population-based measures so they can learn about measurement at a population level and CMS can learn how population-level measurement will impact the MIPS program.

(d) Scoring for MIPS-Eligible Clinicians that Do Not Meet Quality Performance Category Criteria
CMS asks for feedback on safeguards that should be implemented to ensure that physicians submit measures that meet the required case minimum. The agency also requests input on validation processes to follow if a clinician is unable to report on quality measures as required.

AAFP Response
MIPS clinicians should be required to report only measures that fulfill the minimum sample size requirement of 20 patients. If sufficient measures or patients cannot be reported using specialty-specific measures, then cross-cutting measures must be used to complete the set of six measures with a sample size of 20 patients. This approach will encourage the development of a sufficient number of appropriate measures by all specialties to bring parity to quality reporting requirements.

The past Measure Applicability Validation (MAV) process (which was applied when a clinician reported fewer than the required measures) was difficult to understand and implement. The AAFP believes confusion can be avoided in MIPS by enforcing equitable requirements for all clinicians, with no exceptions. Clinicians that do not report at least six measures—including a cross-cutting and outcome-based measure with a sample size of at least 20 patients—should receive a score of zero for each measure not meeting the requirement.

6.a (2)(e) Incentives to Report High Priority Measures
CMS proposes 2 bonus points for each outcome and patient experience measure, as well as 1 bonus point for other high-priority measures over and above those required. Neither population-based measures, nor a performance rate of zero would earn bonus points. The agency also proposes that bonus points be available for measures that are not scored (not included in the top six measures for the quality performance category score) as long as the measure has the required case minimum and data completeness.

AAFP Response
We appreciate the effort aimed at establishing a bonus structure for activities that encourage reporting high-priority measures. However, the proposed structure is too complex and will be misunderstood by most clinicians, particularly those in smaller practices that lack extended analytic support. Lack of understanding of how to earn bonus points will place smaller practices at a disadvantage compared to larger practices. As people become more accustomed to MIPS, the bonus point structure may be more useful. Therefore, the AAFP recommends the bonus point structure be delayed until future years.

(f) Incentives to Use CEHRT to Support Quality Performance Category Submissions
In addition to its high-priority bonus, CMS proposes 1 bonus point under the quality performance category score, and up to a maximum of 5% of the denominator of the quality performance score, if the eligible clinician performs “end-to-end electronic reporting” (i.e., use of EHR to document demographic and clinical data elements; export and transmit data electronically to a third party or directly; or to aggregate, calculate, filter, and submit electronically with a third party). This incentive is available for all submission methods except claims.