Regarding the specialty designation of medical homes, NCQA is the only program that currently offers specialty recognition. The standards for specialty medical home certification under the 2016 NCQA Patient-Centered Specialty Practice (PCSP) program align much more closely with the PCMH standards than in the past. While these standards call for expanded coordination and collaboration with primary care, we believe a specialty medical home designation alone, in the absence of a primary care PCMH, is not sufficient to warrant special treatment under MIPS. Specialty practices support and complement a primary care patient-centered medical home, but do not replicate all aspects of PCMH, and do no replace the need for a primary care medical home. We also are concerned that only one such specialty certification program exists (e.g., the NCQA PCSP program), and should not be specifically validated by CMS. In addition, we are concerned that the existing recognition programs "teach to the test" rather than drive and support sustainable change. We support restricting the designation of PCMH status solely to primary care-focused patient medical homes and oppose awarding credit to specialty-focused medical homes.

Finally, we recognize that some TINs may have some practices with PCMH designation, and some without PCMH designation. Although, the AAFP recognizes that trying to separate out PCMH participants and non-participants would be overly burdensome. We believe it is unfair to small practices that have invested in PCMH recognition to be scored the same as practices that have not. Accordingly, we do not believe the full TIN should get CPIA credit simply because one site in the TIN has PCMH recognition. Granting PCMH CPIA credit to an entire TIN based on the PCMH recognition of one site within the TIN represents a huge opportunity for gaming of the system. A TIN should only receive PCMH CPIA credit in proportion to the number of practice sites within the TIN that have PCMH recognition.

3. CPIA Data Submission Criteria
a. Submission Mechanisms
CMS proposes that data be submitted via qualified registry, EHR, QCDR, CMS Web Interface, and attestation. An agreement between a MIPS-eligible clinician or group and a health IT vendor, QCDR, or quality registry for data submission for CPIA as well as other performance data submitted outside of CPIA could be contained in one agreement. An additional submission by a claims method would be used only to supplement CPIA submissions. For example, MIPS-eligible clinicians using telehealth with modifier GT could get automatic credit.

*AAFP Response*
The AAFP agrees that a clinician participating in telehealth and submitting claims for this service should receive automatic credit with no data submission required. We would also suggest that clinicians submitting these cognitive care codes [chronic care management (CCM), transitional care management (TCM), and advance care planning (ACP)] should get credit for CPIAs.

b. Weighted Scoring
CMS proposes to divide CPIA activities into medium- and high-weight categories. High-weight category activities are defined as:

- Being aligned with National-Quality Improvement Organization;
- The CPC;
- Programs that require performance of multiple activities such as the Transforming Clinical Practice Initiative (TCPI);