measures that meet case minimums or are without a benchmark. For the Quality category, CMS anticipates clinicians will select the measures most relevant to their practice, and in most circumstances, have a sufficient number of cases. CMS will monitor trends in reporting to identify gaming. In the Resource Use category, if too few cases are attributed, CMS will not score the category. In terms of CPIA, CMS believes all physicians should have sufficient activities and will receive a score. For the ACI category, CMS recognizes that some specialties may not have sufficient measures.

CMS proposes that CPIA is the only category that will always have a performance score. The agency proposes that if a MIPS-eligible clinician receives a score for only one performance category, the agency would assign an adjustment factor of 0% for the year.

AAFP Response
Reweighting due to insufficient quality measures will not be an issue if all clinicians are required to meet the same quality measure reporting requirements. Consistency in requirements will reduce complexity and eliminate inequities in the QPP. Primary care physicians have demonstrated a commitment to improvement and have designed an abundance of quality measures. That same commitment should be expected of all specialties, as each has had many years to develop sufficient quality measures. If acceptable specialty-based quality measures are unavailable, clinicians should be required to report cross-cutting measures or receive a zero for either unreported measures or measures without a sufficient number of patients. CMS's continued willingness to make allowances for this lack of specialty-based measures places specialties at an advantage over primary care providers, both in terms of performance under QPP and in terms of resources expended to support quality improvement.

We agree that reweighting the Quality score would be appropriate if a clinician does not receive a Resource Use or ACI score.

We agree, in concept, with the proposal that if a MIPS clinician receives a score for only one performance category, an adjustment factor of 0% should be assigned for the year. However, if all clinicians are held to the same requirement—reporting six quality measures, including one outcomes-based measure and one cross-cutting measure with a sufficient number of patients—then all clinicians should have a score in at least two categories (CPIA and Quality). Thus, there would be no need to assign an adjustment factor of 0%.

7. MIPS Payment Adjustments
a. Payment Adjustment Identifier and CPS Used in Payment Adjustment Calculation and
CMS proposes to use a single identifier—TIN/NPI—for all MIPS-eligible clinicians, regardless of whether the TIN/NPI was measured as an individual, group, or APM Entity group. In other words, a TIN/NPI may receive a CPS based on individual, group, or APM Entity group performance, but the payment adjustment would be applied at the TIN/NPI level. CMS is proposing to use the single identifier for the payment adjustment for the following reasons:

- Using TIN/NPI would allow CMS to correctly identify which TIN/NPIs are still MIPS-eligible clinicians after exclusion criteria are applied.
- TIN/NPI is mutually exclusive on all of the agency's measurement identifier options. Therefore, CMS believes this identifier can be used consistently for individual, group, or APM scoring standard identifiers, all of which are not mutually exclusive.