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Via Electronic Submission (www.regulations.gov)

March 1, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD
episodegroups@cms.hhs.gov

Re: AAMC Comments on CMS Episode Groups

Dear Acting Administrator Slavitt:

The Association of American Medical Colleges (AAMC or Association) welcomes the opportunity to comment on the process and methodology used to develop episode groups, patient condition groups, and codes for use in resource measurement under the Medicare Access and CHIP Reauthorization Act (MACRA). The AAMC is a not for-profit association representing all 145 accredited U.S. allopathic medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

As the Centers for Medicare and Medicaid Services (CMS) develops episode and patient condition groups, it is important for CMS to have a transparent process that allows adequate time for meaningful feedback about resource use measurement prior to implementation. We appreciate CMS's solicitation of feedback but remain concerned about the short time frame for comment given the complexity of episode grouper design.

Prior to implementation of the episode groups for use in resource measurement under MACRA, CMS should:

- Update episode groups to reflect the transition from ICD 9 to ICD 10
- Appropriately adjust episode groupers for risk, including socio-demographic factors
- Align Resource Use Measures with Quality measures
- Develop episode groups for patients with multiple chronic conditions that frequently occur together

- Examine care coordination and its impact on resource use in the context of alternative payment models.
- Ensure grouper methodology is transparent
- Develop episode groups using claims data and clinical data from electronic health records and registries, where appropriate.
- Ensure that inpatient add-ons, such as Indirect Medical Education (IME) and Disproportionate payments are removed from episode groupers.

A more detailed discussion of these issues follows.

CMS Should Address Transition from ICD-9 to ICD-10

CMS constructed 46 episode types representing conditions and procedures that are prevalent in the Medicare fee for service (FFS) population. To construct these episodes CMS groups clinically related services to the episode based on service and/or diagnosis codes on the claims. The episodes are triggered based on clinical condition or the occurrence of a specified procedure.

We are concerned that using ICD-9-CM diagnosis and procedure codes from the claims data as a building block for the episodes has significant reliability issues. Some diagnosis and procedure codes are general which could be difficult to group. The codes do not contain adequate information for risk adjustment. In addition, there is lack of consistency among providers in their selection of diagnosis codes used to report a given clinical condition. To help with validity, claims-based groupers should be cross-validated against clinical data (e.g. from electronic health records).

One of our major concerns with the 46 episode groups is that they are based on ICD-9-CM diagnosis and/or procedure codes, which are no longer reported. While ICD-9-CM reached its capacity at 14,000 codes, there are approximately 69,000 ICD-10-CM Codes that are tailored to be more specific in identifying the patient's condition. Similarly, there are substantially more specific ICD-10-PCS codes with an increase from approximately 3,800 ICD-9-PCS codes to approximately 72,000 ICD-10-PCS codes

The AAMC recommends that to address the ICD-9 to ICD-10 transition, CMS should develop a process to identify the appropriate ICD 10-CM codes for the 46 episode groups, CMS and the Center for Disease Control and Prevention created General Equivalency Mappings (GEMS) to crosswalk ICD-9-CM codes to ICD 10-CM codes. We caution against using the GEMs as the only mechanism to crosswalk the ICD-9 codes in the episode groups. While GEMs may be a great resource, it has many limitations. The GEMs do not take into account all the information that a physician uses to choose the best and most applicable diagnosis. The Association recommends that CMS seek the input of clinicians, representatives from specialty societies, and others with expertise in diagnosis coding to determine which ICD 10-CM codes to use in the episode groups. Identifying the ICD 10-CM codes for the episode groups is a massive undertaking and it is important that CMS provide sufficient time to allow meaningful input from experts on the appropriate ICD 10-CM codes.

CMS should Use Appropriate Risk Adjustment To Account for Patient Characteristics

To account for the variation in characteristics of patients, the episode grouper must adjust for risk. Differences in patient severity, rates of patient compliance with treatment, socio-demographic status, patient engagement, patient preferences for treatment approaches, and sites of care, can all drive differences in average episode costs. Appropriate risk adjustment is essential so that differences in patient characteristics that are beyond a health care provider's control do not have an unfair impact on a provider's performance score.

The bias against providers who care for complex patients clearly is demonstrated when looking at the 2015 Value Modifier Experience Report. This report showed that of the 106 groups that went through quality tiering, none of the groups with the patients in the highest quartile of risk received an upward adjustment, and a little over 30 percent had a downward adjustment.

