American College of Physicians
Leading Internal Medicine, Improving Lives

August 15, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-1631-P
Room 445–G, Hubert H. Humphrey Building
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 American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) Request for Information (RFI) on Patient Relationship Categories and Codes, as required by the Medicare Access and CHIP Reauthorization Act (MACRA). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP strongly supported the passage of MACRA, as well as ensuring the most accurate measurement of resource use as possible. In this context, the College would like to reiterate that we believe the Congressional intent behind the inclusion of patient relationship categories and codes within MACRA is to address concerns that the current algorithms and patient attribution rules fail to accurately link the cost of services to a clinician and also to more directly engage clinicians in the development and use of more accurate resource use measures. Along these lines, we are appreciative of CMS issuing this RFI in order to receive feedback in advance of issuing an operational list of patient relationship categories and codes.

Overarching Recommendations

1) Patients and consideration of patient impact must be paramount.

As ACP has stated in our recent letters to CMS in response to the MACRA proposed rule and the draft Measure Development Plan,[1] the College strongly recommends that CMS work to ensure that patients, families, and the relationship of patients and families with their physicians are at the forefront of the Agency's thinking in the development of both the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) pathways. It is critically important to recognize that the legislative intent of MACRA is to truly improve care for Medicare beneficiaries and thus, the policy that is developed to guide these new value-based payment programs must be thoughtfully considered in that context. ACP believes that the patient relationship categories and codes, if implemented in a thoughtful manner, can not only better engage clinicians in the development and use of more accurate resource use measures, but also more appropriately recognize and identify the relationships of patients with their clinicians. CMS therefore should consider how to also take beneficiary preferences into account when identifying the primary care clinician (i.e., their primary Medicare doctor), perhaps by using the automated mechanism that is being proposed for the Medicare Shared Savings Program (MSSP) within the 2017 Medicare Physician Fee Schedule Notice of Proposed Rulemaking (NPRM).

2) Full consideration of the impact on and need for buy-in and input from participating clinicians is critical—the initial emphasis must be on learning and improvement.

The College also urges CMS to ensure that the implementation of these categories and codes is carried out in a manner that fully considers and minimizes the impact of reporting burden on the participating clinicians and that has appropriate flexibility to allow for learning and improvement in the approach by both the Agency and the clinicians. It is a certainty that the initial implementation of these categories and codes will identify necessary areas of improvement in terms of the category definitions, the methodology by which they are submitted, how they are used to attribute cost and patient outcomes to physicians and other clinicians, and potentially other unintended and unexpected impacts—and it is critical that clinicians not be unfairly penalized as this learning process gets underway.

Along these lines, ACP would like to reiterate our recommendation from our comments on the MACRA proposed rule that CMS use its authority to adjust resource use down from 10 percent in the first performance period by setting resource use at zero and increasing the quality performance category by 10 percent to make up for the difference. This change is critical for the first performance year, as these new codes for patient relationships, as well as those for care episodes and patient conditions—which are intended to be utilized as a group for attribution purposes to better tie each clinician's role in the treatment of a patient for an episode of care to the resource use related to that care—will not be available yet.

[1] https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf; https://www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf

The College is also supportive of CMS conducting a pilot test of the patient relationship categories and codes, as has been recommended by the American Medical Association (AMA) in their response letter to this RFI. This pilot test could be conducted during the initial performance year and would allow the Agency, as well as clinicians, the ability to more effectively identify any issues and necessary adjustments prior to their implementation on a broader scale. Additionally, depending on the results of this pilot test, **ACP further recommends that CMS consider using its authority to keep the resource use category minimal in the second performance year[2] as these codes are initially implemented.** This will allow for the necessary monitoring, learning, and improvement, as discussed above, to take place before resource use measurement is fully rolled out.

No matter what approaches CMS may use to test, implement, and ultimately roll-out these patient relationship categories and codes, the College strongly recommends that the Agency thoughtfully consider and actively address the reporting burden. Clinicians and practices already will be trying to learn and understand the new, complicated requirements of the Quality Payment Program (QPP) in order to navigate the varying reporting elements in each performance category, while also continuing to integrate clinical updates into their practices and see patients. CMS must consider any expected or potential opportunity costs of this requirement in terms of its impact on time spent by clinicians providing care for patients. Therefore, it must be made clear where these codes need to be recorded on claim forms and the Agency must ensure that Medicare contractors can easily accept and process this new information.

3) Small practices need to be provided every opportunity to succeed.

