a group TIN). If a MIPS-eligible clinician has multiple CPSs, CMS proposes a multi-pronged approach to select the CPS that would be used to determine the MIPS payment adjustment. First, CMS proposes that if a MIPS-eligible clinician participates in a MIPS APM, then the APM Entity CPS will be used instead of any other CPS (such as a group TIN CPS or individual CPS). CMS proposes that if a MIPS-eligible clinician has more than one APM Entity CPS for the same TIN (by participating in multiple MIPS APMs), CMS would apply the highest APM Entity CPS to the eligible clinician. Second, if a MIPS-eligible clinician reports as a group and as an individual, CMS would calculate a CPS for both the group and individual identifier, using the highest CPS for the TIN/NPI.

*AAFP Response*
In general, the AAFP supports the proposal to use the CPS associated with the TIN/NPI combination in the performance period. The AAFP also supports the proposal to use the NPI's performance for the TIN(s) under which the NPI was billed during the performance period in cases where there is no CPS associated with a TIN/NPI during that span.

The AAFP's support extends to the proposal to use a weighted average CPS based on total allowed charges associated with the NPI from the performance period in scenarios where the MIPS-eligible clinician billed under more than one TIN during the performance period, and the MIPS-eligible clinician starts working in a new practice or otherwise establishes a new TIN that did not exist during the performance period. We think this proposal makes more sense than the agency's alternative proposal to take the highest CPS from the performance period. As CMS notes, the alternative approach may reward eligible clinicians for prior performance that represent a relatively small portion of the eligible clinician's practice during the performance period.

The AAFP supports the agency's inclination not to have the performance follow the group (TIN) rather than the individual (NPI). We acknowledge that such an approach would be administratively simpler for group practice administrators. However, as CMS observes, it would penalize eligible clinicians who earned a positive adjustment based on their performance during the performance period if their new TIN had a lower CPS. It would also create an incentive for poor performers to move to high performing groups solely for the purposes of avoiding a negative payment adjustment. We believe MIPS-eligible clinicians should be accountable for their performance when it is accurately and appropriately measured. Having performance follow a group rather than an individual is contrary to that principle.

Finally, in cases where a TIN/NPI could have more than one CPS associated with it from the performance period, we generally support the proposed multi-pronged approach to select the CPS that would be used to determine the MIPS payment adjustment. As we understand it, that approach gives priority to the CPS of an APM Entity. We believe this is consistent with encouraging eligible clinicians to be part of APM entities.

The AAFP disagrees with the proposals in which CMS attempts to:

- Apply the highest APM Entity CPS to the eligible clinician in cases where a MIPS-eligible clinician has more than one APM Entity CPS for the same TIN (by participating in multiple MIPS APMs); and
- Calculate a CPS for both the group and individual identifier and use the higher CPS for the TIN/NPI in cases where a MIPS-eligible clinician reports as both a group and as an individual.