evaluated based on Quality, Resource Use, CPIA, and ACI. The statistical reliability of the measures used in those areas depends on the number of cases in the denominator, which is almost always number of beneficiaries rather than allowed charges. Under the agency's definition, an eligible clinician who provided $11,000 in billing charges to five Part-B enrolled Medicare beneficiaries would not be excluded based on the low-volume threshold. However, neither the AAFP nor CMS should have any confidence in the Quality and Resource Use measures from a five-beneficiary sample. Accordingly, we recommend that CMS define MIPS-eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS-eligible clinician or group who, during the performance period, provides care for 125 or more Part B-enrolled Medicare beneficiaries. At the level of 125 or more Part B-enrolled Medicare beneficiaries, both the AAFP and CMS can have confidence in the Quality and Resource Use measures without regard to the billing charges involved.

(ii) Payment Amount Method: Threshold Score Calculation: Numerator
CMS proposes that the numerator would be the aggregate of all payments from all other payers to the Advanced APM Entity's eligible clinicians—or the eligible clinician in the event of an individual eligible clinician assessment—under the terms of all Other Payer Advanced APMs during the QP Performance Period.

AAFP Response
The AAFP support this definition of numerator because if a beneficiary is attributed to an ACO and sees a clinician outside that ACO, payments made to the non-ACO clinician will not count towards this numerator, even if the ACO is an Other Payer Advanced APM.

8. APM Incentive Payment
a. Amount of the APM Incentive Payment
(1) Incentive Payment Base Period
CMS proposes to use the full calendar year prior to the payment year as the incentive payment base period from which to calculate the estimated aggregated payment amounts.

AAFP Response
We support this proposal for the reasons outlined in the proposed rule.

(2) Timeframe of Claims
For the incentive payment base period, CMS proposes to use a complete calendar year of claims with 3 months of claims run-out from the end of the calendar year. CMS estimates that incentive payments could be made approximately 6 months after the end of the incentive payment base period, or roughly mid-way through the payment year. However, CMS proposes that the APM Incentive Payment would be made no later than one year from end of the incentive payment base period. CMS does not propose to set a specific deadline mid-way through the payment year, because it believes doing so could pose operational risks in the event that 6 months is impracticable in a given year for reasons that CMS cannot predict.

AAFP Response
The AAFP supports the proposal to use a full year of claims, plus a 3-month claims run-out in calculating the APM payment incentive. As noted in the proposed rule, on average, 99.3 percent of Medicare claims are processed within three months of the end of the calendar year, which is more than sufficient for calculating the APM payment incentive.