With respect to allocating the supplemental service payments to individual NPIs in scenarios in which payment for a supplemental service payment is made in the aggregate to an APM Entity, we ideally support the CMF amounts being assigned to the individual NPI to whom the patient is attributed. If that is not possible, then we favor splitting the CMF amounts equally between the multiple NPIs within the APM Entity as long as those NPIs are limited to the ones actually providing care management. We believe that this approach is preferable to developing a method to "assign" the NPI for which the CMFs would be counted in their APM Incentive Payment calculation based on the plurality of visits with that beneficiary. Equally dividing the CMF amounts among the NPIs is the simplest approach, an attractive feature in an otherwise complicated payment system. We also suspect that, in the end, it may also be just as "fair" as the alternative assignment approach.

Finally, concerning cash flow mechanisms, we support CMS's proposal to calculate the estimated aggregate payment amount using the payment amounts that would have occurred for Part B covered professional services if the cash flow mechanism had not been in place. As noted in the proposed rule, to the extent that cash flow mechanisms do not change the overall amount of payments to physicians, CMS's proposed approach makes sense.

(6) Treatment of the APM Incentive Payment in APM Calculations
Section 1833(z)(1)(C) of the Act states that the amount of the APM Incentive Payment shall not be taken into account for purposes of determining actual expenditures under an APM and for purposes of determining or rebasing any benchmarks used under the APM. CMS anticipates that each APM will have in place a procedure to avoid counting APM Incentive Payments toward determining actual expenditures or rebasing any benchmarks under the APM.

AAFP Response
We agree with CMS that it seems reasonable to expect that each APM will have in place a procedure to avoid counting APM Incentive Payments toward determining actual expenditures or rebasing any benchmarks under the APM.

b. Services Furnished Through CAHs, RHCs, and FQHCs
(1) Critical Access Hospitals (CAHs)
In the case of eligible clinicians who furnish services at CAHs that have elected to be paid for outpatient services under Method II, the APM Incentive Payment would be based on the amounts paid for those services attributed to the eligible clinician, as identified using the attending NPI included on a submitted claim, in the same manner as all other covered professional services. CMS proposes that the APM Incentive Payment would be made to the CAH TIN that is affiliated with the Advanced APM Entity, consistent with how CMS proposes to make the APM Incentive Payment to eligible clinicians who practice at locations other than Method II CAHs.

AAFP Response
We strongly disagree with CMS's proposal in this regard. Section 1833(z)(1)(A) of the Act explicitly states, "…there also shall be paid *to such professional* an amount equal to 5 percent of the estimated aggregate payment amounts for such covered professional services under this part of the preceding year." (Emphasis added) The law clearly requires the APM Incentive Payment to be made to the QP, not the TIN that is affiliated with the Advanced APM Entity through which the eligible clinician met the threshold during the QP performance period.