It makes sense that APM entities would be identified by a combination of APM identifier and APM entity identifier (similar to the TIN/NPI combination for individual eligible clinicians). We also think it makes sense for CMS to be able to link individual eligible clinicians with APM entities, but it is a significant administrative burden to go from there to what CMS proposes in this regard.

3. Exclusions

a. New Medicare-Enrolled Eligible Clinician

Consistent with sections 1848(q)(1)(C)(v) and (vi) of the Act, CMS proposes that a new Medicare-enrolled eligible clinician be defined as a professional who first becomes a Medicare-enrolled eligible clinician within the Provider Enrollment, Chain and Ownership System (PECOS) during a year-long performance period and who has not previously submitted claims as a Medicare-enrolled eligible clinician either as an individual, an entity, or a part of a physician group or under a different billing number or tax identifier. These eligible clinicians will not be treated as a MIPS-eligible clinician until the subsequent performance period. CMS also proposes that in no case would a MIPS adjustment factor (or factors) apply to the items and services furnished by new Medicare-enrolled eligible clinicians.

AAFP Response

The agency's proposal is entirely consistent with the statute as amended by MACRA. The statute intentionally did not provide CMS latitude in this regard.

b. Qualifying APM Participants (QP) and Partial Qualifying APM Participant (Partial QP)

CMS proposes (at §414.1310) that the definition of a MIPS-eligible clinician does not include qualifying APM participants (defined at §414.1305 and Partial QPs defined at §414.1305) who do not report on applicable measures and activities that are required to be reported under MIPS for any given performance period.

AAFP Response

The agency's proposal is entirely consistent with the statute as amended by MACRA. The statute intentionally did not provide CMS latitude in this regard.

c. Low-Volume Threshold

CMS proposes at §414.1305 to define MIPS-eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS-eligible clinician or group if, during the performance period, they have Medicare billing charges less than or equal to $10,000 and provide care for 100 or fewer Part B-enrolled Medicare beneficiaries (*emphasis added*). CMS believes this is a value-oriented strategy because it retains as MIPS-eligible clinicians those who are treating relatively few beneficiaries, but who engage in resource-intensive specialties, or those who are treating many beneficiaries with relatively low-priced services. By requiring the $10,000 and providing care for 100 or fewer Part B-enrolled Medicare beneficiaries criteria to be met, CMS believes it can meaningfully measure performance and drive quality improvement across the broadest range of clinician types and specialties. Conversely, it excludes MIPS-eligible clinicians who do not have a substantial quantity of interactions with Medicare beneficiaries or furnish high-cost services.

AAFP Response