In addition to the recommendations outlined above regarding addressing the impact on participating clinicians and ensuring learning and improvement by all key stakeholders, the College urges CMS to actively consider and address the unique issues that small practices may face as this requirement is implemented. As discussed in our letter to the Agency on the MACRA proposed rule, the College believes that the implementation of the virtual groups provision is an important step towards establishing a viable and effective quality payment program. It will allow small practice clinicians to aggregate their data to allow for more reliable and valid measurement as well as serve as a platform to facilitate shared accountability and collaborative efforts. This virtual group option is as important for resource use as it is for quality measurement. Many small practices do provide the bulk of primary care services in continuing care relationships with their patients; however, access to additional, supportive, and preventive services for these patients may be limited, particularly in rural areas. Virtual groups that not only consider aggregated data across primary care practices, but also encourage the connection of primary care medical homes with specialist medical homes and other critical services can provide a more accurate picture of the overall quality of care and resource use by small practices**. Further, as per our recommendations in our letter on the MACRA proposed rule, if the Agency is unable to provide a virtual group option through rulemaking for the first year,**

[2] The statute states that resource use can go up to no more than 15 percent in year 2, but then must account for 30 percent for year 3 and subsequent years.

then as a backup, ACP recommends that CMS treat small practices in a manner similar to how they were treated in the phase-in of the Value-based Payment Modifier (VM) program.

4) Transparency needs to be prioritized in order to build trust.

Finally, ACP urges CMS to ensure the utmost transparency in how the Agency attributes cost, based on the use of the patient relationship categories and codes, along with the codes for care episodes and patient conditions—which, as noted above, are intended to be utilized as a group for attribution purposes to better tie each clinician's role in the treatment of a patient for an episode of care to the resource use related to that care. It must be made clear how the cost for an episode of care will be attributed across the multiple clinicians that may be involved—and also when physicians may be caring for a patient on behalf of another physician who is temporarily unavailable (e.g., due to vacation or illness), as well as for physicians providing care to patients who co-locate (e.g., "snowbirds" who primarily reside in the north, but may also spend several months in a southern state during the winter). Prioritizing transparency in the approach to measuring resource use and involving participating clinicians in the testing and implementation is critical to building trust—and trust in all of the data to be used for determining a physician's composite score within MIPS is paramount to achieving success in the implementation of MACRA and meeting the true intent of the law.

Responses to Selected CMS Questions for Consideration

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?

ACP believes that the categories proposed by CMS are a good start and do begin to address most clinical situations—this draft category list includes:

- Continuing Care Relationships
- Acute Care Relationships
- Acute Care or Continuing Care Relationship

However, we recommend that the Agency consider other approaches that have been outlined in the literature. One such approach is typology of specialist roles that has been offered by Forrest.[3] In brief, this typology includes the following categories:

1. Cognitive Consultation: provide diagnostic or therapeutic advice to reduce clinical uncertainty
2. Procedural Consultation: perform a technical procedure to aid diagnoses, cure a condition, identify and prevent new conditions, or palliate symptoms

[3] Forrest CB. A typology of specialists' clinical roles. Arch Intern Med. 2009;169(11):1062-1068. http://archinte.jamanetwork.com/article.aspx?articleid=415082

3. Co-manager with Shared Care: share long term management with a primary care physician for a patient's referred health problem
4. Co-manager with Principle Care: assume total responsibility for long-term management of a referred health problem
5. Primary Care Clinician: provides a medical home for a group of patients

As part of the College's work to define the Patient-Centered Medical Home Neighborhood (PCMH-N),[4] we have further recommended a modification of the roles outlined by Forrest. This includes the following categories, as defined in the 2010 ACP policy paper:

- Preconsultation exchange—intended to expedite/prioritize care—a preconsultation exchange either answers a clinical question without the necessity of a formal specialty visit ("curbside consultation") and/or better prepares the patient for specialty assessment. This category includes the establishment of general referral guidelines to help expedite timeliness and appropriateness of referrals, and also provides guidance on what defines an "urgent" consult and how these should be specifically addressed. Several national specialty/subspecialty societies have already developed referral guidelines, and these should be utilized to inform this process.
- Formal consultation—to deal with a discrete question/procedure—is a formal consultation limited to one or a few visits that are focused on answering a discrete question. This may include a particular service request by a [Patient-Centered Medical Home] PCMH—or other primary care practice—for a patient. A detailed report and discussion of management recommendations would be provided to the PCMH/primary care practice. However, the specialty/subspecialty practice would not manage the problem on an ongoing basis.
- Co-management:
    - With Shared Management for the disease—the specialty/subspecialty practice provides guidance and ongoing follow up of the patient for one specific condition. Both the PCMH/primary care practice and specialty/subspecialty practice are responsible for clear delineation of expectations for the other. Within this model, the specialty/ subspecialty practice will typically provide expert advice, but will not manage the illness on a day to day basis.
    - With Principal care for the disease—both the PCMH/primary care practice and specialty/ subspecialty practice are concurrently active in the patient's treatment, but the specialty practice's responsibilities are limited to a discrete group or set of problems. The PCMH/primary care practice maintains responsibility for all other aspects of patient care, and remains the first contact for the patient.
    - With Principal care of the patient for a consuming illness for a limited period—the specialty/subspecialty practice needs to temporarily become the first contact for care of the patient because of the significant nature and impact of the disorder. However, the PCMH/primary care practice still receives on-going

