The AAFP agrees the performance period should be used to determine a benchmark for new measures. We support using a consistent baseline period for all measures and moving the baseline, reporting, and performance periods as closely together as possible.

The AAFP agrees additional credit should be given for reporting new measures to allow for building infrastructure and learning the intricacies of the measure specifications. We support assigning a 3 as the lowest score for new measures.

The AAFP has serious concerns that, without timely and transparent communication relative to benchmarking, clinicians cannot make appropriate choices about technology and practice improvement investments in time for the start of the 2017 performance period.

(b) Assigning Points Based on Achievement
CMS proposes to establish benchmarks using a percentile distribution, separated by decile categories. For each set of benchmarks, CMS proposes to calculate the decile breaks for measure performance and assign points for a measure based on the decile range in which the performance rate falls. Eligible clinicians would receive at least 1 point for reporting a measure if they meet the case minimum. Topped out measures would be scored and weighted differently. Rather than assigning up to 10 points per measure, CMS proposes to limit the maximum number of points a topped out measure can achieve based on how clustered the scores are. All scores within the cluster would receive the same score.

AAFP Response
We support the use of the decile scoring method, as opposed to a flat percentage, for non-topped-out measures. We support limiting the maximum score of topped-out measures by scoring all scores within a cluster the same. The AAFP supports limiting the ability to report no more than two topped-out measures to avoid potential “gaming”. The AAFP encourages CMS to actively identify topped-out measures and promptly remove them well in advance (i.e., one year) of the reporting year in order to allow physicians to adjust their quality reporting plans and workflow.

(c) Case Minimum Requirements and Measure Reliability and Validity
CMS proposes a 20-case minimum, except for the all-cause hospitalizations measure of 200, which CMS proposes does not include MIPS-eligible clinicians who individually report or solo practitioners or groups of two-to-nine MIPS-eligible clinicians. CMS would exclude measures if they are found to be unreliable, with excluded measures having no impact on the score.

AAFP Response
The AAFP recognizes the current use of measures, such as the all-cause readmission measure in VM. However, in our experience, physicians’ interaction with and understanding of the VM program and the resultant QRURs are low. The EIDM registration is cumbersome and time-consuming to complete (often taking several weeks to receive approval); the required roles are not obvious; the current portal is not intuitive to navigate; reports take significant time to download; and once downloaded, are difficult and time-consuming to interpret. We propose a phased-in approach for population-based and global outcome measures in which the MIPS program would begin with the six measures (including one cross-cutting and one outcome-based measure) for scoring. We believe that population-based measures should be tested in the program before composite performance scores are based on their results. For the first two years, CMS needs to collect and disseminate data to eligible clinicians on global outcome and