

April 9, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 314-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments on CMS Proposals for Patient Condition Groups and Care Episode Groups

Dear Administrator Verma:

I am writing to express serious concerns regarding the proposed Patient Condition Groups and Care Episode Groups that were posted on the CMS website on December 23, 2016, to provide suggestions for improvements, and also to provide comments and respond to the questions in the document titled “Episode-Based Cost Measure Development for the Quality Payment Program” that was posted at the same time.

The Urgent Need for Better Claims Data to Support Value-Based Payment

As you know, all of the current value-based payment methodologies used by Medicare and other payers are based primarily on information derived from healthcare claims data. However, the information contained in claims data was not designed for this purpose. The limited information available in current claims data creates weaknesses in the payment models that are based on the data, which in turn creates serious problems for the healthcare providers paid under these models and for the patients who need care from those providers.

In developing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress recognized that current healthcare claims data would not be adequate for either resource use measurement under the Merit-Based Incentive Payment System (MIPS) or for the development and implementation of Alternative Payment Models (APMs). To address this, Section 101(f) in Title I of MACRA added Section 1848(r) to the Social Security Act (42 U.S.C. 1395w-4(r)), which requires development of three new sets of information – Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories – and corresponding codes to record this information on claims forms. Congress also recognized that obtaining better claims data was an urgent need, and so Section 1848(r) mandates a very detailed process and specific deadlines in order to ensure that better data can be recorded on claims forms beginning on January 1, 2018.

The CMS Proposal Doesn't Address the Needs for Better Coding

In light of the importance and urgency of this issue, we were extremely disappointed with the material that CMS posted for comment in December. **The proposed Care Episode Groups and Patient Condition Groups fall far short of what could or should have been developed in response to Congress's mandate.** Specifically:

Care Episode Groups should be more than relabeled procedure and diagnosis codes.

The Care Episode Groups and codes that MACRA requires in Section 1848(r) are needed in order to provide a better approach to defining and measuring episodes of care than the “episode grouper” approaches CMS and other payers have been using. Episode groupers are complex and highly error-prone because they try to determine the relationship between the services a patient receives long after those services have been delivered, using information on claims forms that was designed for billing purposes, not for defining clinical episodes. Although resource use measures calculated using these imperfect grouper methodologies may provide helpful information in some cases, they will never be sufficiently accurate or reliable to use for defining Alternative Payment Models or for holding physicians accountable for resource use under the Merit-Based Incentive Payment System (MIPS).

By requiring the creation of Care Episode Groups and codes, Congress clearly signaled a desire to assure that episode definitions and measures would no longer be constrained by the limits of current procedural and diagnostic coding on claims forms. It also clearly wanted to enable physicians to indicate the nature of the care episode that was underway at the time care is delivered, rather than having CMS try to determine that retroactively.

Yet the “episode groups” posted for comment in December are nothing more than retitled ICD-10 codes for chronic conditions, HCPCS codes for procedures, and DRG codes for acute inpatient medical conditions. Using the exact same codes that already appear on claims forms, as CMS has proposed, does nothing to provide the greater breadth and depth of information needed for both MIPS and APMs. **Recommendations for a better approach are provided later in this letter.**

Patient Condition Groups shouldn't simply be another name for diagnosis codes.

The resources required to care for an individual patient during a particular episode of care and the outcomes that can be achieved for that patient will depend heavily on the specific needs and characteristics of the patient and the physicians' and patient's ability to access and use different treatment options. Unless measures of resource use during episodes of care are appropriately adjusted for differences in these factors, one physician could be penalized for being “high cost” relative to other physicians when in reality, that physician's patients had greater needs than the patients treated by other physicians.

Unfortunately, the risk adjustment systems currently being used by CMS and other payers do not identify or adjust for many of the most important differences in patient needs. Many of the characteristics that cause patients to legitimately require more services and resources or to have worse outcomes aren't captured in current diagnosis codes, such as stage of cancer, severity of heart failure, functional status, etc.

But rather than creating a mechanism through which physicians could identify the patients who have these characteristics, CMS has apparently decided to interpret the “patient condition groups” required in MACRA as a synonym for “chronic condition episodes” and to simply use existing ICD-10 codes to define them. Here again, CMS’s proposal to use the exact same codes that already appear on claims forms does nothing to improve the accuracy or reliability of risk adjustment systems either for MIPS or APMs. **Recommendations for a better approach are provided later in this letter.**

Failure to Consider the Needs of Alternative Payment Models

We were also extremely disappointed that the document released with the proposed codes discusses episode groups and codes only in the context of the Resource Use measures required as part of MIPS, and there is no discussion in the document of the important role these codes can and should play in Alternative Payment Models. In the very first paragraph of Section 1848(r), Congress stated that the purpose of developing Care Episode Groups and Patient Condition Groups was “for purposes of the Merit-based Incentive Payment System...and alternative payment models...” [emphasis added]. Yet in the document “Episode-Based Cost Measure Development for the Quality Payment Program” that CMS released in December, alternative payment models are only mentioned briefly in the descriptions of MACRA at the beginning of the Executive Summary and in the Introduction section of the document, and nowhere else.

We urge that CMS explicitly seek input from providers, medical specialty societies, and other stakeholders who are developing or implementing Alternative Payment Models in order to determine how Care Episode Groups and Patient Condition Groups can best support Alternative Payment Models.

Lack of Collaboration and Transparency in Response to MACRA’s Mandates

Congress clearly wanted CMS to work collaboratively and interactively with stakeholders in developing the Care Episode Groups and Patient Condition Groups and associated codes. Indeed, Section 1848(r) is titled “Collaborating with the Physician, Practitioner, and Other Stakeholder Communities to Improve Resource Use Measurement.” Two separate rounds of input regarding the care episode and patient condition groups and codes are mandated by MACRA.

To date, CMS has also not released any information on the comments and input that it has received nor has it explained whether and how it has used that input. Although notice and comment rulemaking clearly does not support the kind of collaborative approach Congress wanted to see, one advantage of notice and comment rulemaking is that all comments submitted are publicly available and CMS responds specifically to each comment submitted. In contrast, the public comments submitted to date on the care episode groups and patient condition groups do not appear to be accessible anywhere. The document posted in December states that CMS received comments, but the document does not describe what those comments were and it does not indicate whether and how the proposal responds to those comments.

For example, CHQPR submitted detailed recommendations to CMS on how to define Care Episode Groups and Patient Condition Groups 14 months ago (a copy of our February 15, 2016

letter is attached). There is no indication in the material posted in December that CMS gave any consideration to these recommendations.

The CMS website indicates that Acumen “convened a Clinical Committee comprised of more than 70 clinical experts from over 50 professional societies... from August – September 2016. This Committee provided input on identifying a candidate list of episode groups for development and in determining the billing codes that trigger each episode group. The clinical review and recommendations obtained from the Clinical Committee were used to inform the draft list of episode groups and trigger codes posted by CMS in December 2016 for public comment.” However, no information has been made publicly available on what was recommended by the committees created by Acumen.

We urge CMS to (1) publicly post all of the comments it has received, all materials that its contractor has developed, and summaries of the meetings that the contractor has held; and (2) explicitly respond to the comments it receives.

Failure to Meet the Deadlines in MACRA

Finally, we are very disappointed that **CMS has failed to meet the statutory deadlines established in MACRA.** Section 1848(r)(2)(E) required that a “draft list of the care episode and patient condition codes ... (and the criteria and characteristics assigned to such code)” be posted no later than 270 days after the end of the previous comment period. The previous comment period ended on February 15, 2016; 270 days after that was November 11, 2016. However, the draft codes were not posted until six weeks later, on December 23, 2016.

It is clear in reading Section 1848(r) that the specific deadlines Congress mandated for each step in the input process were designed to ensure that the new codes would be finalized and available for use on claims forms beginning on January 1, 2018. Under MACRA, there are four steps CMS is required to take in developing Care Episode Groups and Patient Condition Groups, and the times allowed for those steps are, respectively, 180 days, 120 days, 270 days, 120 days, and 270 days following the completion of the previous step, starting with the enactment of MACRA on April 16, 2015 and ending with CMS posting an “operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).” The cumulative effect of those deadlines is that the operational list of codes would be posted before the end of 2017.

