clinicians or groups to capture and report on more meaningful activities. CMS may propose use of QCDRs for identification and acceptance of additional measures and activities which encourages the use of QCDRs

AAFP Response
When considering the QCDR, if activities are given a high weight, an eligible clinician should be allowed to report on no more than one CPIA that involves a QCDR. If the score is retained at medium, the eligible clinician should be allowed to report on no more than two QCDR activities. The AAFP believes sub-specialties will primarily rely on QDCR to get full credit in this category without actively engaging in CPIAs.

g. ACI Performance Category
MACRA includes the meaningful use (MU) of certified EHR technology (CEHRT) as a performance category under the MIPS. It is referred to by CMS in this proposed rule as the ACI performance category. This category will be reported by MIPS-eligible clinicians as part of the overall MIPS program. The four performance categories shall be used in determining the MIPS CPS for each MIPS-eligible clinician. In general, MIPS-eligible clinicians will be evaluated under all four of the MIPS performance categories, including the ACI performance category.

AAFP Response
The AAFP was pleased that the MACRA in essence sunsets the EHR incentive program (Meaningful Use/MU) and harmonized the program with the value-based modifier and the Physician Quality Reporting System (PQRS). We believe that while MU resulted in greater adoption of health information technology, it has significantly missed the mark in improving care and the ability for eligible professionals to care for patients. Interoperability, which was the key tenant of the Health Information Technology for Economic and Clinical Health (HITECH) Act, is only marginally better than prior to the start of the MU program even after investing tens of billions of dollars. Also during the life of the MU program, we have seen a steady decline in EHR satisfaction and usability. We are also concerned that certified EHR technology still lacks the needed functionality and usability to drive toward the goals of improving the patient experience of care, improving the health of populations, and reducing the per-capita cost of health care. Although the proposed component of ACI improves on the requirements of the MU program, we believe the burden of compliance still outweighs the benefit that patients will experience.

At the time of passing the HITECH Act, there were no other significant levers to drive health care delivery reform. With the passage of the Affordable Care Act (ACA) and MACRA, this is no longer true. CMS now has the ability to implement policy focused on incentivizing outcomes instead of structural and process end points. We believe that the focus on structural and process measures, coupled with aggressive policy timelines, has led to many implementations detrimental to care efficacy and efficiency. Also, the variation in patient needs and medical practice makes it difficult to craft simple, one-size-fits-all policies. The result is a series of complex, fits-no-one policies that diverts practice resources away from care delivery to the management of administrative complexity and waste. With health IT adoption well underway and the utilization of health IT as the only way to achieve the desired outcomes efficiently and effectively, with value-based payment rewards, it is time to drop health IT utilization measures. Given this and the overall complexity of the MIPS program, which needs to be dramatically simplified to be successful, we believe the current proposal for ACI has missed the mark in a major way and demands reconsideration.