treatment episode the data on costs/utilization and quality/outcomes. This would require the identification of specific outcomes related to the condition or service being measured, rather than some general measure, such as all cause readmissions. If CMS properly selects and designs Resource Use measures tied to episodes of care and provides timely and actionable data, it has an opportunity to impact costs, care improvement activities and physician behavior. Lastly, syncing data on costs/utilization and quality/outcomes will create an opportunity to improve risk adjustment and attribution methodologies to the individual clinical condition or treatment being measured.

(i) Attribution
For acute condition episodes, CMS proposes to attribute those episodes to MIPS-eligible clinicians that bill at least 30 percent of IP E&M visits during the initial treatment, or "trigger event," that opened the episode. In addition, for procedural condition episodes, CMS proposes to attribute those episodes to MIPS-eligible clinicians who bill a Medicare Part B claim with a trigger code during the trigger event of the episode. Since it is possible for more than one MIPS-eligible clinician to be attributed to a single episode using either rule, will CMS then split the Resource Use measures among attributed clinicians, based on the care they deliver?

AAFP Response
The AAFP believes patients should be attributed to the physician who bills the largest portion of Part B allowable charges, as defined by CMS in this proposed rule as plurality of claims, for acute condition and treatment episodes instead of what is proposed. We believe that assigning attribution based on number of visits does not attribute patients to the physician that can make the biggest impact on reducing costs and would disproportionally hold the primary care physician responsible for the Resource Use of the specialist.

(ii) Reliability
CMS proposes to use the minimum of 20 cases for all episode-based measures listed in Tables 4 and 5.

AAFP Response
The AAFP urges CMS to use a minimum reliability threshold of 0.7 for all resource use measures used in MIPS. The minimum number of cases needed to achieve a reliability threshold of at least 0.7 will vary for each of the episode-based measures based on each measure's statistical characteristics. Thus, CMS should determine the minimum number of cases separately for each measure such that each achieves at least 0.7 reliability.

(4) Future Modifications to Resource Use Performance Category
In the future, CMS intends to consider how best to incorporate Part D costs into the Resource Use performance category.

AAFP Response
We urge CMS to review the AAFP's letter sent to CMS on May 9, 2016, in regards to the proposed rule titled, "Medicare Program; Part B Drug Payment Model." In the letter, the AAFP applauded the agency's efforts to apply common sense, value-based payment (VBP) principles to the delivery of physician-administered pharmaceutical and biologic treatments. Much of the information contained in that letter describes how to best control the costs of drugs by focusing on measuring its performance.