can track participation by eligible clinicians in activities that improve quality, practice performance, and patient outcomes. An additional data field could be added that would enable the providers of accredited educational activities to designate those activities that are MIPS-CPIA compliant. Then, the AAFP would report eligible clinician participation in such activities to CMS on a periodic basis. In addition to engaging CME accreditors to leverage existing oversight mechanisms and streamline eligible clinician's reporting requirements, this approach would also enable the nation's CME and non-physician continuing educational infrastructure to function as trusted intermediaries to engage the clinical community in CPIAs.

We strongly urge CMS to include in the final rule a role for CME accreditors (such as the AAFP) to facilitate the engagement, attestation, and auditing of eligible clinician's participation in CPIAs that is consistent with the aims of the Quality Payment Program (QPP). The AAFP is prepared to assist you, and we welcome any questions that you may have in this regard.

c. Submission Criteria
The agency proposes that high-rated CPIA would receive 20 points and medium-rated CPIA receive 10 points. To achieve the highest CPIA score, in most cases a MIPS-eligible clinician must get 60 points through a combination of medium and high activities. The exceptions to this are for small groups of 15 or fewer eligible clinicians; those practicing in rural and health professional shortage areas (HPSA); and non-patient facing eligible clinicians that only need to do two activities (either medium or high) to get the highest score or one CPIA for half the score. Those in an APM get 30 points for APM participation and need to select additional CPIAs for the additional 30 points. Eligible clinicians must select each QCDR CPIA separately and report separately on them to get credit for each. CMS seeks comment on expanding the CPIA inventory and what restrictions should be placed around CPIA measures and activities that incorporate QCDR participation.

AAFP Response
The AAFP agrees that those clinicians in small groups, rural settings, and HPSAs, will face challenges implementing the MIPS program, and we believe that eligible clinicians in medically underserved areas should be added to this list. Eligible clinicians in all of these categories face challenges related to lack of infrastructure and financial reserves that make undertaking and reporting CPIA difficult. Small group clinicians will be further handicapped since virtual groups are not an option in the first performance year. As noted above, CME that improves performance, however, will help this demographic of clinician meet their CPIA requirements.

Note, we do not think that non-patient facing clinicians fall into this same category. <u>The AAFP believes that non-patient facing clinicians should be able to choose enough CPIA to participate fully.</u>

When considering the QCDR, if activities are given the high weight as suggested above, an eligible clinician should be allowed to report on no more than one CPIA that involves a QCDR. If the score is retained at medium, the eligible clinician should be allowed to report on no more than two QCDR activities. The AAFP believes sub-specialties will primarily rely on QDCR to get full credit in this category without actively engaging in CPIA.

d. Required Period of Time for Performing an Activity
The agency proposes that each CPIA must be performed for at least 90 days during the performance year to get credit. In the future, this time period may be expanded or shortened and CMS seeks feedback in this regard.