August 23, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1651–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I am responding to the proposed rule that, among other policy changes, updates and make revisions to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for 2017 as published by the Centers for Medicare & Medicaid Services (CMS) in the July 15, 2016, *Federal Register*.

Within this proposed rule in "Section X. Comprehensive End-Stage Renal Disease Care Model and Future Payment Models," CMS asks:

> *How could primary-care based models better integrate with Alternative Payment Models (APMs) or Advanced Alternative Payment Models (AAPMs) focused on kidney care to help prevent development of chronic kidney disease in patients and progression to ESRD? Primary-care based models may include patient-centered medical homes or other APMs.*

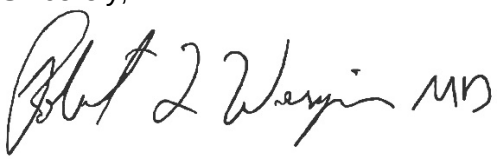
While the AAFP supports CMS efforts to comprehensively address and appropriately pay for ESRD services, the AAFP has consistently made the point that we do not want to see fragmented care under fee-for-service replaced with fragmented care under APMs. We believe that you and other CMS officials share our concern that such an outcome would be contrary to the intent of APMs, which should promote the delivery of comprehensive, coordinated, and patient-centered care. As articulated in our June 24, 2016, comment letter sent to CMS and specific to specialty- or disease- focused APMs, the AAFP cautions the agency about needlessly fragmenting care through a plethora of specialty or disease-focused APMs. The AAFP continues to call for APMs to be primary care-centered, since there is ample evidence that primary care-oriented health systems are more effective, more efficient, and yield better

outcomes for patients than systems that are not. Of the clinically active AAFP members, nearly half (45 percent) work in an officially recognized patient centered medical home. This demonstrates family physicians' commitment to transitioning away from a model of symptom and illness based episodic care to a system of comprehensive coordinated primary care for children, youth and adults and illustrates the lack of need for specialty- and disease- focused APMs that can fragment care.

If CMS moves ahead with creating specialty- or disease-focused APMs, then the AAFP strongly urges CMS to require all specialty- or disease-focused APMs to initiate contact with the primary care physicians serving Medicare patients in that geographic area, so patients receiving care through a specialty- or disease-focused APMs are also connected with their primary care physician and continue to receive high-quality, coordinated, comprehensive, and patient-centered care. Similar to when a patient is admitted to the hospital and asked who their primary care physician is for purposes of the discharge summary, the specialty- or disease-focused APM should ask their ESRD patients who their primary care physician is in order to facilitate proper communication. Primary care physicians are best suited to lead a team of professionals dedicated to providing proactive, preventive, and chronic care management through all stages of a patient's life.

The AAFP appreciates that this proposed rule continues efforts to improve care for Medicare beneficiaries with ESRD, and we continue to assert that primary care physicians are best suited to provide continuing responsibility for providing patients' comprehensive care. We also appreciate the opportunity to offer CMS these comments. For any questions you might have, please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair