



## DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DEC - 1 2016

*Administrator*

Washington, DC 20201

Wanda D. Filer, MD  
Board Chair  
American Academy of Family Physicians  
1133 Connecticut Ave., NW  
Suite 1100  
Washington, DC 20036

Dear Dr. Filer:

Your predecessor, Dr. Robert L. Wergin, provided the attached April 11, 2016 letter to CMS articulating the American Academy of Physicians' (AAFP) vision of how the Medicare Access and CHIP Reauthorization Act of 2015 can fundamentally change the health care delivery system to achieve the goals of improving the patient experience of care, improving the health of populations, and reducing the cost of health care. Because of the thoughtful comments expressed in the April letter, the Centers for Medicare & Medicaid Services (CMS) is supplying this response to the AAFP. CMS has taken into consideration, feedback from many stakeholders, including your organization, and has issued the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model Incentive final rule with comment period (81 FR 77008, Nov. 4, 2016); which addresses the Quality Payment Program. We also addressed payment for primary care services under the Medicare calendar year 2017 Physician Fee Schedule (PFS) final rule (CY 2017 PFS final rule, 81 FR 80170, Nov. 15, 2016).

The CMS shares the AAFP's commitment to advancing a health care delivery system that rewards better care and smarter spending, and we recognize that primary care plays an important role in creating that system. The final Quality Payment Program rule is designed to advance this goal by better aligning incentives and more closely tying Medicare payments to the cost and quality of patient care.

The Quality Payment Program will equip clinicians with the tools and flexibility to provide high-quality, patient-centered care. With clinicians as partners, we are building a system that delivers better care, one in which: clinicians work together and have a full understanding of patients' needs, Medicare pays for what works and spends taxpayer money more wisely, and patients are in the center of their care, resulting in a healthier country. This final rule with comment period is informed by a months-long listening tour with nearly 100,000 attendees and nearly 4,000 public comments. As we continue to engage in policy making, we will continue to listen and refine our approach, in order to best advance these goals and to create robust and compelling pathways for physicians and their clinical teams to participate.

We appreciate the AAFP's comments regarding the value of primary care services paid for under the PFS. We have long been committed to supporting primary care, and we have increasingly recognized care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth. We have undertaken a number of efforts designed to address inequities in the payments made under the PFS. In 2013, we began

paying separately for transitional care management to recognize the work of primary care physicians treating beneficiaries discharged from an institution. In 2015, we began paying separately for non-face-to-face chronic care management services for beneficiaries with two or more chronic conditions. In the CY 2016 PFS proposed rule, we sought comments on how Medicare might continue these efforts related to recognizing additional resource costs of cognitive work, improve payment for collaborative care models, and reduce administrative burdens associated with reporting chronic care management services.

In the CY 2017 PFS final rule, we continued our ongoing efforts to improve payment within traditional Fee-for-Service Medicare for primary care and patient-centered care management. We finalized several revisions to the PFS focused on improving how Medicare pays for primary care, care coordination, and mental health care. These changes include:

- Making separate payment for certain existing Current Procedural Terminology (CPT) codes describing non-face-to-face prolonged evaluation and management services;
- Revaluing existing CPT codes describing face-to-face prolonged services;
- Making separate payment using new codes to describe the comprehensive assessment and care planning for patients with cognitive impairment (e.g., dementia) and for patients requiring chronic care management;
- Making separate payment using new codes to pay practices that use interprofessional care management resources to treat patients with behavioral health conditions;
- Making separate payment for codes describing chronic care management for patients with greater complexities; and
- Making several changes to reduce administrative burden associated with the chronic care management codes to remove potential barriers to furnishing and billing for these important services.

We appreciate the information the AAFP provided about additional ways that we can improve payment accuracy under the PFS, and as we continue our efforts to make appropriate payments for primary care services, we will consider this information. In particular, we look forward to working closely with the AAFP and all physicians to implement the Quality Payment Program. We thank the organization for the feedback and hope that we can count on you to help us engage family practice physicians so that all physicians may be successful in the Quality Payment Program.

Sincerely,



Andrew M. Slavitt  
Acting Administrator