attestation. For some, these issues devolve into a back-and-forth scenario; in each occurrence the member in question receives a demand for payment within a short time frame or to provide additional information. These experiences cannot occur again with the audits under MACRA.

e. Data Validation and Auditing
CMS proposes to combine past program integrity process of data validation from PQRS and auditing process from EHR incentive program into one set of requirements for MIPS-eligible clinicians and groups. They will selectively audit MIPS-eligible clinicians on a yearly basis. If selected, the eligible clinicians or group would be required to comply with data sharing requests within 10 business days and provide substantive, primary source documents as requested. If an eligible clinician or group is found to have submitted inaccurate data, CMS would recoup overpayments.

AAFP Response
The AAFP has no problem with the auditing process itself. However, we do call for clear deadline expectations to be set on both sides and insist that audit initiation be timely (within 12 months of the end of a performance year). Also, a 10-business-day deadline may not be feasible in all circumstances. CMS needs to factor in the possibility of vacation, sick leave, maternity care, etc. Thirty business days seems more reasonable. Clinicians also need to be provided clear examples of documentation well in advance of the submission deadline and technical assistance needs to be made available to help with the process.

9. Third-Party Data Submission
a. Qualified Clinical Data Registries (QCDRs), (3) Information Required at the Time of Self-Nomination and c. Qualified Registries (3) Information Required at the Time of Self-Nomination

In these two sections, CMS requests information required at the time of self-nomination for QCDRs and qualified registries. This includes a data validation plan for both individual eligible clinicians and groups, which meet the following: For individuals, it is encouraged that 3 percent of the TIN/NPIs submitted by the QCDR be sampled with a minimum sample of 10 TIN/NPIs or a maximum sample of 50 TIN/NPIs. For each TIN/NPI sampled, it is encouraged that 25 percent of the TIN/NPI's patients (with a minimum sample of five patients or a maximum sample of 50 patients) should be reviewed for all measures applicable to the patient.

AAFP Response
It is important to note that requirements for data validation plans are sufficient to ensure accuracy of data, yet this requirement must be balanced with the burden of validation and auditing by the QCDR entity or qualified registry. We do not have sufficient information to comment on whether the proposed requirements are adequate to ensure data quality, nor can we comment as to whether the proposed requirements will be burdensome across various structures of QCDRs and registries. We hope CMS receives ample qualitative commentary in order to better judge whether the proposed numbers and percentages for validation plans strike an appropriate balance.

a. QCDRs, (4) QCDR Requirements for Data Submission, and c. Qualified Registries, (4) Qualified Registry Requirements for Data Submission
The rule proposes to require mandatory attendance of third parties for monthly support conference calls, as well as at the kick-off meeting in Baltimore, MD. More than one unexcused absence could result in the QCDR or registry being precluded from participation in the program for that year.