The AAFP urges CMS to withdraw these measures and instead use care episode-based groups as the sole method of measuring Resource Use 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 the proposed rule as a plurality of claims, rather than the methodology suggested in this proposed rule.

Physicians that are part of an Advanced APM have agreed to be responsible for total costs and have incentives and mechanisms available to review, manage and reduce total costs. However, physicians outside such arrangements have limited control over the actions and costs of specialists, are offered no incentives for reducing total costs, and have no agreed-upon goals or mechanisms in place to review, manage and reduce total costs. Primary care physicians outside advanced APM arrangements cannot anticipate that multiple specialties will work together toward total cost of care reduction and should not be held accountable for these costs, many of which will be generated by specialists. Rather, the physicians who generated the costs should be held responsible for such costs.

MIPS APM category

The AAFP completely objects to the implementation of the entire section of this proposed rule related to "MIPS APMs." This section of the proposed regulation is incredibly confusing and we have concerns that, as written, CMS is incentivizing physicians to remain in the fee-for-service program rather than to continue their progress towards APMs. In concept, we believe physicians and practices should proceed towards Advanced APMs versus slipping back into the fee-for-service program. CMS and CMMI have implemented policies in the MSSP program that allow ACO's to maintain a neutral financial position for a defined period of time. We believe that this approach may be appropriate in this regulation – allow APMs to sit between the two programs, not eligible for the 5% Advanced APM bonus, but not subject to the MIPS methodology either for a period of time such as two years. At the completion of this time period, the APM would either have to move into the full Advanced APM program or be subjected to the MIPS criteria as applicable with no special consideration under any of the four categories.

Thank you for the opportunity to work with you to stand up a program that meets the needs of Medicare beneficiaries, their physicians, and the Medicare program. We remain steadfast in our desire to see this law succeed. To improve the final rule, we offer the following summary and detailed comments.

E. MIPS Program Details

1. MIPS-Eligible Clinicians

a. Definition of a MIPS-Eligible Clinician

CMS proposes to define a MIPS-eligible clinician (at §414.1305) as a physician (as defined in section 1861(r) of the Act), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5) of the Act), a certified registered nurse anesthetist (as defined in section 1861(bb)(2) of the Act), and a group that includes such professionals. CMS intends to consider using its authority under section 1848(q)(1)(C)(i)(II) of the Act to expand the definition of MIPS-eligible clinician to include additional clinicians (as defined in section 1848(k)(3)(B) of the Act) made eligible through rulemaking in future years. Additionally, CMS proposes (as defined at proposed §414.1305) to allow those not yet subject to MIPS adjustments the option to report voluntarily measures and activities for MIPS. Those who choose to voluntarily report on applicable measures and activities specified under MIPS, would not receive a MIPS payment adjustment but would use this opportunity to learn the