However, due to the delay in posting the draft codes, the current comment deadline of April 24, 2017 is only 220 days before the end of 2017. If CMS takes the 270 days currently allowed under statute to finalize the codes, the codes would not be ready until February of 2018, after the codes are supposed to already be in use on claims forms.

Of even greater concern, however, is that what was posted in December did not include “the criteria and characteristics assigned to such code” as required in MACRA. In fact, in the spreadsheet that contains the proposed groups and codes, CMS explicitly states “the draft list does not currently include specifications for episode sub-groups.” The spreadsheet states that “future development of acute inpatient medical condition episodes will entail an evaluation ... of whether patients who share a given DRG are sufficiently similar to patients assigned other DRGs to warrant lumping into a single episode group, or sufficiently different from one another to

warrant splitting into two or more sub-groups,” and it states that “CMS is considering development of episode sub-groups” “for surgical and percutaneous approaches,” “by indication,” “for mastectomy with or without breast reconstruction,” “by location (i.e., cervical, thoracic, lumbar),” and “by etiology of fracture as well as number of levels treated.” (These statements suggest that to date, CMS has primarily focused attention on inpatient and surgical procedure episodes rather than chronic conditions or acute medical conditions that do not require surgery.)

Due to the superficial and incomplete nature of the current version of the proposed codes, it is clear that significant revisions will be needed before the groups and codes can be operationalized. **It will be essential for stakeholders to have another opportunity to review and comment on a revised and more detailed version of the codes before they are finalized. We urge that CMS make a commitment to: (1) release a revised set of Care Episode Groups/codes and Patient Condition Groups/codes, with full definitions, no later than June 30, 2017; (2) allow stakeholders at least 60 days to comment on the revised groups/codes; and (3) incorporate the input received into the definitions and codes and release final versions no later than November 30, 2017. This will allow the new codes to be used on claims forms beginning on January 1, as Congress intended, and provide stakeholders with full information on the codes at least one month in advance.** CMS commendably released a revised set of Patient Relationship Categories and codes for additional comment in advance of the statutory deadlines, and it should also release a revised set of Care Episode Groups, Patient Condition Groups, and associated codes as soon as possible this year to allow additional stakeholder input.

How to Create Better Care Episode Groups and Patient Condition Groups

A number of medical specialty societies are developing Alternative Payment Models (APMs) to support high-quality care for patients who have the acute and chronic conditions that physicians in those specialties treat. In many cases, these APMs include specific definitions and codes for two or more phases or “episodes” of care experienced by patients with those conditions, and the APMs also define categories of patients and associated codes based on patient characteristics that affect resource use and outcomes in a particular phase or episode of care.

Since Section 1848(r)(1) explicitly states that the purpose of developing Care Episode Groups and Patient Condition Groups is to support alternative payment models as well as MIPS, it would be very unfortunate if CMS tries to develop Care Episode Groups and Patient Condition Groups and associated codes for MIPS in ways that conflict with the efforts of the specialty societies and others who have been working to develop APMs. Consequently, **we urge that CMS contact medical specialty societies that are developing APMs and make every effort to either adopt or adapt the episode groupings and patient categories those societies have developed into the overall framework for care episode and patient condition groups that CMS develops in response to MACRA.**

Fortunately, despite being independently designed to support care for very different types of health conditions, the APMs that have been developed to date by several specialty societies have many common elements to their structures. These commonalities suggest a default structure for Care Episode Groups and Patient Condition Groups that CMS can use for most health conditions

and combinations of conditions until specific Alternative Payment Models have been developed for those conditions or combinations of conditions.

Defining Episodes in Terms of Phases of Care

One common element in many of the APMs currently being developed is that separate payment amounts and quality measures are being defined for two or more phases of care that correspond to clinically distinct sets of services and outcomes for patients. For example, APMs being developed for several different types of chronic diseases have identified the following distinct phases of care:

- (1) the diagnostic phase, when a physician makes a determination as to whether a patient with symptoms has a particular disease or not;
- (2) the treatment planning phase, when treatment options are identified and discussed with a patient diagnosed with a disease;
- (3) initial treatment for a chronic disease, when the patient begins to receive the chosen treatment along with appropriate education and support, and when effectiveness and side effects are monitored in order to adjust treatment; and
- (4) maintenance of treatment for a chronic disease, when a patient continues to receive a treatment that is achieving its expected effect.

A patient may cycle back and forth through one or more of these phases, e.g., because their condition worsens, because they develop other acute or chronic health problems that require adjustments in treatment, because new, more effective treatments become available, or because the patient's poor response to treatment calls into question the accuracy of the diagnosis.

Since different types and amounts of services, different types of outcomes, and in many cases different physicians will be associated with each of these phases of care, it makes sense to define each of them as a separate "episode of care." Resource measures and payment models based on these four separate episodes will be far more clinically meaningful than lumping all patients who have been diagnosed with the chronic disease regardless of the phase of care into a single never-ending "episode" the way that most episode groupers do.

For acute conditions, there is also a diagnostic phase and a treatment planning phase, but instead of an initial treatment phase and maintenance phase, one can define a different phase:

- (5) (time-limited) treatment for an acute condition, when the patient receives a treatment (e.g., medication) or a procedure (e.g., surgery) for the condition and also any follow-up care needed for recovery. This same category can be used for a procedure performed for diagnostic or screening purposes (e.g., a colonoscopy).

A separate phase of care should also be defined for complications:

- (6) treatment of a complication, if a new acute condition has resulted from previous treatments for other conditions. This category could also be used for treatment of an acute exacerbation of a chronic condition.

Finally, there is a different phase of care for patients who do not have an acute or chronic health problem that requires active treatment, but who need help in preventing problems from developing:

(0) a preventive care phase, when patients without a health problem are monitored to ensure they receive evidence-based preventive services. (When a preventive service is actually delivered, the procedure would be treated as part of category 5.)

Defining Groups of Patients with Similar Needs and Expected Outcomes

Another key commonality among many APMs currently being developed is that 3-4 categories of patients are being defined within each phase of care. The patients in each category are similar to each other in terms of their needs for services and expected outcomes, but they differ from the patients in other categories based on objective characteristics that affect the amount of resources needed to treat the patients, the outcomes that can be achieved for the patients, or both. Different payment amounts can then be established for each category of patient in the same episode of care, reflecting the fact that the patients will need different types and amounts of services, and quality or outcome measures can be calculated separately for each category of patients to reflect the differences in expected outcomes.

Instead of assuming that there is a linear relationship between patient characteristics and resource needs or outcomes that can be determined through a regression formula, as the CMS HCC system and many other risk adjustment systems do, categorical stratifications allow for non-linear relationships without requiring a complex coding system. Using 3-4 different severity/risk categories for each type of condition rather than continuous risk adjustment is very similar to the structure used in the MS-DRG system for hospitals and it is similar to a structure that CMS is using to stratify the Care Management Fees in its Comprehensive Primary Care Plus demonstration.

The patient characteristics that have the biggest effect on resource use and outcomes during an episode of care will differ depending on the specific type of condition that is being treated during the episode. For example, if a patient is being treated for cancer, the stage of cancer has a very large impact on the cost of treatment and the likelihood of survival, far more than whether the patient has a comorbidity such as knee osteoarthritis. On the other hand, for a cancer-free patient who is being treated for knee osteoarthritis, stage of cancer is meaningless, but the severity of their arthritis is very important to understand in determining what will be needed to treat their knee problem and the ability of alternative treatments to improve their mobility. There are no ICD-10 codes for either stage of cancer or severity of knee arthritis, so this information cannot be obtained from claims forms today. The only way to obtain the information is to ask physicians to record it for the patients for whom it is relevant.

In addition to the stage and severity of disease, the following patient characteristics that are not adequately reflected in ICD-10 codes will likely affect resource use for many types of patients:

- **Patient Functional Limitations.** A patient's functional limitations (e.g., inability to walk) can have an equal or greater effect on costs and outcomes as do their medical conditions. Patients who are unable to walk or drive or are unable to carry out activities of daily living will have greater difficulty caring for themselves and greater difficulty obtaining traditional office-based ambulatory care services, which can lead to increased use of more expensive

healthcare services. For example, one analysis found that there were hospital admissions for 34% of Medicare beneficiaries who had functional limitations as well as chronic diseases, but there were admissions for only 20% of the Medicare beneficiaries who had 3 or more chronic conditions but no functional limitations. The researchers also found that the majority of the beneficiaries on whom Medicare spent the most had both chronic conditions and functional limitations.

