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August 15, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Patientrelationshipcodes@cms.hhs.gov

Dear Mr. Slavitt:

Re: CMS Patient Relationship categories and codes

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) Patient Relationship Codes and Categories document. The AAMC is a not-for-profit association representing all 145 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and, 93 academic and professional societies. Through these institutions and organizations, the AAMC represents 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Faculty physicians at academic medical centers (AMCs) are usually organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of which require highly specialized care. Often care is multidisciplinary and team-based. Faculty physicians frequently are organized under a single tax identification number (TIN) with many specialties and subspecialties, such as burn surgery, cardiac surgery, and general surgery, to name a few. A large percentage of the services provided at AMCs are delivered as tertiary, quaternary, or specialty referral care. A patient may be transferred to or seek care at an AMC because the care needed is not available in a patient's neighborhood/region. It is important for CMS to recognize the unique characteristics of AMCs and the patients they treat as these patient relationship categories and codes are developed.

Section 1848 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the development of patient relationship categories and codes that identify the relationship and responsibility of a clinician to a patient. Claims submitted for items and services after January 1, 2018 must include a patient relationship code that CMS can use to attribute patients to clinicians to compare resource use per patient and other measures. The AAMC appreciates that CMS has given stakeholders an opportunity to provide feedback on the patient relationship codes and categories required by MACRA. We are committed to working with the Agency to ensure that MACRA promotes improvements in delivery of care and is not overly burdensome to clinicians and organizations for which they work.

General Comments

We appreciate CMS' effort to obtain input about the best description of clinician's relationships with the patient. The determination of who is ultimately responsible for a patient's health outcomes when multiple providers deliver care is a complex undertaking but is essential with the rapid movement to performance based payments. We recognize that attribution is necessary to link patient level health care quality and spending indicators to specific providers for accountability, but urge against CMS relying solely on one source of data for such attribution. Even with the advent of new provider-reported codes, claims data and other information may still be important to an accurate methodology. Below are some key concerns that CMS should address as these patient relationship codes and categories are developed.

Reduce Reporting Burden

With the implementation of MACRA in 2017 and 2018, physicians will be facing major changes. They will need to report new quality measures, implement clinical practice improvement activities, and change their workflow. Reporting a new set of patient relationship codes during the same time frame will require additional changes to their workflow that would increase burden. Additionally, reporting a new code on every claim for every visit is burdensome. The AAMC urges CMS to ensure that there is minimal reporting burden for physicians. We recommend that CMS consider a different approach that would require proactive reporting of these patient codes only in situations where the patient relationship is not typical for the specialty and services provided.

Provide Context for Use of Codes

It is difficult to provide feedback on these categories without further details regarding how this information would be used, particularly in the context of the episode groups and resource use category of MACRA. Patient relationships can be described in many different ways, so understanding how CMS intends to infer responsibility for cost and quality outcomes from these codes will be essential to offering meaningful comments. AAMC recommends that CMS provide more information regarding their future plans to use the patient relationship categories and codes to attribute cost and patient outcomes and offer stakeholders another opportunity to provide comments.

Provide Proposed List of Codes and Descriptors to Allow Feedback

The AAMC requests that CMS provide the specific codes and descriptions to the public in a timely, appropriate manner to allow for additional feedback prior to implementation. When these codes are finalized, there must then still be sufficient time to make operational and infrastructural changes.

Clinician Interpretation of Patient Categories and Codes May be Inconsistent

While the AAMC welcomes the concept of further refining patient attribution, we are concerned about attributing patients to clinicians based solely on clinician reporting of their subjective interpretations of patient relationships. This proposal would require considerable subjective clinician judgment regarding interpretation of the categories. Clinicians may interpret these categories and patient codes differently for the same scenario. In addition, despite progress

towards truly coordinated care, clinicians may not be aware of the extent to which their patients are also seeking care from other providers. Clinicians may also be discouraged from taking on certain relationships that are high risk if they will be penalized under payment systems. To the extent that self-reported codes are ultimately used in value-based payments, we urge CMS to continue to work with stakeholders to ensure that the categories and codes are clear and that clinicians are trained to accurately interpret these categories.

