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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Information Regarding Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Request for Information (RFI) on Patient Relationship Categories and Codes, as required by section 101(f) of the Medicare Access and CHIP Reauthorization Act (MACRA).

The AMA was engaged in the legislative process that ultimately led to the enactment of MACRA, and believes the new physician payment framework in MACRA must be implemented in a way that will facilitate and support significant improvements in the delivery of care for Medicare patients. We submitted detailed comments to CMS in response to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model proposed rule, including on the Resource Use performance category.

We understand that the current RFI is the first of several opportunities for stakeholders to comment on the development of patient relationship categories and codes. We also note that the law gives CMS some latitude in how this section of MACRA is implemented. The AMA welcomes feedback from the agency on steps the physician community can take to assist in construction and evaluation of these codes and related provisions of MACRA. A participatory process will increase the likelihood that physicians will find the codes or any possible alternatives clinically relevant for their practices, administratively feasible, and helpful in achieving better care for patients.

Overarching Principles

The AMA supports the development of a new method for attributing costs to physicians. We believe previous programs that have attempted to attribute cost to individual physicians, such as the Value-Based Payment Modifier, have major flaws, and we appreciate the opportunity to work with CMS to develop a more effective method of attributing costs to physicians.

In addition, we urge CMS to work with stakeholders throughout the development of new attribution tools and methods to ensure that they are implemented in a way that provides flexibility, minimizes the reporting burden on physicians, and allows small, independent practices to be successful.

We believe CMS needs to provide additional information on how it plans to use these patient relationship categories and codes to attribute cost and patient outcomes to physicians. In order to provide useful feedback on these categories, CMS must provide more details regarding how patient relationship designations will interact with the episode groups that are also required under MACRA to attribute cost, as well as any claims-based quality measures to physicians. We look forward to working with CMS to further develop these methodologies as additional information is released. We outline below what we believe should be some of the key principles in the development of patient relationship categories and codes.

Pilot Testing is Imperative

The AMA believes CMS must conduct a three-phased pilot test of the patient relationship designations that they ultimately propose. First, CMS must implement a pilot program to test whether the patient relationship categories it proposes will work in practice and determine their impact on physicians' cost and administrative burden. Following that testing, CMS should make necessary adjustments to the categories based on feedback from the pilot. Then, CMS will need to evaluate the impact on the calculation and comparison of physician resource use. Finally, if the codes are finalized, CMS will need to allow physicians time to pilot test its systems using the new patient relationship categories.

In order to ensure a successful launch of the patient relationship categories and/or codes, CMS must have physician buy-in. We believe that physicians will be significantly more likely to appreciate the necessity of reporting patient relationships if they know that the categories have been tested and proven to successfully and accurately attribute cost to physicians.

The AMA also asked CMS, in our MACRA comments, to pilot the episode groups. CMS should run a pilot program testing both of these new programs simultaneously, which would better illustrate to physicians how CMS actually plans to attribute the cost of episode groups using patient relationship categories.

We understand there are serious time constraints with launching a pilot program, given that the statute requires reporting of patient relationship categories starting in 2018. However, the AMA wants to ensure that resource use and cost attribution are done correctly, and we are willing to work with CMS to help implement a pilot program.

Reduce Reporting Burden for Physicians

Physicians will face significant changes in 2017 and 2018 as they begin participating in MIPS. They will have to adopt new workflows, report on new quality and electronic health records measures, and implement Clinical Practice Improvement Activities. If physicians have to adopt further changes related to reporting patient relationship categories, such as reporting new codes on each individual claim form, it will significantly increase their administrative burden. We urge CMS to implement the patient relationship categories in a manner that minimizes the burden on physicians and their staff. Please see

below for the AMA's specific recommendations on how to implement the patient designations in the least burdensome way for physicians.

Address Logistical Issues while Developing Patient Relationship Categories and Codes

The AMA has concerns that CMS is developing the patient relationship categories before considering logistical issues, such as where the codes will be reported on the claim form. We believe that the patient relationship categories and logistical issues must be addressed simultaneously. In order to help create workable, accurate patient relationship codes, physicians must understand where they would report these on individual claim forms and CMS will need to ensure that it has followed all the steps that may be necessary to ensure that claims forms and Medicare contractors can accept and process new patient relationship information. We urge CMS to ensure that all teams developing the patient relationship categories and codes, as well as those charged with determining how these codes will be reported, are involved in the process and engaged with stakeholders from start to finish.

Divide Cost Attribution among Providers

In order for these patient relationship categories to be successful, they must accurately attribute cost, in conjunction with the episode groups, to physicians who actually have control over the cost of the care they are attributed. The AMA urges CMS not to hold multiple physicians accountable for the same total cost of care. If there is an episode of care that is attributed to three physicians, we urge CMS to develop a way to divide the cost of care among physicians in proportion to the amount of care they provided and/or controlled within the episode. Flexibility will be needed because the exact attribution and cost allocation rules are likely to vary according to the type of service or condition involved. CMS, therefore, must provide more information regarding how the patient relationship categories and episode groups will attribute care to physicians, and must continue to work with stakeholders to ensure the care attribution methodology accurately attributes cost to the physicians who actually have control over the cost of care.

Possible Unintended Consequences

The AMA further urges CMS to design the patient relationship designations in a way that allows small, independent practices to be successful. We have concerns that requiring physicians to report a new code on every claim may create a significant burden for physicians, especially small practices and solo practitioners, requiring them to hire additional staff and spend less time with patients. This could create a further push toward physicians becoming employed by hospitals and the consolidation of healthcare groups. We believe that small, independent practices are a vital component of our nation's healthcare system, and must be maintained.

In addition, CMS must ensure that using patient relationship codes to attribute cost to physicians does not create an access problem for patients. CMS must ensure that they develop cost attribution methodology in a way that adequately accounts for risk adjustment and does not penalize physicians for treating higher cost patients.

<u>Response to Questions</u>

It is the AMA's intention that the following comments will provide guidance to CMS as it further develops the patient relationship categories and codes. The AMA also urges CMS to consider and

incorporate the specific medical specialty society comments on the individual relationships, which reflect the relevant patient relationships that tend to be provided by their members.

Question 1: Are the draft categories clear enough to enable physicians and practitioners to consistently and reliably self-identify an appropriate patient relationship category for a given clinical situation? As clinicians furnishing care to Medicare beneficiaries practice in a wide variety of care settings, do the draft categories capture the majority of patient relationships for clinicians? If not, what is missing?

The five patient categories proposed by CMS are summarized as follows:

i. Clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care.
ii. Clinician who provides continuing specialized chronic care to the patient.
iii. Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode.
iv. Clinician who is a consultant during the acute episode.
v. Clinician who furnishes care to the patient only as ordered by another clinician.

Potential Alternatives

The AMA does not believe the categories CMS proposed will fully account for all patient relationships, and we believe there are simpler categorization methods CMS should consider. We caution CMS that there is no perfect solution or global rule that can apply to all patient and physician relationships. However, we believe the possible alternatives below should be considered as possible means of better capturing the majority of patient relationships and minimizing administrative burden for physicians.

- Relationships could be categorized as either continuous or episodic, and either broad or focused, resulting in four categories: continuous/broad, continuous/focused, episodic/broad, and episodic/focused.

    - **Continuous/broad**. This category would include physicians who provide the principal care for a patient, where there is no planned endpoint of the relationship. Care in this category is comprehensive, dealing with the entire scope of patient problems, either directly or in a care coordination role.
    - **Continuous/focused**. This category could include a specialist whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time. For example, a rheumatologist treating a patient with rheumatoid arthritis with biologics. The rheumatologist would deal with the rheumatological issues of the patient, for the "foreseeable future." The relationship would not be fundamentally changed if an acute problem develops that is within the scope of the rheumatologists' practice; however, this would not be considered broad care unless the rheumatologist also takes care of all health care needs for the patient (this may occur sometimes, in which case the rheumatologist would be in the continuous/broad category). Another example is medical oncology. The oncologist's management of the patient's care might change over time if the

patient completes a course of treatment and then needs to be monitored afterwards, but the relationship is continuous and focused.