[4] https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf

treatment information, retains input on secondary referrals, and may provide certain, well-defined areas of care.

- Transfer of patient to specialty/subspecialty PCMH for the entirety of care—this refers to situations in which the specialty/subspecialty practice assumes the role of the PCMH/primary care practice after consultation with the patient's current personal physician, and approval by the patient. The PCMH model is mostly aligned with a primary care practice and is specialty nonspecific. Thus, there may be situations in which the specialty/subspecialty practice may be the medical home for a subgroup of their patients. The specialty/subspecialty practice would be expected to meet the requirements of an approved third-party PCMH recognition process, and affirm the willingness to provide care consistent with the "Joint Principles," including the delivery of first-contact, whole-person, comprehensive care. This situation is best represented by a specialty/subspecialty practice that is seeing a patient frequently over a relatively long period for the treatment of a complex condition that affects multiple aspects of his or her physical and general functioning. Representative examples include:
    - An infectious disease practice caring for a patient with HIV/AIDS with complex medical and treatment issues.
    - A nephrology practice caring for a dialysis patient with end-stage renal disease.

To facilitate the implementation of the roles outlined above and therefore maintain a more effective and patient-centered communication between primary care and subspecialist doctors, ACP has developed a High-Value Care Coordination Toolkit[5] that provides practical resources for clinicians in primary care and subspecialist practices—whether they are a PCMH or PCMH specialty/subspecialty practice or not—to better understand and articulate their expectations and responsibilities with regard to their relationships with their patients.

The College is aware that the National Committee for Quality Assurance (NCQA), in its comments[6] on this RFI, has proposed an approach whereby CMS would build upon Forrest's approach by using eight categories to help clarify the potential patient-clinician relationships. While we are not endorsing the NCQA's proposal per se, we join with NCQA in encouraging CMS to consider the concept of making the PCMH and PCMH-N a basis for better defining patient relationship categories and codes.

No matter what specific approach is used to categorize physician-patient relationships for the purposes of resource use or other approaches to measurement, the Agency must recognize the importance of clearly defining primary care by using the Institute of Medicine (IOM, now the National Academy of Medicine) definition: "The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the

[5] https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit

[6] http://www.ncqa.org/public-policy/comment-letters/ncqa-comments-on-patient-relationship-categories-and-codes

context of family and community."[7] Further, as is outlined in the College's "Ethics Manual" and was stressed in ACP's 2013 paper, "Principles Supporting Dynamic Clinical Care Teams," "assignment of specific clinical and coordination responsibilities for a patient's care within a collaborative and multidisciplinary clinical care team should be based on what is in that patient's best interest."[8] Along these lines, CMS also should consider how to take beneficiary preferences into account when identifying the primary care clinician, perhaps by using the automated mechanism that is being proposed for the MSSP program within the 2017 Medicare Physician Fee Schedule NPRM. In the case of the fee schedule NPRM, CMS is proposing to use an automated mechanism to allow beneficiaries to select their primary care physician rather than requiring the Accountable Care Organization (ACO) or the physician to collect the information and communicate it back to CMS. The Agency is considering options for how this automated process for selecting a physician could occur. For example, a beneficiary could select their "favorite" physician through www.mymedicare.gov, Physician Compare, or 1-800-Medicare. This voluntary assignment option would be available to beneficiaries starting in early 2017, and the beneficiary attestations would be used for assigning beneficiaries to ACOs beginning in performance year 2018. Once this process is in place for the MSSP/ACO program, it could be applicable for other aspects of the Medicare program, including as part of the process to determine a physician-patient relationship for the purposes of more appropriately measuring resource use.

Additionally, the College seeks greater clarity as to how CMS will address situations in which two clinicians may reasonably claim the same relationship to a patient for an episode of care. As care delivery moves toward true team-based approaches, this scenario is one that will occur—and even be appropriate, such as in the case of co-management situations—on an increasing basis.

