While the AAFP disagrees that health IT utilization measures are useful in achieving the desired goals, we believe this AAFP proposal complies with current requirements in statue. It simplifies the ACI component without hindering progress toward the goals of the original MU program and the current MACRA proposal.

In addition to the new proposals for ACI, we believe that the government needs to ensure the last mile of the Direct exchange is completed for all those sending and receiving Direct messages and attachments. CMS, the Department of Veterans Affairs (VA), the Department of Defense (DoD), other federal agencies, and major health care payers need to ensure that eligible clinicians in the private sector have the capability to coordinate care easily utilizing the Direct exchange. To do this, we believe that the federal government should:

- Support the development of national provider directories that include provider Direct addresses;
- Ensure that certification of health IT addresses usability and ease-of-use of the Direct exchange, and the products are graded with respect to these qualities;
- Ensure that content or payloads delivered as attachments to Direct messages are made more uniform and capable of being computable by senders and receivers using the Direct exchange to share health information; and
- Financially penalize CEHRT vendors that participate in information blocking behavior and/or a determination is made that certified interoperability functionality is not functioning in the market as tested during certification.

h. APM Scoring Standard for MIPS-Eligible Clinicians Participating in MIPS APMs
CMS proposes that qualifying APM participants that are not MIPS-eligible could be excluded from MIPS and be considered Partial Qualifying APM Participants (Partial QP). Partial QPs are not MIPS-eligible unless they opt to report and be scored under MIPS. All other eligible clinicians participating in APMs are MIPS-eligible and subject to MIPS requirements.

For these Partial QPs, CMS aims to reduce the reporting burden so that eligible clinicians do not report to both APM and to MIPS. There will be specific criteria for the APMs that get preferred scoring under MIPS or "MIPS APMs." For the purposes of the APM scoring standard, CMS proposes to consider a participant in an APM Entity (an individual or a group). To be a "MIPS APM," a clinician or group must meet certain criteria:

1. APM entities participate in an APM under an agreement with CMS;
2. APM entities include one or more MIPS-eligible clinicians on a participation list;
3. The APM bases incentives on performance (at either the APM Entity or eligible clinician level) on cost/utilization or quality measures.

*AAFP Response*
The AAFP is very concerned about CMS's proposal to implement a "MIPS APM" category. In the design of this law and explanations provided by CMS staff in publicly-presented presentations before the proposed rule was released, the design was relatively simple and understandable. A National Provider Identifier (NPI) was in MIPS, reported to MIPS, and was rated and paid through MIPS. Alternatively, the NPI resided within an APM, met certain eligibility criteria and qualifications, and was paid through the metrics of that APM. There was little middle ground. The middle ground that did exist was that an NPI within an APM that fell below the low-volume threshold or did not meet all the eligibility criteria, those NPIs received their available