submitted information from clinicians. Under the original proposal, payers are the final arbitrator on payer arrangements; this alternative makes them the initial arbitrator. Clinicians should be able to challenge a determination that a payer arrangement in which they are participating does not qualify as an Other Payer Advanced APM and provide additional information for review and revision of the initial determination. This would ensure clinicians are not dependent on a payer to attest the accuracy of submissions, to which they have limited control.

Lastly, the AAFP urges CMS to make this a once-in-a-while process where after a payer submits information on its payer arrangement, CMS would assess whether the payer arrangement meets the Other Payer Advanced APM criteria. If it does, the payer arrangement is certified for a period of time (i.e., three years). The certification would last for a period of time or until the payer makes substantive changes to the arrangement that would disqualify it as an Other Payer Advanced APM. CMS should allow maximum flexibility for private payers to innovate new APM frameworks and not inadvertently create regulations that have a chilling effect on private payers' ability to innovate. The certification process for Other Payer Advanced APMs would add a much-needed regulatory certainty and eliminate much-hated administrative burdens on clinicians. The AAFP believes it would be more manageable for CMS to receive a lower number of submissions from payers than clinicians and to have those submissions contain more accurate and relevant information.

CMS also proposes that for Advanced APM Entities and eligible clinicians participating in Medicaid, CMS will initiate a review and determine in advance of the QP determination period the existence of Medicaid Medical Home Models and Medicaid APMs based on information obtained from state Medicaid agencies and other authorities, such as professional organizations or research entities. The AAFP supports this determination process for the reasons laid out in the preceding paragraph and would urge CMS to apply a similar process for determining whether other payer arrangements meet the Other Payer Advanced APM criteria.

The Balanced Budget Act of 1997 authorized CMS to contract with public or private organizations to offer a variety of health plan options for beneficiaries, including coordinated care plans and preferred provider organizations, private-fee-for-service (PFFS) plans, and other plans. Furthermore the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), updated and improved the choice of plans for beneficiaries under Part C, and changed the way benefits are established and payments are made. As CMS gains continued experience with the Medicare Advantage (MA) program and as new legislation changes MA program requirements, it should periodically revise regulations at Part 422 of Chapter 42 of the Code of Federal Regulations to ensure private payers submit this much-needed information in order to strengthen its ability to select stronger applicants for participation in various programs, remove consistently poor performers, and strengthen beneficiary protections.

(1) Use of Methods
CMS proposes to calculate Threshold Scores for eligible clinicians in an Advanced APM Entity under both the payment amount and patient count methods for each QP Performance Period. CMS also propose that it would assign QP status using the more advantageous of the Advanced APM Entity's two scores.

AAFP Response
We appreciate the agency's intent to align threshold amounts within Medicare and private payers. However, we question the proposed reliance on a combination of billing charges and number of Part B-enrolled Medicare beneficiaries. Under MIPS, eligible clinicians will be