(c) Baseline Period
CMS proposes to establish the baseline period as two years prior to the performance period and suggests this period would be used to set benchmarks for the Quality category (except for new measures), which the baseline would be the current performance period. For the Resource Use category, the performance period will be used to set benchmarks. An alternate proposal would use the baseline period to set benchmarks for the Resource Use category and assess performance at measure level.

AAFP Response
The AAFP cautions that there may be misalignment when using benchmarks from one year for Resource Use and a different year for quality measures. While quality is always a top priority, quality focus is driven also by payment incentives. The AAFP strongly encourages CMS to improve their processes, software, and technology—just as physicians have been required to do—to allow more real-time analysis and feedback. A two-year delay in providing physicians with this data seriously undercuts the value and utility of quality improvement of data. Ideally, all categories should use the same year to determine benchmarks.

(2) Scoring the Quality Performance Category
(a) Quality Measure Benchmarks
CMS proposes to break baseline period measure performance into deciles and to create separate benchmarks for submission mechanisms that do not have comparable measure specifications. Further, the agency proposes to develop separate benchmarks for EHR submission options, claims submission options, QCDRs, and qualified registries submission options. Regarding the Web Interface option, CMS proposes to use the benchmarks from the Medicare Shared Savings Program and apply the MIPS method of assigning 1-10 points to each measure. All scores below the 30th percentile would be assigned a value of 2.

CMS also proposes to weight the performance rate of each MIPS-eligible clinician and group submitting data on the quality measure by the number of beneficiaries used to calculate the performance rate. CMS would include APM Entity submissions in the benchmark without scoring APM entities using this methodology. CMS proposes that at least 20 MIPS-eligible clinicians must report the measure and meet the case minimum for the benchmark calculation. CMS would exclude measures with a 0% performance rate.

AAFP Response
Establishing dissimilar benchmarks for the same measures for different reporting mechanisms seems contrary to the definition and purpose of a benchmark. The AAFP urges CMS to eliminate unnecessary and counterproductive complexity from this program. We support using the same benchmarks across reporting mechanisms for the same measure. We realize documentation may affect the performance on electronic measures. However, such documentation issues need to be addressed and corrected by clinicians prior to the reporting period for measures they plan to report using electronic mechanisms. We support that CMS monitor the need for separate benchmarks for measures that contain only data for Medicare patients to determine if separate benchmarks should be established (e.g., claims and Web Interface).

The AAFP agrees that 0% performance rates should be excluded from benchmark calculations. Furthermore, we agree with weighting the performance rates according to the number of beneficiaries.