In reviewing the statues governing the MU program [American Recovery and Reinvestment Act (ARRA), ACA, MACRA], we believe there are only a few mandatory requirements for the ACI components:

- Eligible clinicians must use certified EHR technology (CEHRT).
- The requirements must include a prominent component of information exchange:
    - The measure of this must be at the "satisfaction of the Secretary."
    - CEHRT must be connected using standards to provide information exchange.
- Eligible clinicians must report quality measures and the reporting must be integrated across MU and PQRS.
- The Secretary shall seek to improve use of EHRs by requiring more stringent measures of MU over time.
- The EHR reporting period is defined as any period (or periods) as specified by the Secretary.
- In 2019 and beyond, the Secretary shall determine if a MIPS-eligible clinician is a meaningful user.
- MU must be a performance category for MIPS and be 25 percent of the composite score. That percentage can be reduced to no less than 15 percent at the discretion of the Secretary should MU adoption reach 75 percent.

Due to current law, we understand that CMS cannot completely abandon health IT utilization measures, yet we do believe that CMS can significantly improve and reduce administrative complexity and burden while complying with current law. The AAFP recommends a new construct for the ACI component of MIPS. First, we recommend that the certification process be improved to:

- Increase the testing requirements for interoperability, namely care transitions, secure messaging, and application programming interfaces (API);
- Increase the testing around the support of the common core clinical data set and its integration in the EHR technology; and
- Perform both benchmark and field testing of CEHRT to be sure these capabilities are available in the market place and can be deployed at the practice/hospital site.

Secondly, establish a post-market surveillance system to allow reporting by eligible clinicians for events where CEHRT is not living up to the certification requirements. Also allow reporting by patients and clinicians for events where MIPS-eligible clinicians did not have attested functionality available or there was information-blocking behavior. Reporting would help HHS track compliance with attestation and could be a stream of data to pinpoint needed audits.

Thirdly, we recommend that the requirements and scoring of ACI be replaced with the following:

- Base score requirement would still be 50 percent of the total score for ACI.
- To achieve a full-base score, the MIPS-eligible clinician must:
    - Use CEHRT and attest that it is in place for the reporting period;
    - An exclusion for periods of acceptable down time (system maintenance, switching of systems, decertification of current system, etc.) would be included as to not penalize eligible clinicians for situations outside of their control;
- Protect health information as currently proposed in this regulation;
- Performance score would still be 50 percent of the total score for ACI;
- MIPS-eligible clinicians would receive 5 points for each of the 10 measure specifications listed in the proposed rule if they attest that functionality was available for use during the reporting period (the same exclusion for acceptable down time would apply here).