- **Episodic/broad**. This category may include hospitalists and skilled nursing facility (subacute) physicians. These physicians have broad responsibility for the comprehensive needs of the patients, but only during a defined period and circumstance.
- **Episodic/focused**. This category could include surgical and other specialists focused on particular types of treatment. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of intervention. There is an expected course of post-intervention recovery after which the relationship typically ends. During that period, care may be delivered by a team and the surgeon would be the principal provider. It might also be a medical sub-specialist dealing with a time-limited problem, such as a newly acquired or periodically recurring infection or flare-up of a chronic problem.
- We believe these four categories may better capture patient relationships, however, with these four categories there may still be a need for CMS' proposed (v), a clinician who furnishes care to the patient only as ordered by another clinician. This relationship may not be adequately captured by the alternative categories suggested above and may need to be a separate option for physicians who are only providing care ordered by other clinicians.

- CMS could develop default patient relationship codes that a particular physician would be assumed to have had with the patient unless the physician specifically identified a different relationship with a particular patient. CMS already has information on a physician's site of service, specialty and Current Procedural Terminology or International Classification of Disease code provided on claim forms. The AMA believes it may be possible, using this information, to determine a physician's typical relationship with patients. For example, most of the time a primary care physician would be continuous/broad and a surgeon would be episodic/focused. As we stated previously, there will always be exceptions, and in those cases, physicians could provide additional information on the claims form to indicate the patient relationship category for the particular service.

We believe this approach would significantly reduce the reporting burden for physicians.

- The statute states "claims submitted for items or services furnished by a physician or applicable practitioner on or after January 1, 2018 shall, **as determined appropriate by the Secretary,** include – (A) applicable codes," and "use the patient relationship codes reported on claims to attribute patients (in whole or part) to one or more physicians and applicable practitioners." We believe this gives CMS the discretion to only require the reporting of these codes on claims when the patient relationship category is outside the physician's typical patient relationship.

- CMS should also consider using modifiers rather than codes to identify physicians' patient relationships. This would require less modification of the current claims form and should pose a smaller administrative burden for physicians than using an entirely new set of codes. In addition, CMS has processes already in place for the maintenance and publication of Healthcare Common Procedure Coding System modifiers.

The AMA also offers the below feedback on the five proposed patient relationship categories.

Avoid "Primary" In Patient Relationship Categories

We urge CMS to avoid using the phrase "primary care provider" when describing patient relationship categories. We believe that this will cause unnecessary confusion among physicians, as many physicians who may not be considered typical primary care providers might be responsible for providing the majority of the patient's care in certain circumstances. For example, an oncologist may take over the principal care role during a patient's cancer treatment, even though they may not consider themselves a "primary care physician." Therefore, in order to avoid any confusion for physicians, we urge CMS to use the term "principal" instead of "primary" when defining which physician is responsible for the overall coordination of a patient's care.

Allow Multiple Physicians to Report the Same Patient Relationship

The AMA believes multiple physicians must be able to report the same patient relationship category for the same episode of care. This is particularly important in team-based care arrangements, where more than one physician may be considered to be the principal care physician. For example, hospitalists and intensivists often share the same patients during a hospital stay. We believe both physicians should be able to select the same patient relationship category if they both feel they are a principal care provider. In addition to having multiple physicians in the same category for the same patient, a physician may fall into multiple categories for the same patient, for example: An interventional radiologist or cardiologist may read a CT early in the morning for patient A, which would be a diagnostic service, and then later that same day perform an intervention on patient A to treat the diagnosed issue. We believe the physician should be able to report the CT with category (v) and the intervention with category (iii). Alternatively, if CMS adopts the continuous/episodic and broad/focused approach described above, both activities would fit within episodic/focused category.

