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 Principles of the Patient-Centered Medical Home and the five key functions of the CPC initiative.

The AAFP recommend CMS establish a process to review and grant medical home recognition authority to any entity that meets the necessary criteria as a PCMH accreditor. This would be similar to processes currently used for hospital and laboratory accreditation. The AAFP, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association have joint Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs that build on the Joint Principles of the Patient-Centered Medical Home, which the four groups developed and adopted in February 2007. CMS could use these guidelines in exercising such a deeming authority. In addition, the AAFP encourages the inclusion of state-based, payer sponsored, or regional PCMH recognition programs.

The AAFP urges CMS to consider the inclusion of state-based, payer-sponsored, or regional PCMH recognition programs. These programs often provide more direct support and lower expenses for practices, while being customized to the need of health care consumers in that region.

Regarding the specialty designation of medical homes, while the standards for specialist medical home certification under the 2016 NCQA PCSP program align much more closely with the PCMH standards than in the past and 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 PCMH, but do not replicate all aspects of PCMH and do not replace the need for a primary care medical home. We also are concerned that only one such specialty certification program exists—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 PCMH designation solely to primary care-focused patient medical homes and oppose awarding credit to specialty-focused medical homes.

(d) Calculating the CPIA Performance Category Score
To determine the CPIA performance category score, CMS proposes to sum the points for all of the MIPS-eligible clinician's reported activities and divide by the proposed CPIA maximum score of 60. CMS will consider modifications in future years.

AAFP Response
The AAFP supports scoring the CPIA category as described. However, the AAFP believes non-facing clinicians must be held accountable for practice improvement similar to their patient-facing peers. Non-patient facing clinicians should be able to choose enough CPIA activities to score 60 points and do not warrant special consideration. The AAFP believes those clinicians in small groups, HPSAs and rural areas deserve special consideration and supports adding medically underserved areas to this group for special consideration.

Clinicians should be allowed to report the same activities in the first two years of MIPS, but this may need to be revisited in the future as more experience is gained in the CPIA category.