- **Barriers in Accessing Healthcare Services.** Having health insurance does not automatically assure that a patient can access the care they need. High deductibles or high cost-sharing levels may discourage individuals from seeking needed care or taking prescribed medications, which can result in avoidable complications and higher overall expenses that are outside the control of their physicians and other healthcare providers. Living in rural areas where long distances are required to travel to provider locations and where there is a lack of public transportation can also make it difficult for patients to obtain needed care regardless of the benefit design in their health insurance plan.

Suggested Care Episode Groups, Patient Condition Groups, and Codes

In order to define Care Episode Groups and Patient Condition Groups consistent with the above concepts, we recommend that CMS establish the following new HCPCS codes to indicate the following phases of care and categories of patients:

G9900: Preventive care

G991x: Diagnosis of a new symptom

G9911: Level 1 – Low Need Patients

G9912: Level 2 – Moderate Need Patient

G9913: Level 3 – High Need Patients

G9914: Level 4 – Very High Need Patients

G992x: Treatment planning for a new diagnosis

G9921: Level 1 – Low Need Patients

G9922: Level 2 – Moderate Need Patient

G9923: Level 3 – High Need Patients

G9924: Level 4 – Very High Need Patients

G993x: Initial new or revised treatment for a newly diagnosed or significantly worsened chronic condition

G9931: Level 1 – Low Need Patients

G9932: Level 2 – Moderate Need Patient

G9933: Level 3 – High Need Patients

G9934: Level 4 – Very High Need Patients

G994x: Continued treatment for a chronic condition

G9941: Level 1 – Low Need Patients

G9942: Level 2 – Moderate Need Patient

G9943: Level 3 – High Need Patients

- G9944: Level 4 – Very High Need Patients
- G995x: Treatment for an acute condition, treatment for an exacerbation of a chronic condition, or delivery of a diagnostic procedure
- G9951: Level 1 – Low Need Patients
- G9952: Level 2 – Moderate Need Patient
- G9953: Level 3 – High Need Patients
- G9954: Level 4 – Very High Need Patients
- G996x: Treatment for a complication resulting from a treatment or procedure
- G9961: Level 1 – Low Need Patients
- G9962: Level 2 – Moderate Need Patient
- G9963: Level 3 – High Need Patients
- G9964: Level 4 – Very High Need Patients

These generic episode codes would be converted to a specific condition-based episode using the relevant ICD-10 code that the provider reports along with the episode code. For example, if a provider submitted the G9942 Care Episode Code along with an ICD-10 code for heart failure, it would indicate that a patient was receiving continued treatment for their heart failure and that the patient had other characteristics (such as moderate severity of their heart failure and some difficulty accessing outpatient services) that indicated they needed a moderate level of services. (All of the Care Episodes should be tied to the underlying condition being treated, not to a procedure, so that there is no financial incentive to deliver one procedure over another in achieving the best outcomes for the patient.)

The generic Care Episode codes described above would only be used for a particular health condition until more specific codes were developed for that condition by the relevant medical specialty society. As condition-specific Care Episode Groups and Patient Condition Categories are developed by specialty societies, either for MIPS or APMs, these codes could be reviewed and approved by the CPT Editorial Panel just as procedural service codes are today. This would ensure consistency of definitions. (There would likely need to be a new category of CPT codes established for Care Episode Groups since they do not represent discrete services as existing Category I and III CPT codes do.)

Associating Individual Services with Episodes

For each combination of Care Episode code and ICD-10 code, the services that would be included or excluded from the episode would need to be identified in order to measure resource use within that episode and to avoid double payment under an APM. **Rather than having CMS use episode grouper software to guess at how to assign services to episodes, providers should be given a way to explicitly indicate the type of episode to which a service should be assigned. To accomplish this, 7 modifiers (Y0, Y1, Y2, Y3, Y4, Y5, Y6) should be created for use with existing CPT/HCPCS codes to enable the provider of a discrete service to indicate which type of episode that service was associated with.** For example, if an office visit for an established patient was part of the initial treatment for a newly diagnosed chronic disease, the provider could report 99213-Y4, indicating that a Level 3 office visit was provided in conjunction with initial treatment of the chronic disease.

Definitions of which services should be assigned to particular episodes will still be needed, but these can be used by physicians and other providers to ensure accurate coding of episodes (just as they currently use CPT definitions to ensure accurate coding). CMS should defer to the definitions medical specialty societies are developing as part of APMs wherever possible rather than creating conflicting definitions for MIPS.

Patient Characteristics Used to Define Levels of Need

New Patient Condition Codes should be defined to supplement existing ICD-10 codes in order to objectively assign patients to the different need levels in the HCPCS codes above based on important characteristics that are not captured in ICD-10. The criteria for assigning these to patients would differ depending on what the relevant condition or episode is. For example, the same severity of condition codes could be used for both COPD and heart failure but the criteria for assigning “high severity” to a patient with COPD would differ from the criteria for assigning that same category to a patient with heart failure. In cases where stage or severity levels are captured by ICD-10 codes, those codes would be used instead of the generic Patient Condition Codes.

- ZZ1.xx Stage/Severity of condition
 - ZZ1.1 Early Stage/Mild Severity
 - ZZ1.2 Intermediate Stage/Moderate Severity
 - ZZ1.3 Advanced Stage/High Severity
- ZZ2.xx Patient Functional Status
 - ZZ2.1 High Functional Status
 - ZZ2.2 Moderate Functional Status
 - ZZ2.3 Low Functional Status
 - ZZ2.4 Very Low Functional Status
- ZZ3.xx Access to Healthcare Services Needed for Treatment
 - ZZ3.1 Little Difficulty Accessing Necessary Healthcare Services
 - ZZ3.2 Moderate Difficulty Accessing Necessary Healthcare Services
 - ZZ3.3 Significant Difficulty Accessing Necessary Healthcare Services

Use of Patient Relationship Categories and Codes

The Patient Relationship Categories that MACRA requires could be identified by attaching modifiers to both the Care Episode codes and the CPT HCPCS codes for the discrete services. As was described in our January 6 letter commenting on CMS’s revised proposal for patient relationship categories and codes (a copy of which is attached), we recommend modifiers be created for the following six Patient Relationship categories.

- Z1. 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.

- Z2. 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.
- Z3. 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.
- Z4. 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.
- Z5. 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.
- Z6. 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.

For example, if a physician reported a G9942-Z2 Care Episode Code and Patient Relationship Modifier along with an ICD-10 code for heart failure, it would indicate that the physician was taking responsibility for continuing care and coordination for the patient’s heart failure. If a provider reported G9942-Z5, it would indicate that the provider was delivering a specific service ordered by another clinician as part of the ongoing management and treatment of the patient’s heart failure.

The Advantages of Coded Categories for Payment and Performance Measurement

Using new CPT/HCPCS codes for the Care Episode Groups and Patient Condition Groups enables the codes to be used both for MIPS and different types of APMs, as Congress intended:

- If the provider is participating in an APM in which payment will be made prospectively for an entire episode, then the provider could bill and be paid for the Care Episode code for that episode, and no separate payment would be made for services delivered as part of that episode of care.
- If the provider is participating in an APM in which payments are made for individual services but total spending is reconciled against an episode budget, then the provider would continue to bill and be paid for individual services described by CPT/HCPCS codes, but the provider would also submit the Care Episode Group code to indicate that the patient was part of a particular type of episode for which a payment budget had been defined.
- If the provider is participating in MIPS, the provider would continue to bill and be paid for individual services described by CPT/HCPCS codes, but the provider could also submit one or more Care Episode Group codes to indicate the context in which the services were being delivered so that resource use and quality measures could be calculated and compared to other similar patients.

Moreover, creating HCPCS codes that define episodes and patient need categories enables an Alternative Payment Model to be implemented by both providers and payers using their existing billing and claims payment systems, rather than forcing providers to wait to find out what they will be paid until after payers have made risk adjustment calculations and forcing payers to create a new step in the process of determining the provider's payment.

