AMA
AMERICAN MEDICAL ASSOCIATION

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January 6, 2017

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:

The physician and medical student members of the American Medical Association (AMA) thank you for allowing continued input on the patient relationship categories and codes required by section 101(f) of the Medicare Access and CHIP Reauthorization Act (MACRA).

The AMA submitted comments to the Centers for Medicare & Medicaid Services' (CMS) previous request for information (RFI) on patient relationship categories and codes on August 10, 2016 based on the information provided by CMS at that time. We are pleased that CMS adopted many of the proposals developed by the AMA, including the alternative patient relationship categories: continuous/broad, continuous/focused, episodic/broad, episodic/focused, and only as ordered by another physician. As we stated in our earlier comment letter, we believe these four categories more accurately capture patient relationships than the categories CMS had originally proposed. We also support CMS' decision to use Healthcare Common Procedure Coding System modifiers to identify patient relationship categories. Use of modifiers is likely to be less disruptive to practice workflows and to the current claims submission process than using an entirely new set of codes would be.

While we appreciate CMS' incorporation of the AMA's suggested patient relationship categories and use of modifiers to identify these categories, there are several issues related to patient relationship categories and codes discussed below that still need to be addressed.

- **Consider potential default assignment of relationship codes based on specialty or practice patterns:** The AMA's previous comment letter urged CMS to develop default patient relationship codes that a particular physician would be assumed to have with a patient, unless the physician specifically identifies a different relationship. Since CMS already has information on a physician's site of service, specialty, Current Procedural Terminology, and Internal Classification of Disease codes from the physician's Medicare claims, establishing a default code for each physician could significantly reduce their reporting burdens.

- **Pilot testing is imperative:** Conducting pilot testing will provide an opportunity for CMS and stakeholders to discover any possible issues that may arise from the patient relationship categories and make any necessary refinements. In order to ensure a successful launch of the patient relationship categories or codes, CMS must have physician buy-in and an opportunity to test the accuracy and appropriateness of these new tools. We believe that physicians will be significantly more likely to appreciate the necessity of reporting patient relationships if they know the categories have been tested, proven to be workable, and accurately attribute costs to physicians.

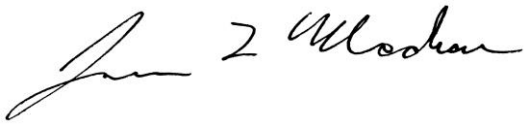
- **Ensure all possible relationships have been captured:** While the AMA believes the framework of patient relationship categories CMS laid out in this RFI is the correct approach, we urge CMS to continue to work with individual specialty societies to ensure all possible physician and patient relationships have been captured. CMS should engage with specialty societies that have concerns that the existing categories do not capture their physician's relationships, and create additional categories if needed.

- **Divide cost attribution among providers:** In order for these patient relationship categories to be successful, they must accurately attribute costs of care to physicians that the physicians can actually influence or control. The AMA urges CMS not to hold multiple physicians accountable for the same total costs of patient care. If an episode of care is attributed to two or more physicians, for example, we urge CMS to divide the cost of care among the physicians in proportion to the amount of influence or control they had over the episode's cost through their ordering or provision of services included in the episode.

- **Provide additional information on implementation:** CMS should provide more information regarding how it plans to use these patient relationship categories and codes to attribute cost and patient outcomes to physicians. In order to continue to generate 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 to physicians. In addition, there are a number of administrative questions that need to be addressed such as whether reporting the patient relationship code modifier once on the claim form will suffice, and whether physicians exempt from Merit-Based Incentive Payment System reporting are also exempt from recording patient relationship codes.

The AMA continues to 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 and minimizes the reporting burden on physicians. We appreciate that much of our previous feedback is reflected in this RFI, and we look forward to continuing our dialogue with CMS as more information is provided. We also look forward to providing additional feedback once we better understand how CMS will use these categories and codes. 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,



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