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

The definition provided by CMS of an acute care episode is as follows:

> Acute episodes may encompass a disease exacerbation for a given clinical issue, a new time-limited disease (e.g. acute bronchitis), a time-limited treatment (e.g., surgery, either inpatient or outpatient) or any defined portion of care (e.g., post-acute care) so long as it is limited, usually by time, but also potentially by site of service or another parameter of healthcare. It may occur or span inpatient and outpatient settings. Continuing care occurs when an episode is not acute, and requires the ongoing care of a clinician.

ACP does not believe that this definition is sufficient, particularly given that as it is written, any episode that is not acute is considered chronic or continuing care. There are often times when a patient's acute situation becomes continuous. For example, a 75-year old individual with co-

[7] Donaldson M, Yordy K, Vanselow N. Defining Primary Care: An Interim Report. Washington, DC: National Academies Pr; 1994

[8] http://annals.org/article.aspx?articleid=1737233

morbidities may present with “acute bronchitis” and be sent home with instructions to treat it symptomatically; however, he/she then returns the following week with worsening symptoms and a diagnoses of pneumonia that must then be followed for a more extended period of time, potentially including hospitalization. It is difficult to determine how to classify the initial episode as it is only known retrospectively that it is connected to the subsequent continuing illness.

Additionally, patients can often be classified as both acute and chronic for an episode of care. For instance, treating an acute exacerbation of congestive heart failure, which is part of ongoing chronic care management, but can lead to worsening intensive management and then, ideally, returning to baseline.

Therefore, ACP recommends that CMS consider potential alternatives to simply using acute versus continuing. Taking an approach that builds on the relationship categories initially outlined by Forrest, and considered in the context of the PCMH-N—as discussed above—could help resolve these definitional and clarity issues.

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

CMS should implement the use of these codes in the simplest manner possible—and ensure that the system used for implementing these codes has a minimal burden on practices, with special consideration for physicians in solo, small, and rural practices who may have significantly fewer resources available for implementation. To aid practices in determining the appropriate patient relationship categories, CMS could develop a decision tree or workflow that assists practices in categorizing each clinician’s relationship with a patient based on a specific service being provided. This tool could be automated using existing information in physician records including place of service, patient condition/diagnosis, and electronic health record (EHR) data to give greater certainty to physicians on the selection of a patient relationship code for a given visit. CMS could test this automated tool through the pilot testing referenced in our comments above, to allow for any necessary refinements to the decision tree to occur in advance of full implementation of these codes. Additionally, these patient relationship codes should not be required on claims until EHR and practice management software vendors have time to sufficiently update their systems to accommodate any documentation associated with these code sets.

As the automated processes described above are being developed and tested, CMS should provide technical assistance and education that is tailored to the different roles that clinicians and their staff may have in coding and billing. This would include education for practices with designated coders and those in which other non-clinical staff perform many of the coding and billing functions. This education should be clear and transparent in references to how these codes need to be recorded and documented on claims, as well as to the relationship that these codes have to the episode groups and patient condition codes that will be used together to measure resource use. Educational materials should provide extensive examples of scenarios for each category including specialty- and subspecialty-specific examples to assist physicians in selecting the appropriate category.

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?

There are a variety of different ways that practices place documentation on claims. In addition to clinicians, practices may choose to use trained coders, non-licensed staff, or others to perform various documentation functions that are required to bill claims. As noted above, CMS should tailor education on patient relationship codes to each type of staff who may be involved in coding and billing to ensure that every person who may be involved in implementing the new code set is aware of how to properly document the codes in different scenarios.

Also, as noted above, the Agency should consider methods of taking beneficiary/patient preference into account, potentially using the automated mechanism that is being proposed for the MSSP in the 2017 Medicare Physician Fee Schedule NPRM.

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?

ACP recommends that CMS use modifiers to determine the relationship that each clinician has with the patient when multiple clinicians are billing on a single claim. Because clinicians and their staff are already familiar with modifiers in general, this will make the transition to using patient relationship codes on a claim smoother.

However, even if CMS uses a documentation format with which practices are familiar by utilizing modifiers, we reiterate that implementing a new code set to document something that previously has not been included on claims will be a significant challenge, and we urge the Agency to take steps to make the burden that this transition places on practices as minimal and automated as possible.

Thank you for considering our comments on this RFI regarding patient relationship categories and codes. Please contact Shari M. Erickson, MPH, Vice President, Governmental Affairs and Medical Practice, by phone at 202-261-4551 or e-mail at serickson@acponline.org if you have questions or need additional information.

Sincerely,

Robert McLean, MD, FACP, FACR
Chair, Medical Practice and Quality Committee
American College of Physicians