Implementing the Codes on the CMS 1500 Form

The codes and modifiers described above could be used with the current CMS 1500 Billing Form through the following process:

- Reporting of all of the codes should be voluntary. Physicians and other providers who do not want to participate in an APM or to better control how resource use is measured for the care they deliver can continue to code and bill exactly as they do today.
- The ICD-10 codes and any Patient Condition Codes for additional patient characteristics relevant to an episode of care should be reported on line 21 of the CMS 1500 form, the same line where all ICD-10 codes are already being reported. The new Patient Condition Codes described above would only be reported on a CMS 1500 form when the form is being used to report a G99xxx Care Episode Code.
- The ICD-10 code for the primary condition associated with the episode should be reported in field 21-A, which is already used for the primary diagnosis associated with individual procedures.
- The G99xxx Care Episode Code(s) should be reported on line 24, the same line where all HCPCS codes are already being reported. The Diagnosis Pointer in field 24-E should refer to the diagnosis code that defines the episode.
- In field 24-E, the provider reporting the episode should include a modifier indicating the appropriate Patient Relationship Category defining the provider's role in the episode.
- Any discrete service associated with a particular episode should be reported using the appropriate CPT/HCPCS code along with (1) a modifier indicating the type of Care Episode Group and (2) a modifier indicating the provider's Patient Relationship Category.

This process is intended to allow the new codes to be used on the existing CMS 1500 Billing Form in a way that will limit the need for changes in current billing and claims payment systems. However, no matter what process is used, **it will be difficult to implement Alternative Payment Models successfully using a billing form that was designed for the traditional fee-for-service payment system. We urge that CMS begin immediately to develop a new billing form that is specifically designed to report Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories as well as discrete services and diagnoses.**

Comments and Responses to Questions on the Document Posted in December

In addition to the above recommendations, we offer the following comments on the information and questions in the document “Episode-Based Cost Measure Development for the Quality Payment Program.”

- The document purports to describe issues associated with “cost measures,” but the issues discussed all relate to measures of *CMS spending*, not actual *provider costs*. For example, on page 7, the document states “a cost measure represents the Medicare payments...for the items and services furnished to a patient during an episode of care...” The amount that CMS pays for a service may have little or no relationship to the actual costs of delivering that service, and there are many high-value services that healthcare providers deliver for which there is no payment at all. Under Alternative Payment Models, the “cost” to CMS (i.e., its payments) for a patient’s services and the actual costs providers incur to deliver those services may differ in new ways. Consequently, the proposed measures should not be referred to as “cost measures” unless CMS intends to actually try to measure providers’ costs for delivering services. MACRA uses the term “resource use” measures, and CMS should use that statutory term for measures of spending, while reserving the term “cost measures” for measures designed to truly measure the actual cost providers incur in delivering care.
- On page 8, the document states that “episode groups focus on clinical conditions requiring treatment.” This is an inappropriately narrow definition. There are patients with clinical conditions that require active monitoring but not necessarily “treatment,” and many patients at end-of-life require palliative care or other types of support but not “treatment.”
- On page 8, the document states that a chronic condition episode should be “triggered using codes for evaluation & management combined with ICD-10 diagnostic information on claims.” If this were desirable, there would have been no need for Congress to include a section in MACRA requiring the development of care episode groups and codes. A patient with a chronic disease could receive the assistance they need through services that are not currently described by evaluation & management codes, so trying to define episodes solely with E/M codes is inappropriate.
- On page 9, the document states that the goal of dividing episodes into sub-groups is to “offer a meaningful clinical comparison,” but then says this must be balanced “against the need to have an adequate number of cases that can be attributed to a given clinician.” If a clinician only treats a small number of cases of a particular type, that may be a reality of the care delivery process (e.g., reflecting the fact that there are relatively few patients with the condition being treated in any particular community) and statistical manipulations cannot overcome this. Combining dissimilar patients into a single group for measurement purposes may increase the number of cases but also increase the uncontrollable variance and thereby reduce the reliability of the measure.
- On page 10, the document states that “Acumen, LLC is soliciting expert clinical input ... regarding how to use information from claims to inform the attribution of services to clinicians.” The purpose of the Patient Relationship Categories and codes required by MACRA is to avoid the need for retrospective attribution systems. CMS has already released two versions of the Patient Relationship Categories and is required to finalize the

categories and codes this month (April 2017). These should be used as the mechanism for attributing episodes and services to clinicians.

- On page 13, the document states that episodes are initiated by a “trigger event” which is “identified by certain procedure or diagnosis codes,” and then “the grouping algorithms identify and aggregate the related services.” As noted above, MACRA requires the creation of Care Episode Groups and codes in order to provide a way for clinicians to indicate whether an episode has been initiated and what services are associated with it, reducing or eliminating the need for grouping algorithms that rely solely on procedure and diagnosis codes.
- On page 14, the document indicates that episode groups may only be developed for conditions where there are “opportunities for improvement.” Although it is likely that there are opportunities for improvement in all aspects of healthcare, it is inappropriate to ignore patient conditions and procedures where quality is currently high and spending is low, since healthcare payment systems need to support continuation of good care, not just improvement where there are currently problems.
- On page 17, the document indicates that CMS is considering defining acute episodes in a way that does not distinguish the place of service or the performance of a procedure. We support this approach. The generic episode groups that we recommended earlier are all based on the patient’s underlying conditions and needs, not on the specific procedures or treatments delivered or the locations where the services were delivered.
- On page 18, the document indicates that CMS is considering a “single episode group for outpatient chronic care with adjustment for comorbidities and demographics.” Patients with different types of chronic diseases need very different kinds of services, and patients who have a particular chronic disease need different kinds of services at different stages of their care. Consequently, it would be completely inappropriate to try and group them all into a “single episode group.”
- On page 18, the document asks for comments on how to obtain information on disease severity and staging. As we recommended earlier, new Patient Characteristic codes should be created for important patient characteristics that are not currently captured in ICD-10 codes, and these should be used to assign patients to different Patient Condition Groups (need levels) within individual Care Episode Groups.
- On page 19, the document again discusses “attributing” services to clinicians and suggests that this might be done using “percentages of the resources for an episode that could be attributed to physicians serving in different roles.” As noted several times above, the purpose of the Patient Relationship Categories and codes required by MACRA is to avoid the need for retrospective attribution systems. Moreover, in addition to Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories, a fourth piece of information is essential to effective resource use measurement – identifying the physician who *ordered* a service, not just the physician who *delivered* the service. The current measures of resource use that are used by CMS are seriously flawed because they may assign accountability for a service to a physician who delivered the service even if the physician did not order it, and the resource use measures may fail to assign accountability for a service to the physician who ordered the service if it was delivered by a different physician or provider. Congress recognized the importance of solving this problem, and so in addition to the requirements in

Section 1848(r)(4)(A) that claims forms include codes for Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories, Section 1848(r)(4)(B) requires that the National Provider Identifier of the ordering physician or practitioner be included on the claims form if the service was ordered by a different physician or practitioner than the individual who delivered the service. Although Medicare regulations already require this information, the statutory requirement in MACRA will ensure that this information is consistently available. **We recommend that measures of resource use within Care Episode Groups utilize information on whether a provider ordered a service or made a referral for services in addition to the information provided by the codes for Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories.** (Detailed suggestions on how to do this were contained in our February 15, 2016 letter, a copy of which is attached.)

- On page 20, CMS asks how to incorporate Part D spending into episode group development. Medications are a major mechanism of treatment and prevention. In some cases, use of medications is a more cost-effective way to treat or prevent a condition and in other cases, other types of care are more cost-effective. Failing to include spending on medications in measures of resource use or in alternative payment models creates an inappropriate financial incentive to use medications instead of other types of treatment or care. Since the majority of medications received by Medicare beneficiaries are paid for through Part D, it is clearly essential that Part D spending be included in episode spending measures. Moreover, including spending on Part B medications but excluding spending on Part D medications would create an inappropriate incentive for physicians to prescribe Part D medications even when Part B medications would be more cost-effective. It is certainly possible that a shift in treatment from Part D medications to Part B medications or other services paid for under Part A or Part B would increase *Medicare* spending even though *total* spending would decrease (because the Part D plans would receive the savings), but this is an artifact of the way Medicare pays for services. Providers should not be penalized for delivering the most cost-effective care to patients simply because of differences in the categories under which Medicare pays for particular services.

