CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM

320 Ft. Duquesne Boulevard
Suite 20-J
Pittsburgh, PA 15222
Voice: (412) 803-3650
Fax: (412) 803-3651
www.CHQPR.org

August 15, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments on Proposed Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

Thank you for the opportunity to provide input to CMS as it considers how to implement the provisions of the Medicare Access and CHIP Reauthorization Act (MACRA) requiring the creation of Patient Relationship Categories and Codes. The following are comments on the document titled "CMS Patient Relationship Categories and Codes" that was posted on the CMS website.

Recommended Changes to Proposed Patient Relationship Categories and Codes

It makes sense to define patient relationship categories based on the specific types of health problems that a patient is experiencing, the specific types of services the patient is receiving for those problems, and the specific roles that individual physicians are playing with respect to those problems and services. However, the proposed categories of "acute care relationships" and "continuing care relationships" are too simplistic and poorly defined. For example, none of the following situations is adequately or accurately captured by the proposed categories:

- A patient has a primary care physician or specialist who provides overall coordination of the patient's care, but when the patient has an acute episode (e.g., a hip fracture), a new physician (e.g., an orthopedic surgeon) manages all or part of the care that is specifically associated with the acute episode. That new physician will not be responsible for "providing or coordinating the overall health care of the patient" during the episode, nor will that physician merely be "a consultant during the acute episode." The primary care physician or specialist will continue to be responsible for managing the patient's care for their other conditions throughout the acute episode, while the new physician manages the care related to the acute episode.
- A patient has a primary care physician who provides preventive care and minor acute care on an ongoing basis, but the patient develops a chronic condition, and that condition is managed by a physician specializing in that condition. The primary care physician is not "responsible for providing or coordinating the ongoing care of the patient for chronic and acute care," is not providing "continuing specialized chronic care to the patient," and

is not "providing or coordinating the overall health care of the patient during an acute episode," which are the only categories available in the proposed list.

- A patient has a primary care physician and a specialist, or two specialists, who are jointly managing the care of a chronic condition. One physician is serving as the lead physician, and the other is providing a portion of the patient's care. The second physician has a "continuing care relationship" with the patient but is not providing care "only as ordered by another clinician."
- A physician orders a service for a patient that is to be delivered by another physician in a face-to-face session (i.e., it is not just non-patient-facing clinicians who deliver services that are ordered by other clinicians).
- A physician serves as a consultant to another physician regarding a specific aspect of managing a patient's care for a chronic disease. The physician is not a consultant during an acute episode, nor is the physician furnishing care as directed by the other physician.

In addition, none of the proposed categories effectively address physicians who take responsibility for determining a diagnosis for a patient's symptoms, which could represent an acute condition, a chronic condition, or nothing at all.

The patient relationship categories defined by Congress in Section 1848(r)(3)(B) more effectively cover many of the above situations than do the categories proposed by CMS in its draft document. The five categories proposed by CMS should be dropped, and the categories defined by Congress should be used instead:

(i) a physician (or other practitioner) who considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

(ii) a physician (or other practitioner) who considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

(iii) a physician (or other practitioner) who furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

(iv) a physician (or other practitioner) who furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; and

(v) a physician (or other practitioner) who furnishes items and services only as ordered by another physician or practitioner.

In order to more accurately define the full range of relationships between physicians and patients, **CMS should add the following three categories to the five Patient Relationship Categories already defined by Congress:**

(vi) a physician (or other practitioner) who considers themself to have the primary responsibility for managing the care of a particular health condition (such as cancer) or a combination of health conditions (such as diabetes and coronary artery disease) over a period of one month or more.

(vii) a physician (or other practitioner) who works in close coordination with one or more other physicians to jointly manage the care of a particular health condition or combination of conditions over a period of one month or more.

(viii) a physician (or other practitioner) who takes the lead responsibility for determining a diagnosis for a patient's symptoms, or for verifying the accuracy of an existing diagnosis, utilizing the services of other physicians, practitioners, and providers as necessary.

In addition to the categories themselves, it will be important to have a way for a physician to explicitly indicate the specific conditions or episodes with respect to which they are playing these roles. Moreover, if a physician is not playing the lead role with respect to a condition or episode, they will need an easy way to indicate which other physician is playing that role.

Additional Principles for Defining Patient Relationship Categories and Codes

Although the five principles defined in the draft are all desirable, two additional principles should be added:

6. The categories should make sense to practicing physicians and other clinicians, so that it is easy for the physician or clinician to determine which category is most appropriate for the role they are playing with respect to a patient's care.
7. The categories should be necessary for successful implementation of alternative payment models or meaningful measure of value.

Adding any new coding system to claims forms will inherently increase administrative burden on physicians. Consequently it is essential that (a) the codes that are developed be easy for physicians to assign to specific cases (not just easy for them to submit the codes on claims forms) and (b) there will be sufficient benefits in terms of better payment systems and measurement systems to justify the time and effort physicians must spend in assigning codes to cases.

Thank you for the opportunity to offer these recommendations. I would be happy to answer any questions you may have about the recommendations or to provide any additional information or assistance that would be helpful to you in implementing them.

Sincerely,

Harold D. Miller
President and CEO

cc: CMS Deputy Administrator Patrick Conway, MD
Kate Goodrich, MD, Director, CMS Center for Clinical Standards and Quality