The issue of addressing sociodemographic factors is critical, particularly when measuring resource use among certain populations. Recent studies have clearly demonstrated that sociodemographic status (SDS) variables (such as low income and education) may explain adverse outcomes, particularly readmissions. Hospitals and physician groups practices that care for vulnerable patient populations are disproportionately disadvantaged when SDS factors are not accounted for in resource use measurement. The AAMC believes that there are ways to appropriately adjust for SDS by incorporating SDS factors in the risk adjustment methodology. Recently, CMS officials have signaled that the agency intends to adjust the Medicare Advantage star rating system to account for the socioeconomic status (SES) of a plan's enrollees. We strongly recommend that CMS make these adjustments for other programs.

Examine Impact of Using Medicare Part D Expenses as Part of Episode Costs.

CMS must use the per patient total allowed charges for all services provided under Part A and Part B in its analysis of resource use. We recommend that CMS examine the impact of using allowed charges under Part D expenses as part of the episode costs. Pharmacy claims in Part D are an integral part of the cost of health care that a physician may influence. Under Medicare Part B, physicians are reimbursed for the average costs of the drugs they administer when providing outpatient services to Medicare beneficiaries.

IME and DSH Payments Should be Excluded from Episode Groupers

The AAMC applauds CMS for removing from the episode groupers the inpatient prospective payment system add-ons that are paid to support larger Medicare program goals, such as Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments added to inpatient claims types.

CMS Should Develop Episode Groups for Patients with Multiple Chronic Problems

Many Medicare beneficiaries live with multiple chronic conditions (e.g. diabetes, hypertension, poor kidney function). Episodes are hard to define for these patients because it is difficult to distinguish the services furnished for any one condition. CMS solicits feedback on how it should

approach development of patient condition groups for patients with multiple chronic care conditions. One approach would be to develop an episode group for patients with multiple chronic conditions that typically occur together. For example, CMS could establish an episode group for patients with diabetes. In addition, CMS could have another episode group that consists of Medicare beneficiaries that have multiple chronic problems, such as diabetes, hypertension, and heart failure.

CMS asks for feedback regarding the duration of patient conditions groups for chronic conditions. By definition, chronic conditions are ongoing and open-ended. We recommend that CMS construct an episode group that uses a 12-month period for chronic conditions. CMS could design the grouper logic so that it automatically opens a new chronic condition episode in the succeeding 12- month period if the patient had the chronic condition in the past. It is possible that patients will have flare-ups during the same episodes as the chronic condition. However, an adequate risk adjustment methodology can account for these occurrences.

CMS Should Align Resource Use Measures with Clinical Quality Measures

Any system for measuring physician resource use must also include appropriate measures of quality to ensure that lower expenditures do not result from an unacceptable level of quality. We recommend that CMS develop the episode groups first and then identify quality measures for these groups. For some episode groups, good quality measures may already exist. CMS should prioritize the inclusion of quality measures that physicians have experience reporting.

The AAMC strongly believes that all quality measures should be endorsed by the National Quality Forum (NQF) prior to inclusion in a performance program, such as the merit-based incentive performance program (MIPS). NQF endorsement demonstrates that a measure has been tested, is reliable, and can be used in a specific setting. It is important that CMS engage physicians in the selection of quality measures.

In addition, CMS should align Medicare's quality and resource measures under MIPS with measures used by other Medicare programs (e.g. ACO shared savings, BPCI pilot) and commercial insurers. Aligning measures will help to ensure that health care providers are not overwhelmed with administrative burden and contradictory requirements. In addition, it allows for the study of the metric in different care settings to determine its validity. Regardless of the measures chosen, all must be transparent and should be provided to physicians in a timely manner to allow physicians to drill down into the data.

CMS should Examine Care Coordination and its Impact on Resource Use in the Context of Alternative Payment Models

CMS asks for feedback regarding how to address care coordination in measuring resource use. Care for patients with multiple chronic illnesses is done by providers across many specialties. The AAMC strongly supports a system that avoids redundant care, conflicting management advice, high costs and inconvenience.

Information regarding care coordination would be very difficult to derive from claims data since these types of services are not separately billable and therefore are not included on claims. CMS should consider examining care coordination and its impact on resource use in the context of alternative payment models in which physicians have the opportunity to be paid for care coordination services.

