We appreciate the agency's intent with its proposed definition. However, we question the proposed reliance on a combination of billing charges and the number of Part B-enrolled Medicare beneficiaries. Under MIPS, eligible clinicians will be evaluated based on Quality, Resource Use, CPIA, and ACI. The statistical reliability of the measures used in those areas depends on the number of cases in the denominator, which is almost always the number of beneficiaries rather than allowed charges. Under the agency's definition, an eligible clinician who provides $11,000 in billing charges to five Part-B enrolled Medicare beneficiaries would not be excluded based on the low-volume threshold. However, neither we nor CMS should have any confidence in the measures of Quality and Resource Use from a sample of five beneficiaries. Accordingly, we strongly recommend that CMS define MIPS-eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS-eligible clinician or group who, during the performance period, provides care for less than 125 Part B-enrolled Medicare beneficiaries. At the level of 125 or more Part B Medicare beneficiaries seen, we and CMS can have confidence in the measures of Quality, Resource Use, etc. without regard to the billing charges involved.

As an aside, we note that section 1848(q)(1)(C)(iv)(III) refers to the minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period," so CMS should use the term "allowed charges" rather than "billing charges" to be consistent with the statute when discussing this provision. Further, "allowed charges" is a more commonly used and understood term and a more accurate reflection of the eligible clinician's actual volume of Medicare business, which is another reason that the proposed use of "billing charges" is problematic.

d. Group Reporting

(1) Background

CMS proposes that:

- Individual MIPS-eligible clinicians may have their performance assessed as a group if the group is a single TIN associated with two or more MIPS-eligible clinicians, as identified by a NPI, that have their Medicare billing rights reassigned to the TIN;
- To have its performance assessed as a group, a group must meet the proposed definition at all times during the performance period for the MIPS payment year;
- To have their performance assessed as a group, individual MIPS-eligible clinicians within a group must aggregate their performance data across the TIN; and
- A group that elects to have its performance assessed as a group would be assessed as a group across all four MIPS performance categories.

AAFP Response

All of the CMS proposals in this regard seem reasonable, and the AAFP supports them.

(2) Registration

CMS proposes to eliminate a registration process for groups submitting data using third-party entities (e.g., qualified clinical data registry (QCDR) or health IT vendor). Specifically, CMS proposes that a group must adhere to an election process established and required by CMS. CMS does not propose to require groups to register to have their performance assessed as a group except for groups submitting data on performance measures via participation in the CMS Web Interface or groups electing to report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey. For all other data submission methods, groups must work with appropriate third-party entities to ensure the data submitted clearly indicates that the