under CPIA and urge CMS to add medically underserved areas to this group. Variability should not be a concern in the CPIA category, as we believe variability will present itself in the performance rates of the Quality and Resource Use categories.

(c) Points for Certified-PCMH or Comparable Specialty Practice
MACRA specifies that a MIPS-eligible clinician who is in a practice that is certified as a PCMH or comparable specialty practice must be given the highest potential score for the CPIA performance category for the performance period. CMS proposes that PCMH practices are those that have received accreditation from the Accreditation Association for Ambulatory Health Care, the National Committee for Quality Assurance (NCQA), The Joint Commission, and the Utilization Review Accreditation Commission (URAC); or are a Medicaid Medical Home Model or Medical Home Model. CMS further discusses that those who participate in a CMS study on CPIA and measurement would receive the maximum possible number of points.

AAFP Response
MACRA, as approved by Congress, emphasized the role of advanced primary care practices. This emphasis is apparent through the inclusion of the medical home as a preferred delivery model under both the MIPS and APM pathway. It is further emphasized through legislative language that exempts medical home practices from any risk under APMs and the guarantee of maximum scoring under MIPS. It is clear to the AAFP that Congress fully supports the medical home and intends for it to be a model recognized as an Advanced APM. The delivery of high-performing team-based patient-centered primary care is at the heart of the medical home model of care. A significant body of evidence clearly shows the medical home driving reductions in health care costs and/or unnecessary utilization, such as emergency department (ED) visits, inpatient hospitalizations and hospital readmissions. Those with the most impressive cost and utilization outcomes are generally those who participate in multi-payer programs with specific incentives or performance measures linked to quality, utilization, patient engagement or cost savings, such as the CPC initiative.

Today, nearly 50 percent of family physicians practice in a medical home model. CMS's failure to make a medical home model available as an Advanced APM would not only violate Congressional intent, but would undercut more than a decade of progressive transformation in primary care practices – not to mention demoralize tens of thousands of primary care physicians. We urge CMS to identify a medical home model that can be included as an Advanced APM.

The AAFP supports the inclusion of the four nationally recognized medical home programs outlined in the regulation; however, we strongly recommend expansion beyond these four organizations. 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. The AAFP recommends that CMS broaden their definition of PCMH to specifically be inclusive of programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, and/or others in a region or state. The programs to be included should be clearly articulated by CMS in advance, along with transparent criteria and methodology for the addition of new PCMH programs.