An example of an alternative payment model can be found in the AAMC's work with 5 academic medical centers. Working under a CMMI Health Care Innovation Award's grant, the AMC's are implementing a new model of care delivery and technology to allow primary care providers to receive timely, electronic consultations from specialist colleagues. The primary care physician and the specialist receive reimbursement for the time they spend on the consult provided that the consult does not become a referral for a specialty visit. These e-consults enhance care coordination between providers, thereby creating sustainable reductions in unnecessary care. When appropriately implemented, we believe this will reduce costs, utilization, increase patient satisfaction, and improve quality.

Episode groups should be Developed Using Claims Data and Clinical Data from Electronic Health Records and Registries

We applaud CMS for acknowledging in the document that information not included on the claims data is needed to create a more reliable episode. The claims data are devoid of information about patient preferences, degrees of severity and patient risk, and other essential information.. The AAMC recommends that CMS obtain clinical data from electronic health records and registries and merge that clinical data with claims data. As CMS mentions, a patient's stage of cancer and responsiveness history would be very useful in defining cancer episodes but is not available in claims data. An authoritative source of information for cancer episodes are the Surveillance, Epidemiology, and End Results (SEER) Program registries. These registries routinely collect data on patient demographics, primary tumor site, tumor morphology and stage at diagnosis, first course of treatment, and follow-up for vital status. If CMS could merge the SEERS registry data with Medicare claims data, the cancer episodes would be much more reliable.

Episode Groups Should be Transparent

CMS acknowledges they are required to seek stakeholder input throughout the development of episode groups and includes timelines for this input in Appendix A. In addition to soliciting public comment, we think it is critical that CMS use a variety of forums to obtain input from stakeholders on an ongoing basis as CMS develops and refines episode groups. We think it is important to have appropriate clinician representation from the various health care settings, including academic medical centers, in the development of episode groups.

Determining Attribution and Defining Patient Relationship Categories is an Important Component of Resource Use Measurement

One of the major challenges to defining episodes is determining which physician is responsible for the costs during the episode. Under MACRA CMS is required to develop classification codes

to identify patient relationship categories that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or services. In addition, MACRA requires that CMS allow attribution of the resources used to furnish care (in whole or in part) to physicians in a variety of care delivery roles.

In the document, CMS includes a list of five potential patient relationship categories. It is difficult to provide feedback on these categories without further details regarding how this information would be used in the context of the episode groups. In addition, some of the terms are ambiguous. For example, it is unclear whether an "acute episode" implies that services were furnished during an inpatient stay or whether the patient has an "acute" condition that could be treated on an inpatient or outpatient basis. We recognize that CMS will be soliciting additional input in the future on patient relationship codes and we welcome the opportunity to provide more feedback in the future when we have additional information regarding the context.

AAMC recommends that CMS incorporate the recommendations that NQF is developing for the selection and implementation of attribution models. The NQF is currently conducting an environmental scan using a multi-stakeholder Standing Committee, to examine the strengths and weaknesses of the attribution models identified in the environmental scan.

Requirements for Submission of Claims

The Medicare Access and CHIP Reauthorization Act (MACRA) requires that claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018 include applicable codes established for care episode groups, patient condition groups, and patient relationship categories. This is a significant change from prior claims reporting requirements for physicians. The Association strongly urges CMS to provide extensive education and outreach to physicians and other eligible practitioners regarding the information that must be reported on the claims.

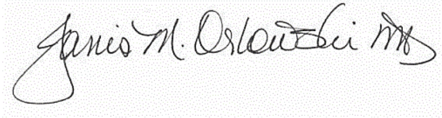
There is also a need for transparency in claim assignments and in how efficiency scores for physicians are calculated to enable physicians to understand their relative performance. If provided enough information, physicians can determine the specific reasons why their practice was more or less costly than their peers, and identify better ways to manage their patients.
In addition to physicians, we recommend that CMS reach out to EHR vendors, who will need to refine their systems to incorporate this new information. There can be many downstream effects when making changes to claims submission, and involving EHR vendors can help to mitigate claims processing problems.

Conclusion

Thank you for your consideration of these comments. The AAMC looks forward to continuing to work with CMS in the future as the episode groups, patient condition codes, and patient

relationship codes are designed and implemented. If you have additional questions, please contact Gayle Lee at galee@aamc.org or 202-741-6429.

Sincerely,



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