By enacting Section 1848(r) as part of MACRA, Congress created a unique opportunity to address long-standing weaknesses in the information collected on claims forms and to solve serious problems with the design of current pay-for-performance systems and alternative payment models that derive from those weaknesses. Rapidly implementing these provisions of MACRA in the most effective and innovative way possible needs to be a high priority for CMS. We would be happy to provide any assistance that would be helpful to you in this process.

Sincerely,



Harold D. Miller
President and CEO

Attachments: February 15, 2016 Letter from Harold Miller to Acting Administrator Andy Slavitt with Recommendations Regarding Implementation of MACRA Section 101(f) Requirements to Improve Resource Use Measurement, Including Comments on “CMS Episode Groups” Document

January 6, 2017 Letter from Harold Miller to Acting Administrator Andy Slavitt with Comments on Revised Proposal for Patient Relationship Categories and Codes

cc: Patrick Conway, MD, Deputy Administrator for Innovation and Quality
Kate Goodrich, MD, Director, Center for Clinical Standards and Quality
Pierre Yong, Director, Quality Measurement and Value-Based Incentives Group
Reena Duseja, MD, Director, Division of Quality Measurement
Theodore Long, MD, Senior Medical Officer, Division of Quality Measurement
Kristin Borowski, Program Analyst, Division of Quality Measurement

February 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: Recommendations Regarding Implementation of MACRA Section 101(f) Requirements to Improve Resource Use Measurement, Including Comments on “CMS Episode Groups” Document

Dear Acting Administrator Slavitt:

Thank you for the opportunity to provide input to CMS as it works to implement the provisions of Section 101(f) of Title I of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that require development of care episode groups, patient condition groups, and patient relationship categories and corresponding codes for use on claims forms. Our comments are intended to respond to the specific questions raised in the document entitled “CMS Episode Groups” that was distributed by the agency last fall, but also to provide more general recommendations in response to the requirements in MACRA for stakeholder input on improving resource use measurement.

Our recommendations are divided into five categories:

- Recommendations for defining Care Episode Groups and codes;
- Recommendations for defining Patient Condition Groups and codes;
- Recommendations for defining Patient Relationship Categories and codes;
- Recommendations for measuring and reporting on resource use; and
- Recommendations for ensuring that Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories support the development and implementation of successful Alternative Payment Models.

I. Recommendations for Defining Care Episode Groups and Codes

Section 1848(r)(2)(D)(i) of the Social Security Act, which was added by Section 101(f) of MACRA, requires the creation of “care episode groups” and corresponding codes for each such group. Section 1848(r)(4) requires that physicians record these codes on the claims forms they submit for their services beginning in 2018.

The Problems With Episode Groupers

The Care Episode Groups and codes that MACRA requires in Section 1848(r) represent a fundamentally different and significantly better approach to defining and measuring episodes of care than the “episode grouper” that Section 1848(n)(9)(A) of the Social Security Act required CMS to develop. An episode grouper is a method of using the diagnosis codes and procedure codes that are recorded on claims forms in an attempt to retrospectively group claims into clinically-related episodes. Episode groupers are complex and highly error-prone because they try to determine the relationship between the services a patient receives long after those services have been delivered, using information on claims forms that was designed for billing purposes, not for defining clinical episodes.

A number of studies, including research commissioned by CMS, have identified the serious problems with episode groupers that use this approach. For example, a 2006 study by the Medicare Payment Advisory Commission found that two commonly used episode groupers, when applied to the same population of Medicare patients, calculated significantly different amounts of spending in episodes with similar names.¹ A 2008 study conducted by Acumen, LLC for the Centers for Medicare and Medicaid Services found that one of these episode groupers assigned the majority of a sample patient’s spending to a Pneumonia episode, whereas the other grouper assigned the majority of the patient’s spending to an Alzheimer’s Disease episode.² A 2012 study conducted for the U.S. Bureau of Economic Analysis found that those same two episode groupers, when applied to a group of commercially insured patients, produced very different classifications of spending into episodes.³

In response to Section 1848(n)(9)(A), CMS has developed two new episode grouper methodologies – the Episode Grouper for Medicare (EGM), which CMS is also referring to as “Method A,” and a second methodology which CMS is describing as “Method B.” Both of these methodologies have been used to create reports for physicians as part of the 2014 Supplemental Quality and Resource Use Reports (QRURs). Although CMS has made available all of the codes and logic used to define the episodes, CMS has not (to our knowledge) released any information to enable an assessment of the validity or reliability of these methodologies and how they perform relative to other groupers. However, no matter how carefully the new episode groupers have been constructed, the results they produce will inherently have errors – potentially serious errors – because they are based on procedure codes and diagnosis codes that do not contain

¹ Medicare Payment Advisory Commission. June 2006 Report to the Congress: Increasing the value of Medicare. Chapter 1: Using episode groupers to assess physician resource use.

² MaCurdy T, Kerwin J, et al. Evaluating the functionality of the Symmetry ETG and Medstat MEG software in forming episodes of care using Medicare data. Acumen LLC. August 2008.

³ Rosen A, Liebman E, Aizcorbe A, Cutler DM. Comparing commercial systems for characterizing episodes of care. U.S. Bureau of Economic Analysis Working Paper Series. June 2012.

sufficient information to accurately determine the episode to which an individual service should be assigned, particularly for patients with multiple health problems.

Although resource use measures calculated using these imperfect grouper methodologies may provide helpful information to physicians in some cases, they will never be sufficiently accurate or reliable to use for defining Alternative Payment Models or for holding physicians accountable for resource use under the Merit-Based Incentive Payment System (MIPS). It would be inappropriate to use flawed grouper methodologies to determine that a physician is “inefficient” because the grouper erroneously assigns unrelated services to an episode of care the physician is managing, and it would be inappropriate to determine that a physician is “efficient” because services they deliver or order are erroneously assigned to episodes being managed by other physicians.

Using Care Episode Group Codes to Solve Problems Inherent in Episode Groupers

Congress wisely recognized that the current *retrospective* approach to measuring resource use using episode groupers is fundamentally flawed and needs to be improved. What MACRA requires is a *concurrent* approach which enables physicians to determine, at the time a service is rendered, the care episode or episodes to which the service should be assigned based on the goal of the service and its relationship to other services that the patient is receiving. MACRA requires that Care Episode Groups be established taking into account “the patient’s clinical problems *at the time items and services are furnished* during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished” [emphasis added].

Although the definitions of episodes and the rules for assigning services to episodes that CMS has developed for its current grouper methodologies could be used as starting points for the definitions and logic for the Care Episode Groups required under MACRA, revisions are both desirable and appropriate because the episode definitions no longer need to be constrained by the limits of current procedural and diagnostic coding on claims forms. The physician can assign a Care Episode Group code to a patient based on whatever criteria are appropriate, rather than just what can be documented using CPT® and ICD codes.

It appears from the questions asked in the “CMS Episode Groups” document that CMS staff do not yet recognize the fundamental difference between the Care Episode Groups and codes required under MACRA and the episode groupers that have been under development so far. The ninth question on page 11 asks “how can the validity of an episode be maximized without such clinical information [on things such as stage of cancer and responsiveness of cancer that is not currently in claims data]?” The answer is that physicians can provide that additional clinical information through the use of properly-designed Care Episode Groups and codes:

- For example, today, it is impossible to accurately define separate treatment episodes for different stages of cancer in an episode grouper because there is no way to accurately determine the stage of a patient’s cancer from either procedure codes or diagnosis codes. However, if separate Care Episode Groups are defined based on stage of cancer, it would be a simple matter for the oncologist treating the cancer to choose the correct Care Episode Group code based on the stage of cancer.

- Today, it is impossible to accurately determine whether one patient is receiving more services than another patient for the same condition because the two patients responded differently to their initial treatment. However, Care Episode Group codes could be defined so that a physician could identify when a second line of therapy was given following the patient's failure to respond to initial treatment.
- Today, because of the uncertainty about the accuracy of diagnosis codes on claims forms for ambulatory services, the CMS groupers require the presence of the same diagnosis code on two separate outpatient Evaluation and Management Service claims for all but very basic health problems. However, Care Episode Group codes can enable physicians to assign a patient to the correct episode group based on a single visit or other outpatient service.