Additionally, we anticipate that multiple providers involved in the patient's care may select the same category to describe their relationship with the patient. It is unclear how CMS will address attribution when multiple providers pick the same category, particularly for multiple providers who select themselves as the "lead" or primary care role. While clinician reported data such as these codes should be helpful for attribution, CMS should also examine other data sources, such as medical claims and data from electronic health records.

Acute and Primary Categories Do Not Reflect Cost

The patient relationship codes should be used only to attribute cost and quality to physicians for beneficiaries for which they have an opportunity to influence the care or coordination of care. Accountability should be divided into the proportion of the care or cost that the physician provides or controls. Physicians who have significant involvement in the patient's care should be held more accountable than those who have limited involvement. For example, a primary care physician may be the lead physician but the consulting cardiologist may be the one recommending a Cardiac CT or cardiac cauterization. A lead physician may not want to disagree with the approach of their cardiologist but certainly should not be held responsible for the resource use in this case. The acute and continuing distinction proposed by CMS does not accurately reflect the extent to which an individual provider is driving the cost and quality outcomes.

Significant Education and Training is Needed

Physicians will need significant education regarding these categories and codes. AAMC is concerned that there is not adequate time to educate physicians, particularly in light of the time frame for other aspects of MACRA implementation. Physicians will be focused on implementation of the many new requirements under the MACRA law. CMS should also broadly communicate the context and future consequences of these patient relationship codes. Faced with myriad new requirements, providers may not realize the implications of these codes on their future performance in value-based payment models or quality reporting scores.

Operational Issues

The AAMC is concerned that CMS has not addressed operational issues related to reporting the patient relationship categories. CMS should provide information regarding where this information would be reported on the claim form. Providers need an opportunity to test submission of claims with these new codes to make sure they understand the process. CMS also will need to provide sufficient time for vendors to make changes to electronic health record systems to incorporate these new codes and test them to make sure that the claims submission process works.

Response to Questions for Consideration

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?

CMS proposes to distinguish patient-clinician relationships by determining which items and services are furnished on an acute basis and which are on a continuing basis. CMS proposes a definition for an acute episode, which would include a disease exacerbation, a new time-limited disease, a time-limited treatment, or a defined portion of care so long as it is limited. It also may occur or span inpatient and outpatient settings. In contrast, CMS defines continuing care as occurring when an episode is not acute and requires the ongoing care of a clinician. Using this framework, CMS seeks to distinguish the different categories of clinician-patient relationships that occur. CMS proposes the following relationship categories and seeks comment on specific questions in the document.

1. Clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care;
2. Clinician who provides continuing specialized chronic care to the patient;
3. Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode;
4. Clinician who is a consultant during the acute episode; and
5. Clinician who furnishes care to the patient only as ordered by another clinician

The AAMC believes that the proposed categories are not clear enough for clinicians to consistently and reliably identify the appropriate category in a given a clinical situation. It can be challenging to categorize relationships based on whether the services are furnished during an "acute episode" or are as "continuing" services. The acute and continuing categories need more refinement. A patient may come to the hospital with an acute condition and remain in the hospital for a long period of time. At a certain point, the condition may be considered chronic or "continuing." It can be difficult to identify when to change the coding from acute to chronic in these instances. Because an acute episode would also include care provided in outpatient settings, there may be confusion regarding at what point in time an acute condition may transition to being considered chronic.

In addition, there are scenarios under which a provider may furnish a continuing care activity but that provider may not have a continuing relationship with a patient. For example, a physician may furnish an annual wellness visit (characterized as a continuing care activity) but then not have an ongoing relationship with the patient after that one time visit. In another example, a visit with a dermatologist for an annual skin check might be considered a continuing care activity, but the dermatologist may only see the patient once per year. In these instances, it is not clear what category and code should be reported under the approach proposed by CMS.

