least in the early years of the program, for the sake of administrative simplicity, the AAFP encourages CMS not to allow TINS to split.

To encourage the creation and growth of virtual groups, the AAFP calls on CMS to allow virtual groups to consist of multiple TINs or for multiple TINs to be classified under a new TIN specific to the new virtual group. The AAFP foresees virtual groups forming in a variety of settings and circumstances, and we encourage CMS not to be overly prescriptive on the administrative structure of these groups.

If CMS allows TINs to split and individual members of a TIN have decided not to join the virtual group, they should be considered as individual EPs, unless CMS has some means to consider them collectively apart from the individuals in the TIN who joined the virtual group.

The AAFP believes CMS should not establish thresholds based on the eligible number of patient-lives attributed to the virtual group and not arbitrarily dictate and restrict the number of providers participating in a virtual group.

As virtual group programs have already been established and have demonstrated favorable quality and cost performance before the implementation of MACRA, the AAFP believes there should not be a limit on the number of virtual groups in the first year. Furthermore, the AAFP sees virtual groups as an opportunity for small group practices to be successful under MACRA. Limiting the availability of this pathway would restrict opportunities for small and independent practices.

The AAFP recommends CMS allow prospective virtual groups to demonstrate through an application process that they have reliable mechanisms in place for establishing patient attribution, as well as for reporting under MIPS throughout the performance period. These mechanisms could include the virtual group receiving patient consent prospectively in a manner similar to the requirements of the chronic care management services. Alternatively, it could include the option for virtual groups to demonstrate patient attribution through previous claims submitted by providers within the virtual group. Either method enables practices in the virtual group to prospectively know which patients are attributed to the group and how the virtual group is performing in real time, allowing—if needed—practices to modify their actions during the performance period and make improvements. We encourage CMS not to be restrictive in how virtual groups demonstrate this and instead allow flexibility for innovative proposals from virtual groups as part of the anticipated application process.

Since CMS and physician practices already offer a way for multi-specialty groups to come together through the Medicare Shared Savings Program, as well as other options for accountable care organizations, the AAFP urges CMS to limit virtual groups to practices of the same or similar specialties. We view the design of virtual groups as intending to increase the number of patients for quality evaluation, which is best done by single or similar disciplines to facilitate comparison. The AAFP believes any limitations should be based on the chosen population, its size, and location, instead of arbitrary mileage restrictions or state boundaries. Since patient populations can be widely dispersed or closely compacted depending on the geographic area, CMS should consider population density or other geographic limitation based on the location of the virtual group.