Specific Recommendations for Defining Care Episode Groups

- **Care Episode Groups Should Be Defined Based on the Patient's Underlying Health Condition That is Being Treated, Not Just a Procedure Chosen for Treatment.** The vast majority of the episodes CMS has developed to date are defined around specific procedures, primarily hospital-based procedures, not the patient's underlying health problem that is being treated or managed. Although it is clearly important to ensure that all of the care during and following a hospital-based procedure is delivered as efficiently and effectively as possible, focusing episodes only on specific procedures ignores the opportunity to reduce costs and improve outcomes by using different procedures and treatments and by performing procedures in lower-cost settings. For example, a knee or hip arthroplasty is one way to treat knee or hip osteoarthritis, but many patients can achieve pain relief and improved mobility using non-surgical approaches while avoiding the inherent risks of surgery. Measuring resource use solely for the patients who receive surgery can unintentionally make physicians who do more surgeries on lower-risk patients look "more efficient" than those who only use surgery for patients for whom other alternatives have failed.
- **Separate Care Episode Groups Should Be Defined for the Same Procedure for Patients with Significantly Different Needs.** In the episodes that have been developed by CMS to date, there is only one episode definition for each type of procedure, despite the fact that in many cases, different combinations of services beyond the procedure itself will be needed for patients with different characteristics. The Inpatient Prospective Payment System used for Medicare payments to hospitals recognizes that the number and types of services needed to manage a patient's care during a hospitalization for a particular procedure will depend not only on the procedure itself, but on the number and severity of the patient's health problems, and so there are several levels of MS-DRGs for each type of procedure, with differing payments for each of the levels.⁴ Since episodes of care are intended to define a more

⁴ CMS has stated in the past that defining clinically meaningful groupings of patients in DRGs has been essential for helping providers manage costs effectively without harming patients. "Because the DRGs were developed to group clinically similar patients, an extremely important means of communication between the clinical and financial aspects of care was created. DRGs provided administrators and physicians with a meaningful basis for evaluating both the process of providing care and the associated financial impacts. Development of care pathways by DRG and profit-and-loss reports by DRG product lines became commonplace. With the adoption of these new management methods, length of stay and the use of ancillary services dropped dramatically... The vast majority of modifications to the DRGs since the inception of the Medicare inpatient hospital prospective payment system ... have almost always been the result of clinicians identifying specific types of patients with unique needs... Central

complete range of services than just the inpatient stay, and since differences in patient needs will result in greater differences in services during episodes that extend beyond a hospital stay, it does not make sense to have only one episode definition for major procedures.

Although Patient Condition Groups could also be used to signal differences in patient needs instead of creating separate Care Episode Groups based on patient needs, it would be better to use the two types of codes in complementary ways. For patient characteristics that predictably result in very different service needs, separate Care Episode Groups and codes should be defined; then Patient Condition Groups and codes can be used to enable better risk adjustment within episodes based on patient characteristics that have smaller or less certain impacts on service needs.

- **Care Episode Groups Should Be Defined Around Sub-Episodes Within Larger Episodes of Care.** Although it is appropriate and desirable to examine resource use and outcomes for the full range of services a patient receives as part of their treatment for a condition, in many cases there is no one physician or health provider who delivers all of the services in the full episode of care, and there may be no physician who is able to supervise or coordinate all of those services. It would be much easier to improve overall efficiency in a care episode if the sources of inefficiencies can be effectively localized and if the impacts of changes in different areas can be measured separately.
 - For example, many patients who are treated in a hospital will receive their post-acute care services not only in a different facility, but in a different state. Although the inpatient and post-acute care services should be better coordinated and managed than they are today in order to improve resource use and outcomes across the full episode, services must also be effectively managed and coordinated within each portion of the episode by those who are delivering those services in order to achieve the best outcomes for the patient.
 - Similarly, an overall episode of care should encompass both the initial procedure and the treatment of any complications of that procedure (e.g., a surgery and a readmission to treat a surgical site infection), and improvements to the overall episode can come from both reducing the number of complications and from improving the treatment of the complications when they occur. Since different physicians and hospitals may be involved in the initial procedure and the treatment of complications, those two portions of the overall episode should be measured separately as well as jointly.

While coordinated care across a full episode is certainly preferable to uncoordinated care, the mere fact that care is being coordinated does not make it good care if the individual components are of poor quality, so it is essential to improve the quality and value of each sub-episode in order to ensure the best overall value in an entire episode of care.

The need for better ways of breaking down large episodes into clinically meaningful sub-episodes can be seen in the 2014 Supplemental QRURs that CMS has been distributing based on data generated by the current episode groupers. The episode spending reports are only disaggregated using traditional payment categories – hospital stays, physician services, DME, etc. – and it is impossible to determine when in the course of an episode those services

to the success of the Medicare inpatient hospital prospective payment system is that DRGs have remained a clinical description of why the patient required hospitalization.” 66 Federal Register 22668, May 4, 2001.

were delivered or why they were delivered, making the reports of relatively little use to physicians who want to improve the quality and reduce the cost of care.

In addition, MACRA indicates that the purpose of developing Care Episode Groups is to support Alternative Payment Models (APMs) as well as the Merit-Based Incentive Payment System (MIPS). In many cases, separate Alternative Payment Models will need to be defined for individual sub-episodes so that providers can have the flexibility needed to improve care within the sub-episode they are managing as well as work together effectively with other physicians and providers as part of a payment model focused on the overall episode. CMS has recognized the value of this in its Bundled Payments for Care Improvement Initiative by defining separate payment models focused solely on the inpatient stay and solely on the post-acute care as well as models encompassing the full episode of care surrounding a hospitalization. Defining Episode Care Groups representing sub-episodes within larger episodes will facilitate the development of the kinds of Physician-Focused Alternative Payment Models that MACRA encourages.

- Care Episode Groups Should Include Diagnostic Episodes as Well As Treatment Episodes.** All of the current condition episode definitions used in episode groupers implicitly presume that the patient’s condition or need has been accurately diagnosed, and the procedural episodes also implicitly presume that the treatment is appropriate based on an accurate diagnosis of the patient’s underlying condition. However, there is growing recognition that many treatments are unnecessary, inappropriate, or ineffective because the underlying diagnosis is inaccurate.⁵ Inadequate payment to support the time and effort needed to develop a good diagnosis is one of the major culprits in erroneous diagnoses.⁶ At the same time, it is well known that there is considerable overuse of testing and imaging in many aspects of the diagnostic process. Consequently, it will be important to define Care Episode Groups for the services used to establish a diagnosis in response to a patient’s symptoms, not just Care Episode Groups based on the treatments delivered after a diagnosis has ostensibly been established.

II. Recommendations for Defining Patient Condition Groups and Codes

Section 1848(r)(2)(D)(i) of the Social Security Act, which was added by Section 101(f) of MACRA, also requires the creation of “patient condition groups” and corresponding codes for each such group. Section 1848(r)(4) requires that physicians record these codes on claims for services they perform beginning in 2018.

The resources required to achieve appropriate outcomes for a patient during a particular episode of care will depend heavily on the specific needs of that patient and their ability to access and use different treatment options. Consequently, measures of resource use, quality, and outcomes need to be adjusted for differences in these factors. Unfortunately, the risk adjustment systems that

⁵ Balogh EP, Miller BT, Ball JR. *Improving Diagnosis in Health Care*. Institute of Medicine; The National Academies of Sciences, Engineering, and Medicine.

⁶ Miller HD. *How Healthcare Payment Systems and Benefit Designs Can Support More Accurate Diagnosis*. Center for Healthcare Quality and Payment Reform 2015. Available at: <http://www.chqpr.org/downloads/HowHealthcarePaymentSystemsCanSupportAccurateDiagnosis.pdf>

CMS and other payers are using today for both resource use measurement and payment have many serious weaknesses that can inappropriately penalize physicians who care for sicker patients and reward physicians who do not, and use of these flawed systems as part of MIPS and APMs could make it harder for higher-need patients to access appropriate care.⁷

In Section 1848(n)(6) of the Social Security Act, Congress required that reports on resource use be adjusted based on patient health status and patient characteristics “to the extent practicable.” In MACRA, Congress recognized that effective adjustment could not be done effectively using the data currently being collected, and so it required the creation of Patient Condition Groups.

