expectations as other MIPS participants and report on six measures. If six measures are not available in the sub-specialty list, the MIPS-eligible clinicians need to report at the higher specialty level. If six measures are still not available that are specialty specific, these MIPS-eligible clinicians should choose measures from the list of cross-cutting measures until they reach a total of six measures. If CMS requires a lower number of quality measures for a particular specialty group in MIPS, then the minimal number should be lowered for all physician specialties. We believe that parity in reporting across all physician groups is critically important.

Advancing Care Information (ACI)

The AAFP believes the current proposal for ACI has missed the mark in a major way and urges immediate reconsideration. Although we believe ACI improves on the requirements of the MU program, the burden of compliance still outweighs the benefit that patients will experience. Due to current law, we understand that CMS cannot completely abandon health IT utilization measures, yet we do believe that CMS can significantly improve and reduce administrative complexity and burden while complying with current law. The AAFP recommends a new construct for the ACI component of MIPS.

Solo and Small Group Practices – Virtual Groups

The MIPS pathway, which aims to create a quality or value-based payment model inside the traditional fee-for-service payment structure, is likely the pathway by which most physicians will be paid in the near term. Given the construct of the MIPS performance categories and the manner in which the composite score will be calculated as articulated in the MACRA Quality Payment Program's proposed rule issued by CMS, it is highly probable that physicians practicing alone or in small groups will be at a significant disadvantage under the MIPS program. CMS's own actuaries noted this in their evaluation of the proposed rule – projecting that 87 percent of solo practitioners and nearly 70 percent of those in practices of 2-9 physicians will receive a negative adjustment in 2019.

Public Law 114-10 recognized that a majority of physicians practice in a clinical setting that includes 5 or fewer physicians. In fact, greater than 50% of family physicians currently practice in such a setting. In an effort to ensure that physicians practicing in such clinical settings were not negatively impacted by the provisions of the law, but in fact have an opportunity to build the capabilities to evolve and succeed under value-based and alternative payment models, Congress included several provisions aimed at providing these physicians and their practices "equal standing" with larger or more integrated groups who may be included in the MIPS cohort.

With respect to the MIPS pathway, Congress expressly established the ability of solo and small groups to aggregate their data – in an effort to remove any methodology biases due to their potential small number of Medicare beneficiaries – through "Virtual Groups." The inclusion of virtual groups was quite deliberate. Language establishing this option was included to provide a plausible mechanism for solo and small group practices to participate and compete in the MIPS pathway against larger groups that would inherently benefit from larger numbers of beneficiaries upon which their evaluation would be conducted.

CMS, in the proposed rule, states that the agency is unable to establish or implement the virtual group option as mandated by Public Law 114-10. This is most unfortunate because not only did the law mandate that these groups be established and made available to solo and small group physicians, but it also eliminates an opportunity for these physicians to participate in an equitable manner in the MIPS program. We know that CMS has experience with the creation of new delivery models, i.e. ACOs, so we do not understand why this model has been determined