complex and worthy of omission from the regulation. As we noted in our RFI response, virtual groups should be designed to incorporate physicians from a single or similar discipline. The geographic factor in our mind is not necessary and should be left to the physicians to determine.

The lack of virtual groups will result in a "methodology bias" between solo and small practices and larger practices, yet they all will compete against each other in the MIPS program. The result for those practices with the most limited financial reserves could be to widen the gap between them and larger practices or those affiliated with health systems. These disparities among practices based on size and location could also introduce – or exacerbate – disparities in outcomes for beneficiaries.

Furthermore, the virtual group policy established a reasonable approach for solo and small group physicians to begin building networks that would encourage them to progress towards more sophisticated delivery models such as medical homes and accountable care organizations. Again, we are shocked and disappointed that this option will not be available.

Given the fact that a provision, mandated by law, to ensure the viability of solo and small physician practices in the MIPS program will not be available for such physicians and their practices in the initial performance period, we are strongly urging CMS to include an interim pathway to virtual groups, as outlined below, in the final regulation.

Physician practices with 5 or fewer physicians, billing under a single TIN, who participate in the MIPS program through the submission of quality data, use of a CEHRT electronic medical record, and participation in clinical practice improvement activities should be exempt from any negative payment updates resulting from the MIPS program until such time that virtual groups – as outlined and mandated by Public Law 114-10 – are readily available. These physician practices are, however, eligible for any positive payment updates that they may warrant based upon their performance in any given performance period.

In short, physicians in a solo practice or small group that participates in the MIPS program should be eligible for positive payment updates if his or her performance yields such payments, but would be exempt from any negative payment update until such time that the virtual group option is available. To ensure that Medicare participating physicians continue to pursue quality and performance improvement, any physician or small group that fails to participate in the MIPS required activities would be subjected to the full negative update.

Furthermore, we recommend that the final regulation redirect such funds necessary from the $500 million set-aside for bonus payments to the top performers towards financing this proposed safe harbor for solo and small practices. We find it difficult to comprehend why CMS would reward an extremely small subset of Medicare participating physicians, while knowingly placing smaller practices at a distinct disadvantage.

Medical Home

MACRA, as approved by Congress, emphasized the role of advanced primary care practices. This emphasis is apparent through the inclusion of the medical home as a preferred delivery model under both the MIPS and APM pathway. It is further emphasized through legislative language that exempts medical home practices from any risk under APMs and the guarantee of maximum scoring under MIPS. It is clear to the AAFP that Congress fully supported the medical home and intended for the medical home to be a model recognized as an Advanced APM, and for good reason. The delivery of high-performing team-based patient-centered primary care is at