Specific Recommendations for Defining Patient Condition Groups

In order for the Patient Condition Groups required under MACRA to solve the serious weaknesses with current methods of risk adjustment, we recommend that they be defined in the following ways:

- **Patient Condition Groups Should Be Defined Based on Differences in Patient Needs Rather Than Ability to Predict Current Spending Levels.** Most current risk adjustment systems, such as Medicare’s Hierarchical Condition Category (HCC) system, were designed to predict how much will be *spent on healthcare services* for a particular patient population, not to measure differences in the extent of patient needs or to predict differences in the outcomes of treatment. These risk adjustment systems use statistical regression analyses to assign a higher risk score to a patient if the amount that is *typically spent* on similar patients is higher, even if those patients did not actually *need* all of the services they received. Conversely, these statistical analyses inherently assign lower risk scores to patients who received fewer billable services, even if the patient needed more services or if the services that were delivered were not billable. Moreover, because these analyses are performed using claims data, they cannot consider patient characteristics that are not recorded in diagnosis codes or differences in services other than those described in procedure codes. As a result, using risk scores calculated as is done today can actually reinforce inappropriate spending, penalize efforts to reduce underuse, and cause providers to focus spending reduction efforts on the wrong patients. Patient Condition Groups should be defined based on input from physicians and other health care providers regarding the characteristics of patients that affect their need for healthcare services.
- **Patient Condition Groups Should be Defined Using Diagnostic Information Not Captured in Current Diagnosis Codes.** One reason that Patient Condition Group codes are needed in addition to diagnosis codes is that current diagnosis codes do not adequately distinguish aspects of some health conditions that can significantly affect the resources needed to treat or manage those conditions and/or the outcomes that can be achieved. For example, in addition to the *type* of cancer a patient has (e.g., breast, colon, lung, etc.), the *stage* of cancer (e.g., whether it has metastasized to other parts of the body) has a significant impact on how it is treated by oncologists and the outcomes that can be achieved for the patient. However, neither the ICD-9 nor ICD-10 diagnostic coding systems has a method for

⁷ For a more detailed discussion of the problems with current risk adjustment systems, see Miller H. *Measuring and Assigning Accountability for Healthcare Spending*. Center for Healthcare Quality and Payment Reform. August 2014. Available at: <http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf>.

recording the stage of cancer, only the type of cancer. Similarly, the ICD-10 coding system has no codes to distinguish the severity of a patient's heart failure, even though the severity of the condition has a significant impact on treatment costs and outcomes for heart failure patients. Patient Condition Groups should be defined so that physicians can distinguish differences in patient needs, such as the severity of health conditions, that go beyond what is possible using diagnosis codes.

- Patient Condition Groups Should Be Defined Based on All of a Patient's Health Problems That Could Affect Costs and Outcomes.** Medicare's Hierarchical Condition Category (HCC) system is a *prospective* risk adjustment system that is based primarily or exclusively on whether a patient had *chronic* health conditions in the previous year, and it completely ignores the potential impact of any newly diagnosed health problems or recent acute conditions or treatments. Not surprisingly, *concurrent* risk adjustment systems that consider new health problems are better able to predict service utilization. Patient Condition Groups should be defined with consideration for all of a patient's current and past health problems that could affect the number and type of services they need during a particular episode of care.
- Patient Condition Groups Should Be Defined Using Patient Functional Limitations as Well as Medical Conditions.** A patient's functional limitations (e.g., inability to walk) can have an equal or greater effect on costs and outcomes as do their medical conditions. Patients who are unable to walk or drive or are unable to carry out activities of daily living will have greater difficulty caring for themselves and greater difficulty obtaining traditional office-based ambulatory care services, which can lead to increased use of more expensive healthcare services. For example, one analysis found that there were hospital admissions for 34% of Medicare beneficiaries who had functional limitations as well as chronic diseases, but there were admissions for only 20% of the Medicare beneficiaries who had 3 or more chronic conditions but no functional limitations. The researchers also found that the majority of the beneficiaries on whom Medicare spent the most had both chronic conditions and functional limitations.⁸ However, since information about functional limitations is not captured effectively by standard diagnosis coding in claims data, it is not incorporated into most risk adjustment models. Another study found that the Medicare HCC risk adjustment model significantly under-predicted actual spending on the subset of patients with functional disabilities.⁹ All of Medicare's current payment systems for post-acute care differentiate payments based on patients' functional status as well as their health problems, so it would be inappropriate to ignore functional status in measuring resource use around episodes that could potentially include the need for post-acute care services. Patient Condition Groups should be defined with consideration of patients' functional limitations as well as their medical diagnoses.
- Patient Condition Groups Should Be Defined to Consider the Barriers Patients Face in Accessing Healthcare Services.** Having health insurance does not automatically assure that a patient can access the care they need. High deductibles or high cost-sharing levels may

⁸ Komisar HL, Feder J. Transforming care for Medicare beneficiaries with chronic conditions and long-term care needs: coordinating care across all services. Scan Foundation and Georgetown University. October 2011. Available at: http://www.thescanfoundation.org/sites/default/files/Georgetown_Trnsfrming_Care.pdf.

⁹ Noyes K, Liu H, Temkin-Greener H. Medicare capitation model, functional status, and multiple comorbidities: model accuracy. *Am J Manag Care*. 2008 October; 14(10): 679-690.

discourage individuals from seeking needed care or taking prescribed medications, which can result in avoidable complications and higher overall expenses that are outside the control of their physicians and other healthcare providers. For patients who live in rural areas, long distances to provider locations, lack of public transportation, etc. can also make it difficult for patients to obtain needed care regardless of the benefit design in their health insurance plan. Patient Condition Groups should be defined with consideration of the barriers patients face in obtaining the most appropriate care for their health problems.

- **Patient Condition Groups Should Be Defined So They Complement Care Episode Groups.** Patient Condition Groups should be defined in ways that complement rather than conflict with or duplicate Care Episode Groups. A patient characteristic that will have an important impact on the cost of treating one type of health condition may have little or no impact on the cost of treating other conditions. One of the many weaknesses with the Hierarchical Condition Category (HCC) system currently used by CMS for risk adjustment is that its categories are too aggregated for some types of episodes.¹⁰ Patient Condition Groups should be defined so that they can be disaggregated or aggregated based on the types of patient characteristics that will affect resource use in specific types of care episode groups.

III. Recommendations for Defining Patient Relationship Categories and Codes

Section 1848(r)(3)(B) of the Social Security Act, which was added by Section 101(f) of MACRA, also requires the creation of “patient relationship categories” and corresponding codes for each such category. Section 1848(r)(4) requires that physicians record these codes on claims for services they perform beginning in 2018.

Weaknesses in Current Methods of Attributing Patients to Physicians

There are serious weaknesses in the methods that CMS and other payers are using today to “attribute” patients to physicians and other healthcare providers¹¹:

- Many patients and the spending on their care are not attributed to any physician or other provider.
- Physicians are attributed the spending for many services that they did not provide or order. In fact, *most* of the spending that is attributed to physicians in typical attribution methodologies results from services delivered by *other* physicians.
- Physicians are not attributed the spending for many of the services they provide. Most attribution systems fail to assign physicians the majority of patients they did care for or the majority of services they delivered.

¹⁰ For example, in the 2014 version of the Medicare HCC risk adjustment system, a patient with colon cancer would have the same risk score as a patient who had a stroke, but one would not expect a patient with colon cancer to receive the same types of services from neurologists, cardiologists, and psychiatrists as would a patient with a stroke.

¹¹ For a more detailed discussion of the problems with current attribution systems, see Miller H. *Measuring and Assigning Accountability for Healthcare Spending*. Center for Healthcare Quality and Payment Reform. August 2014. Available at <http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf>.

These problems arise because the attribution methodologies attempt to assign patients to physicians *retrospectively*, i.e., after the care has already been provided, using statistical calculations based on relative frequencies of office visits and other services, rather than based on the actual nature of the relationship between the physician and patient. So-called “prospective” attribution methodologies do not solve this problem; they simply make the retrospective calculation based on services delivered prior to the period being measured, and then assume that relationships between patients and physicians during the prior period will continue into the current period, even though that is frequently not true.

