The AAFP believes CDS tools should help physicians and their care teams proactively identify diagnostic options; the best treatment options; early warnings of potential problems; and alternative treatments for the physician, care team, and patient to consider. The CDS tool should contain drug information based on evidence-based, up-to-date, and scientific/medical evidence. It should include a mixture of clinical information, such as updated guidelines for the clinical use of drugs, updated safety information, and processed patient data that takes into account their experiences and outcomes. Only with this complete data set will the CDS tool enable physicians to ensure the correct drug dosing; reduce the risk of toxic drug levels; reduce the time to achieve therapeutic drug levels; decrease medication errors; and change prescribing patterns in accordance with evidence-based clinical guidelines. Without the free flow of bi-directional information from all stakeholders working together to improve quality and reduce overall cost, value-based health care will never materialize.

Finally, the AAFP also supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment methodology in Resource Use measures to incorporate social and economic factors such as race, income, education, and geographic region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician's control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified.

f. CPIA Category
CMS proposes that CPIA account for 15 percent of the CPS and that certified patient-centered medical homes (PCMHs) receive the highest potential score. Eligible clinicians or groups who are participating in an APM will earn half of the CPIA points. MIPS-eligible clinicians or groups that fail to report on applicable measures or activities that are required to be reported, will receive the lowest potential score applicable to the measure or activity.

CMS also proposes that PCMH will be recognized if it is a nationally recognized accredited PCMH, a Medicaid medical home model, or a medical home model. The NCQA Patient-Centered Specialty Recognition will also be recognized. Nationally recognized accredited PCMHs are recognized if they are accredited by the:

- Accreditation Association for Ambulatory Health Care;
- The National Committee for Quality Assurance (NCQA) PCMH recognition;
- The Joint Commission Designation; or
- The Utilization Review Accreditation Commission (URAC).

The criteria for being a nationally recognized PCMH are that it must be national in scope and must have evidence of being used by a large number of medical organizations as the model for PCMH.

AAFP Response
The AAFP believes strongly that a physician should not be required to pay a third-party accrediting body to receive recognition as an advanced primary care practice, such as a PCMH. In addition, the PCMH recognition or certification of a practice by an accrediting body may not accurately capture actual advanced primary care functionality.

Therefore the AAFP strongly urges CMS to consider the inclusion of PCMH recognition programs that accredit based on the advanced primary care functions reflected in the Joint