This scenario also raises questions about when a defined episode would begin. Would a diagnostic test be included in the episode once the patient's diagnosis is determined? Or would there need to be a separate way for a physician to report that they are involved in diagnosing the patient's condition? Situations such as this one will add complexity to the reporting process and CMS will need to work closely with the medical profession to determine details for reporting these services.

Question 2: As described above, we believe that there may be some overlap between several of the categories. To distinguish the categories, we are considering the inclusion of a patient relationship category that is specific to non-patient facing clinicians. Is this a useful and helpful distinction, or is this category sufficiently covered by the other existing categories?

The AMA does not support the inclusion of a category or terminology that utilizes "non-patient facing clinicians" in reference to individual physicians or physician specialties. The specialties listed by CMS as examples for category (v), for example, may indeed have direct interaction with patients. In addition, specialties that may typically be considered non-patient facing by CMS, may provide services as a consultant or diagnostician that are patient facing. For example, after a patient is referred for a screening mammogram, the radiologist determines that a diagnostic mammogram is warranted. If the diagnostic mammogram is normal, the radiologist will typically interact with the patient regarding follow up exams. If abnormal, the radiologist will perform additional testing. In this example, the radiologist is actively involved in the diagnosis and treatment options for the patient and would not fit into the same category as

they would if they were remotely reviewing a chest x-ray. Therefore, it would not be appropriate to designate a specialty like radiology as non-patient facing in all situations.

Question 3: Is the description of an acute episode accurately described? If not, are there alternatives we should consider?

As discussed above, the AMA believes that categorizing care as episodic versus continuous may better capture the type of relationship a physician has with a patient. See Question 4 for our additional recommendations on other categories that may be needed.

The AMA also believes the distinction between acute and chronic is not well defined. In clinical practice, an acute situation often becomes chronic. For example, if a person with no cardiac episodes comes in with pulmonary edema, the condition will either go away or it will be chronic. If the patient is in the hospital three months, at what point does the episode become chronic? If a physician is treating an acute episode and it develops into a chronic episode, would the patient relationship be defined as acute or chronic?

In addition, there may be situations where patients can be classified in multiple ways with acute on chronic conditions. For example, a patient with rheumatoid arthritis, being followed by a rheumatologist, on Prednisone and Enbrel comes to a clinic with a hot swollen knee. In this example, all previous care would be considered chronic for prior visits as therapy was being established and monitored. Would the visit for the hot swollen knee now be categorized as chronic or acute?

We believe these examples illustrate that the lines between acute and chronic episodes can blur.

Question 4: Is distinguishing relationships by acute care and continuing care the appropriate way to classify relationships? Are these the only two categories of care or would it be appropriate to have a category between acute and continuing care?

The AMA believes if CMS retains its five originally proposed categories, then additional categories of care are needed. We recommend adding preventive, diagnostic, post-acute, and acute on chronic categories of care.

As described above, there will be numerous situations where a patient has an acute episode while also being treated for a chronic episode. These patient relationships should be categorized as acute on chronic. Alternatively, if CMS adopts the categories proposed by AMA above, these patient relationships could be categorized as episodic/focused.

A patient may also utilize a physician for all preventive services and immediately transition to specialists for acute or chronic care needs. In addition, CMS is also determining the patient relationships for many non-physician providers who may only provide preventive care to a patient. In order to capture these patient relationships, CMS should add a preventive category. We caution CMS, however, that there may be different levels of preventive service for patients who are still healthy versus those that are already sick. Physicians treating these two types of patients would incur vastly different costs for providing preventive services.

Similarly, there may be some instances where the services provided are diagnostic only. For example, a physician whose only relationship with the patient is to conduct a diagnostic test, such as a pathologist or radiologist may be included in this category.