One significant concern is that it is not feasible for a clinician to predict in advance whether they will have a continuing care relationship. If a new patient comes to a primary care physician for an office visit, the primary care physician would not know definitively at the time of the visit whether that patient would continue to return for future visits. The physician cannot assume that because he/she is a primary care provider that there will be a continuing relationship with that particular patient. However, CMS would require the physician to select a patient relationship code to include on the claim form not long after that visit.

This concern is particularly acute in AMCs, where patients have complex medical conditions requiring many different specialists or may have an illness requiring them to travel to the AMC but then return to their home. A recent review of DC Medicaid claims found that individuals with complex chronic disease often saw as many as 3 primary care physicians in a year. Physicians in AMCs also treat more low income patients who enter the AMC through the emergency departments, or because the AMC offers many services, and may be open for longer hours. In these instances, the patient may receive primary care services, but only have one visit with the physician. We are concerned about incorrect attribution if the patient only sees the physician once and the physician includes the code denoting he/she is the primary health care provider responsible for coordinating ongoing care or managing total patient costs. Further, because AMC physicians often see patients for tertiary and quaternary services that are unavailable in their own neighborhoods/regions. These physicians may be the "primary" or "principal" providers for a short period of time but then have little capacity for influencing a patient's total cost of care when they return home. If the AMC physician accurately codes itself as primary for that time period, but the patient does not have a regular source of care at home that also codes as "primary" the AMC provider may be inaccurately attributed responsibility for the patient.

It is also unclear how to code when there is an acute episode and the continuing care provider requests the consultant physician to whom the patient is referred to take over the care of the patient during that episode. As an example, the primary care physician may consult a rheumatologist regarding the care of a patient with an acute joint episode and subsequently decide that the rheumatologist should take over the care of the patient for a period of time. It is not clear at what point the rheumatologist switches from being a consultant (category 4) to being the clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode (category 3). If the condition becomes chronic, it is possible that the rheumatologist and the primary care physician may both code their relationship as the clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care (category 1). We are particularly concerned about these vague distinctions because of the roles these codes may play in assigning responsibility for costs. Physicians at AMCs are often asked to consult on the most high-risk and high-cost patients and different coding practices across settings could disadvantage them if other providers are not also assigning themselves responsibility for the management of these cases.

CMS uses the term "primary" in its description of patient relationship categories. To avoid confusion, the AAMC recommends that CMS uses the term "principal" instead of "primary" to

identify the physician responsible for the overall care of the patient. Primary care is not always delivered by physicians who are internists, generalists, or family medicine practitioners. Some patients, particularly those with multiple chronic conditions, may infrequently see a primary care physician and rather receive most of their primary care from the specialist who is treating their chronic condition. These specialists are often responsible for managing the overall care of these complex patients whose predominant morbidity is related to a single organ system or disorder.

In summary, as currently proposed, these categories and codes are not clear enough for a physician to identify his/her relationship to the patient. Because the codes are ambiguous, we believe it would be better for CMS to rely on information from the claim forms to identify a default relationship between the physician and patient. CMS would have information on the site of service, the physician specialty, the ICD-10 codes and CPT codes reported, and the frequency of services. Using this information, it would be feasible for CMS to identify the physician's relationship with the patient. In addition, CMS could allow physicians who believe that their relationship with the patient differs from what CMS would typically identify as the relationship, to provide additional information by reporting a patient relationship category on the claim form. This approach would improve accuracy and reduce administrative burden.

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 AAMC supports the inclusion of a patient relationship category for non-patient facing clinicians. However, there are circumstances when these specialties are involved in patient care and may need to use a different category to describe their patient relationship. For example, it is presumed that radiologists are non-patient facing; however, interventional radiologists are actively involved with the patient pre-and post-procedure. In these cases, CMS should allow radiologists to report other patient relationship categories as appropriate.

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

As discussed previously, the AAMC believes that as described in the CMS proposal, it would be difficult for a clinician to categorize an episode as acute in certain circumstances. In practice, it is common for a patient to have an acute episode that becomes a chronic problem. For example, a patient who is admitted to the inpatient hospital with exacerbation of congestive heart failure would be initially considered to have an acute episode. However, at a certain point in time, the patient's condition would be considered chronic. It would be difficult for the clinician to identify the point at which the patient's condition is considered chronic. There is a question of whether it would be at hospital discharge, during the first follow-up visit in the clinic or at some other time. The distinction between these categories is clearer in the case of acute conditions such as appendicitis that are treated and resolved.

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 AAMC does not believe that distinguishing relationships by acute care and continuing care is sufficiently refined. As mentioned above, it can be difficult in many scenarios to draw a bright line to distinguish whether a relationship would be considered acute or continuing care. These distinctions also do not reflect which provider may be driving the cost and quality outcomes. There could be many scenarios where a clinician selects the continuing care category 1, but has no other involvement with the patient in driving the cost and quality.

In addition, it is not clear whether acute is meant to denote an urgent problem, such as appendicitis or sepsis, or exacerbation of an existing chronic condition, such as congestive heart failure or diabetes. For example, if an endocrinologist is involved in the care of a patient with diabetes, there is a question of whether the scenario would be characterized as an acute episode due to a flare up or whether the diabetes is considered an ongoing condition and the endocrinologist is part of the continuing care team.

Offering alternative categories or a different framework is difficult without CMS describing the context of how these categories would be applied to accountability methodologies or pay-for-performance programs. However, it may be clearer to use categories, such as "principal" and "consulting" for outpatient services and "principal admitting" and "principal attending" verses consulting for inpatient services.

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

The AAMC reiterates its request that CMS provide an opportunity for robust stakeholder engagement and formal comment on the patient relationship codes themselves, not just the categories of codes. It will only be possible to give meaningful input on technical assistance activities upon seeing the relative ambiguity or clarity of the codes themselves that providers will be expected to use.

Regarding the code categories, the AAMC recommends that CMS provides extensive provider education and outreach regarding these relationship categories prior to implementation and that this assistance be made available sufficiently early for physicians to learn how to meet the CMS requirements. Because these categories of codes are ambiguous, there is a need for additional information that would provide more clarity. CMS should develop many clinical examples for each of the patient relationship categories to assist the physicians in selecting the accurate category. In addition, CMS needs to provide guidance regarding documentation requirements related to the code selection. CMS also will need to provide sufficient time for vendors to make changes to electronic health record systems to incorporate these new codes and test them to make sure that the claims submission process works. We urge CMS to engage in discussions with

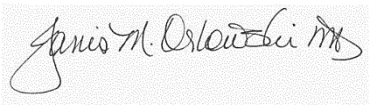
electronic health record and billing vendors as soon as possible to ensure that they incorporate these new codes accurately in their systems.

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***?

If the clinician does not select the procedure and diagnosis code, most likely the coder on staff would be involved in the code selection. This would require that CMS provide education for coders regarding these new categories so that they can select the correct code and relationship. This also further supports the recommendation that CMS consider using default patient relationship categories based on information on ICD-10 codes, CPT codes and frequency of services from the claim forms. There will be considerable additional workflow issues involved in selection and reporting of these new codes to CMS on the claim form, which would only be exacerbated if clinicians are expected to make subjective judgments about the likelihood of a continuing relationship with a specific patient. As mentioned previously, such subjective judgments would be hard for any clinician to make but would be nearly impossible for coding staff not directly involved in the patient interaction.

The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Gayle Lee at galee@aamc.org.

Sincerely,



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