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

January 6, 2017

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 Revised Proposal for Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

Thank you for the opportunity to provide additional comments 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 newest document titled "CMS Patient Relationship Categories and Codes" that was posted on the CMS website.

Recommended Changes to Proposed Patient Relationship Categories

As indicated in the comments we submitted in August, the originally proposed categories of "acute care relationships" and "continuing care relationships" were too simplistic and poorly defined. Although the proposed new categories address some of the concerns with the original proposal, there are a variety of problems with them that need to be resolved before they can be implemented:

- The definitions do not clearly distinguish the level of responsibility that the clinician is accepting regarding the patient's care. A key reason why MACRA required the creation of the patient relationship categories and codes was to create a way for clinicians to declare what aspects of a patient's care they were taking responsibility for and to eliminate the need for the inaccurate retrospective attribution systems that are being used today. For example, the term "continuous/broad" itself does not clearly define what level of responsibility the clinician is taking regarding the patient's care. While the definition says the category "would include" physicians who provide the principal care for the patient, it does not clearly say that everyone who selects this category will be signaling that they intend to play this role.
- A physician may deliver a specific service to the patient to treat a particular condition that is not "ordered" by any other clinician, but the physician may also not be taking any responsibility for any other services the patient receives.
- The word "continuous" could be construed as meaning "constantly," even though there may be situations (such as the episodic/broad category you define) in which the clinician

who generally coordinates care for the patient cedes that coordination responsibility temporarily to another physician. It would seem better to use the word "continuing" to capture the idea that the role does not have a pre-defined time limit.

- The definition you used for the term "focused" implies that it applies only to a single chronic disease or condition, when there will likely be many situations in which a clinician manages care for two or more related conditions even though they are not taking responsibility for all aspects of the patient's care.
- Since the term "episodic" seems to be intended to convey the idea that the clinician's role is time-limited, it would seem clearer to use the term "time-limited" instead, rather than create confusion as to whether the clinician is responsible for a full "episode" of care, particularly when the definitions in episode payment models and resource use measures have not been finalized.
- The categories provide no clear way to distinguish between a clinician whose role is to determine a diagnosis for a condition from a clinician whose role is to either treat or to coordinate treatment services for a condition.

In response to the specific questions you posed in your draft, we do not believe the draft categories are clear enough to enable clinicians to consistently and reliably self-identify an appropriate patient relationship category for a given clinical situation, and we do not believe they capture the majority of patient relationships for clinicians.

To address these problems, we would recommend using the following categories instead of what you have proposed:

1. **Continuing Comprehensive Care and Coordination.** A clinician who is taking responsibility for coordination of all or most of the patient's care, with no planned endpoint. The clinician may deliver all, some, or none of the actual treatment or preventive care services that the patient receives for their health problems or risk factors, but the clinician does accept responsibility for assuring the appropriateness and quality of care the patient receives from other clinicians.
2. **Continuing Condition-Focused Care and Coordination.** A clinician who is taking responsibility for coordination of all or most of the patient's care for one or more specific conditions, with no planned endpoint. The clinician may deliver all, some, or none of the actual treatment services that the patient receives for these conditions, but the clinician does accept responsibility for assuring the appropriateness and quality of care delivered by other clinicians for the condition(s) on which the clinician is focused.
3. **Time Limited Comprehensive Care or Coordination**. A clinician who is taking responsibility for coordination of all or most of the patient's care for one or more specific conditions during a time-limited period, including any services needed from other clinicians for those conditions.
4. **Time-Limited Focused Services.** A clinician who orders or delivers one or more specific services to a patient for a specific health condition or other issue, but who does not take responsibility for coordinating services delivered by any other clinicians.
5. **Delivery of Specific Services Ordered by Other Clinicians.** A clinician who delivers one or more specific services to a patient in response to an order from another physician.
6. **Diagnosis of Symptoms.** A clinician whose role is limited to determining a diagnosis for a patient's symptoms, for verifying the accuracy of an existing diagnosis, or for ruling out a diagnosis for those symptoms.

These alternative categories are more consistent with the categories defined by Congress in Section 1848(r)(3)(B) of MACRA.

Comments on Proposed Patient Relationship Codes

We support the idea of using modifiers to indicate the patient relationship category on claims forms. However, the discussion in your draft document is unclear as to whether you are proposing that a CPT code would be modified by a new Level II HCPCS modifier, or whether a physician would need to also record a new HCPCS II code and attach the modifier to that. We recommend that clinicians be able to attach the Level II HCPCS modifiers for patient relationship categories directly to the relevant CPT Code.

However, we also recommend that one or more new Level II HCPCS codes be created to enable a physician to signal that they have a particular relationship with a patient during a particular period of time independent of whether any billable service has been delivered. For example, a primary care physician may be taking responsibility for coordinating a patient's care during a month even though there was no billable E&M visit or other service with the patient. Unless there is some way for the physician to notify CMS and other payers of that relationship, the patient relationship codes will not completely solve the problems with current attribution systems. Moreover, creating patient relationship categories for "episodic" or "time-limited" relationships begs the question of which episode or time-limited period the relationship refers to. This could be addressed either through the new episode codes required by MACRA or by creating Level II HCPCS codes that indicate the nature of the time period to which the patient relationship applies.

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
Pierre Yong, CMS Center for Clinical Standards and Quality
Theodore Long, CMS Center for Clinical Standards and Quality