We also believe there is a need for a post-acute category for care provided following an acute episode. In order to adequately capture patient relationships at skilled nursing facilities, long term care hospitals, or inpatient rehabilitation facilities, CMS must include a post-acute category.

Question 5: Are we adequately capturing Post-Acute Care clinicians, such as practitioners in a Skilled Nursing Facility or Long Term Care Hospital?

As stated above, we believe that the inclusion of preventive and post-acute patient relationship categories would assist in capturing the practitioners in skilled nursing facilities or long term care hospitals.

We also believe that the site of service alone should not determine the patient relationship category. For example, a nursing home director would be the principal physician for some patients, whereas other patients will be transported to primary care physicians and specialists for visits and ongoing care.

Question 6: What type of technical assistance and education would be helpful to clinicians in applying these codes to their claims?

As stated previously, the AMA believes that extensive outreach and pilot testing the patient relationship categories and/or codes prior to implementation is critical. The requirement to assign patient relationships for every patient a physician sees, has the potential to require even more education than ICD-10 implementation, which was extremely time-intensive and burdensome for physicians. The ICD-10 rules were very specific. The patient relationship categories, however, are more generalized and would require significant education for both physicians and their staff.

We also urge CMS to work with the physician community to develop numerous clinical examples for each patient relationship category in order to assist physicians in choosing the accurate category for each patient.

Furthermore, CMS will need to identify what documentation will be required. Depending on the level of documentation required, varying levels of education will be needed for clinical and billing staff. There will also need to be modification of electronic health records and practice management software. We encourage CMS to engage in detailed conversations with vendors regarding what will be required for this new categorization method to be implemented.

Question 7: The clinicians are responsible for identifying their relationship to the patient. In the case where the clinician does not select the procedure and diagnosis code, who will select the patient relationship code? Are there particular clinician workflow issues involved?

The AMA believes that billers will also need significant education on patient relationship categories. Using our alternative approach above, billers will need to determine when the patient relationship category is clear, given the information already provided on the claim form, or when CMS requires additional information to determine the patient relationship. We urge CMS to choose the most simplistic

patient categorization method available, and to use default patient relationship categories from information already provided on claim forms whenever possible.

The amount of additional work required for both physicians and staff to assign patient relationship codes for each patient, will be significant. There will be numerous workflow and software issues that must be addressed as these new codes are rolled out. As noted earlier, we believe that CMS needs to consult with vendors to address any software implementation and work flow issues.

Question 8: CMS understands that there are often situations when multiple clinicians bill for services on a single claim. What should CMS consider to help clinicians accurately report patient relationships for each individual clinician on that claim?

As indicated earlier, AMA recommends that CMS use modifiers to indicate the patient relationship code on each claim form. We believe this is the simplest way to incorporate patient relationship codes into the billing and claims process. We urge CMS to consider the feasibility of adding a modifier on the current claim form for patient relationship categories. Is there room for an additional modifier on each claim form? What is the average number of modifiers physicians use? Will this be a problem for some specialties that tend to use more modifiers? The AMA asks CMS to consider these questions and provide feedback to stakeholders regarding these logistical issues.

In addition, we urge CMS to provide additional information on how these modifiers will interact with episode groups. How do these categories work with episode groups? Will these codes be used for other purposes such as determining and allocating payments for alternative payment models or quality measures?

As stated previously, we urge CMS to address these logistical issues prior to finalizing any patient relationship categories. We believe that in both inpatient and outpatient settings, adding a modifier to the claim form is the simplest way to report patient relationship categories, however, this method will still be extremely burdensome for physicians unless other steps such as creating default identifiers are taken. We look forward to an ongoing dialogue with CMS regarding how to resolve these logistical issues as more information is provided.

Thank you for your careful consideration of the AMA's comments on the CMS RFI on Patient Relationships Categories and Codes. We appreciate the continued opportunities to offer recommendations to improve the implementation of MACRA. If you should have any questions regarding this letter, please feel free to contact Margaret Garikes, Vice President of Federal Affairs, at Margaret.Garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD