Finally in regards to total per-capita cost of care, primary care physicians refer to specialists when a greater depth of knowledge is needed and rely on the professional opinion and recommendations of the specialist to determine the best course of care. If the specialist in combination with the patient determines that certain tests and procedures are needed, the primary care physician is not in a position to question those decisions nor their associated costs. Most times these tests are completed before the primary care physician is aware they were even ordered. The total cost of care measure holds providers accountable for costs they do not control. We support focusing solely on episode-based care in the Resource Use section and eliminating total cost of care.

Both total cost of care and MSPB were developed to measure hospital performance, and these measures inappropriately attribute costs of patient care that are unrelated to physician practice and particularly, unrelated to primary care practice. The AAFP urges CMS to withdraw these measures and instead use care episode groups as the sole method of measuring Resource Use in order to emphasize high volume and high cost conditions and procedures. The AAFP insists that attribution for patients within care episode groups should be to the physician with the highest Part B allowable charges, defined within this proposed rule as a plurality of claims, rather than the methodology suggested in this proposed rule.

(2) Weighting the CPS
As required by MACRA, the Resource Use performance category shall make up no more than 10 percent of the CPS for the first MIPS payment year and not more than 15 percent of the CPS the second MIPS payment year. Starting with the third MIPS payment year and for each MIPS payment year thereafter, the Resource Use performance category would make up 30 percent of the CPS.

CMS also will closely examine the recommendations from HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) study, once they are available, on the issue of risk adjustment for socioeconomic status on quality measures and Resource Use.

AAFP Response
The AAFP adamantly urges CMS to make timely and actionable data available as Resource Use weighting increases significantly as a proportion of the CPS from 2019 to 2021. As clinicians are held increasingly accountable for costs during the first three years of MIPS, thereby increasing their downside risk, clinicians deserve an increasingly robust and reliable cost forecasting and reporting tool to offset that risk. It is only fair to provide needed tools to clinicians as the weighting of this Resource Use within CPS increases. In addition, the AAFP believes attribution logic and risk adjustment methodologies need to improve continually as Resource Use becomes a larger component of the CPS. It will be imperative that clinicians can reconcile any issues with patient attribution and the attribution needs to be available to the physician no less frequently than quarterly.

The AAFP recommends CMS quickly analyze the ASPE study results to determine how best to apply socioeconomics and social determinants of health into risk adjustment for quality and Resource Use measures. The AAFP believes socioeconomics and social determinants of health factor into improving risk adjustment, chronic disease management, and achieving positive clinical outcomes.