and compensated as they align their practices and commit resources to implement the MACRA provisions.

As AAFP requested in our letter to CMS prior to the release of the proposed rule, we urgently and strongly call on CMS to consider taking the following steps. First, CMS must use 2018 as the initial assessment period for MACRA, and under no circumstances should the initial performance period start any earlier than July 1, 2017. This important step would allow sufficient time for all physicians, in practices small and large, in urban and rural areas, to engage on the key policy elements of MACRA, and this step simultaneously would shorten the gap between the performance period and the payment period. With this step, CMS would assure that primary care physician payment is linked to the most accurate and timely data.

Assuming CMS issues the final rule for MACRA implementation on or around November 1, 2016, our members will need more than two months to select quality measures, identify relevant CPIA, and make necessary changes to reporting mechanisms, etc. This will be especially true for those members not currently engaged in PQRS and/or Meaningful Use. Perhaps 2017 could be seen and designated as a year for reporting only, in preparation for 2018 to be a year of judgement. If this is not possible, we call on CMS to use, at the very least, the second half of 2017 (July 1, 2017 – December 31, 2017) as the initial assessment period for physicians, whether they are participating via the MIPS or APM pathways. This approach would assure CMS has adequate time and resources to provide physicians with data on their performance metrics—a key facet of promoting steps for physicians to assess their own performance and make decisions about participation in MACRA.

The AAFP supports the proposed exclusion from MIPS adjustment for eligible clinicians with less than 12 months of performance data.

Regarding extended leave by MIPS-eligible clinicians, the AAFP is concerned that the use of extended leave might result in gaming by clinicians if they intentionally fall below the low-volume threshold. We would encourage CMS to watch for a pattern of gaming and, if that is the case, act accordingly.

5. MIPS Category Measures and Reporting
a. Performance Category Measures and Reporting
CMS proposes that MIPS-eligible clinicians can submit information via multiple mechanisms, but while they must use one submission mechanism per category, no submission method is required for the Resource Use category since CMS will use claims data. CMS believes it would reduce administrative burden for clinicians if they submitted CPIA, Quality, and ACI through the same mechanism. The proposed rule notes that not all third-party entities will be ready to support practices in this first year.

CMS seeks comment on the use of future rulemaking that requires health IT vendors, QCDRs, and qualified registries to have capabilities to submit all categories.

The agency seeks comments on providing bonus points in the quality scoring section for MIPS-eligible clinicians who submit quality measures through a qualified registry, QCDRs, Web interface, or certified electronic health record technology (CEHRT) submission.