicians' scoring and reimbursements, and penalize clinicians for lack of timely data availability and submission which is beyond their control.

The opportunity to submit throughout the performance period would be advantageous to some practices, but should not be required. Since all practices operate differently, some would find value in a one-time submission while others would appreciate multiple submission opportunities.

Simplification and standardization of submission periods, irrespective of submission mechanism, is recommended. To decrease confusion for MIPS-eligible clinicians as well as for CMS, the AAFP sees an advantage in aligning submission timeframes and setting the same end-date for all submission mechanisms. We suggest that all submission periods run from January 1 through March 31.

b. Quality Performance Category
CMS proposes that for the 2019 MIPS adjustment year, the Quality performance category will account for 50 percent of the CPS, subject to the Secretary's authority to assign different scoring weights under section 1848(q)(5)(F) of the Act. MIPS-eligible clinicians who fail to report on a required measure or activity will receive the lowest potential score applicable to the measure or activity. CMS proposes that MIPS-eligible clinicians must report six measures including one cross-cutting and one outcomes measure. If an outcome measure does not exist for any given sub-specialty, they can then report a high-priority measure. In addition, CMS asks if MIPS-eligible clinicians should be able to select from all measures or from the specialty-specific list. CMS seeks comments on the appropriateness of measures included in the specialty-specific measure set.

AAFP Response
The AAFP supports reasonable and achievable programs that promote continuous quality improvement and that measure patient experiences. The AAFP opposes an approach that requires physicians to report on a complex set of measures that do not impact or influence the quality of care provided to patients.

All measures used in MIPS and APMs must be clinically relevant, harmonized and aligned among all public and private payers, and minimally burdensome to report. To accomplish this, the AAFP recommends that CMS use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers.

The AAFP also supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic factors such as race, income, education, and region. Risk-