Using Patient Relationship Categories to Dramatically Improve Patient Attribution

Congress wisely recognized that the current *retrospective* and *prospective* methods of attributing patients to physicians are fundamentally flawed and need to be improved. MACRA requires creation of a *concurrent* approach that enables physicians to state their relationship with the patient at the time a service is rendered using Patient Relationship Categories. Once these Categories are defined and codes for them are recorded on claims forms, there will no longer be a need for either the problematic retrospective or prospective attribution methodologies that CMS and other payers are currently using.

Recommendations for Defining Patient Relationship Categories

In Section 1848(r)(3)(B), Congress provided a detailed starting point for defining Patient Relationship Categories by requiring they include the following types of relationships between patients and the physicians and other practitioners who provide their care:

- (i) a physician (or other practitioner) who considers themselves 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 themselves 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; or
- (v) a physician (or other practitioner) who furnishes items and services only as ordered by another physician or practitioner.

We recommend that CMS add the following three categories to the five categories already defined by Congress:

- (vi) **a physician (or other practitioner) who considers themselves 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.

IV. Recommendations for Measuring and Reporting on Resource Use

Distinguishing the Providers Who Order and Deliver Services

In addition to Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories, a fourth piece of information is essential to effective resource use measurement – identifying the physician who *ordered* a service, not just the physician who *delivered* the service. The current measures of resource use that are used by CMS are seriously flawed because they may assign accountability for a service to a physician who delivered the service even if they did not order it, and current resource use measures may fail to assign accountability for a service to the physician who ordered the service if it was delivered by a different physician or provider.

Congress recognized the importance of solving this problem, and so in addition to the requirements in Section 1848(r)(4)(A) that claims forms include codes for Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories, Section 1848(r)(4)(B) requires that the National Provider Identifier of the ordering physician or practitioner be included on the claims form if the service was ordered by a different physician or practitioner than the individual who delivered the service. Although Medicare regulations already require this information, the statutory requirement in MACRA will ensure that this information is consistently available.

Using information on both the providers who ordered and delivered services, **we recommend that measures of resource use within Care Episode Groups be divided into four categories for each physician or other practitioner** who indicates (through use of a Patient Relationship Category code) that they are playing a lead or supportive role in a patient's care (other than merely delivering a service in response to orders from other physicians or practitioners)¹²:

1. **Services both *ordered and delivered* directly by the physician/practitioner playing the designated role in the patient's care.**
2. **Services delivered by *other physicians or providers* that are *integrally related* to the services delivered by the physician/practitioner playing the designated role.** For example, if a physician performs surgery on a patient in a hospital, then the payment to the hospital for the surgery and the payment to the anesthesiologist for the anesthesia services are

¹² A more detailed discussion of how to structure resource use measures is available in Miller H. *Measuring and Assigning Accountability for Healthcare Spending*. Center for Healthcare Quality and Payment Reform. August 2014. Available at <http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf>.

integrally related to the payment to the surgeon for performing the surgery, since the surgery could not have been performed without the other services.

3. **Services delivered by other physicians or providers that resulted from orders or referrals from the physician/practitioner playing the designated role.** Resource use measures need to measure these services separately from the services that are ordered and delivered by a physician/practitioner because the physician/practitioner who orders a service generally has only limited control over how the service is actually performed and what resources may be used by the physician/practitioner who delivers it.
4. **Services delivered by other providers that were related to services delivered or ordered by the physician/practitioner playing the designated role, but not directly delivered or ordered by that individual.** For example, if a patient develops a surgical site infection after discharge from a hospital and is admitted to a different hospital for treatment of that infection, the surgeon who performed the surgery did not deliver or order the treatment for the infection, but the treatment for the infection is clearly related to the procedure that the surgeon performed. However, the responsibility for the fact that the related services were needed may have been shared between the physician/practitioner playing the designated role and other physicians or providers (e.g., a surgical site infection may develop because of poor wound care by a post-acute care provider), so it is appropriate to measure this aspect of resource use separately from the services that were directly delivered or ordered by the physician/practitioner playing the designated role.

Measuring Resource Use for Unpaid Services

We recommend that CMS should permit physicians and other providers to voluntarily submit claims forms describing all services they deliver even if those services are not currently eligible for payment under Medicare. Many physicians are providing a variety of high-value services to patients for which there is no direct payment under Medicare. For example, when a physician responds to a patient concern through a phone call, there is no payment to the physician for the time they spent on that phone call. That physician may have used fewer resources to successfully address the patient's need than a physician who would ask a similar patient to come in to the office for a visit or a physician who would tell the patient to go to a hospital emergency department, but the fact that the physician was not paid by Medicare does not mean that no resources at all were expended on the patient's care. A calculation that does not include the time spent or costs incurred on these unpaid services is not a true measure of the resources used in delivering health care.

Moreover, because CMS is using the resource use measures to make or modify payments to physicians for their services, it is important to know all of the services that are being delivered as part of a patient's care. For example, in its Comprehensive Care for Joint Replacement (CJR) Program, CMS is planning to adjust the annual payment budgets based on the spending levels achieved by all participating providers. If a provider develops a new type of service (e.g., a new type of home-based rehabilitation service) that is not currently billable to Medicare and uses that service to reduce spending on billable services, the surplus under the CJR program would enable the provider to cover the costs of the new type of service. However, it would be inappropriate for CMS to then reduce the payment budget for the episode to the amount that the provider is

spending on *billable* services, because that would mean the provider would no longer be able to afford to deliver the unbillable service, even though that was what allowed the overall spending to be reduced in the first place.¹³

The only way to know what is really being done to achieve better value when a provider redesigns care and what resources will be needed to sustain that is to allow the provider to record the services that are being delivered without direct compensation. In many cases, there are CPT codes available to describe these services even though Medicare does not pay for them, so it would be feasible for physicians to record when these services were provided. Submission of this information should be voluntary, not required, however, since there would be an administrative cost to the physician for which he or she would receive no compensation.

V. Recommendations for Ensuring that Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories Support the Development and Implementation of Successful Payment Models

Section 1848(r) explicitly indicates that one of the purposes of creating Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories is to support the development and implementation of Alternative Payment Models.

Just as most current resource use measurement systems are based on problematic retrospective episode grouper and attribution methodologies, most current Alternative Payment Models being implemented by CMS and other payers are based on problematic retrospective attribution and reconciliation methodologies because there are not adequate ways for physicians to signal that a patient is receiving services that are to be supported by a specific payment model. The ability to bill for services using codes defining Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories could facilitate and dramatically accelerate the development of more innovative and effective approaches to Alternative Payment Models. For example, a physician who is willing to accept a bundled payment for all of the services included in a Care Episode Group could bill Medicare for that bundled payment (or trigger the calculation of an episode budget for the services) using the code defined for that Care Episode Group, and the physician could indicate that they are managing all of the care during that episode by recording the appropriate Patient Relationship Category code. The amount of the payment could be adjusted based on the patient's needs using one or more Patient Condition Group codes that the physician records in conjunction with the Care Episode Group code.

However, these new codes could only be used to facilitate billing and payment under Alternative Payment Models if the codes are defined in ways that complement and support those Alternative Payment Models. Consequently, it is essential that CMS specifically seek input from physician groups, medical specialty societies, and others that are developing Alternative Payment Models (APMs), particularly the Physician-Focused Alternative Payment Models required under

¹³ For a more detailed discussion of this problem, see Miller H. *Bundling Badly: The Problems With Medicare's Proposal for Comprehensive Care for Joint Replacement*. Center for Healthcare Quality and Payment Reform. 2015. Available at: <http://www.chqpr.org/downloads/BundlingBadly.pdf>

MACRA, as it works to define Care Episode Groups, Patient Condition Groups, and Patient Relationship Categories under Section 101(f).

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

Sincerely,

A handwritten signature in black ink, appearing to read "H. D. Miller". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Harold D. Miller
President and CEO

cc: Patrick Conway, MD, Acting Principal Deputy Administrator, CMS
Kate Goodrich, MD, Director, CMS Center for Clinical Standards and Quality
Rahul Rajkumar, MD, Deputy Director, Center for Medicare and Medicaid Innovation
Richard G. Frank, Assistant Secretary of HHS for Planning and Evaluation
Scott Smith, Director, ASPE Division of Health Care Quality and Outcomes
Members of the Physician-Focused Payment Model Technical Advisory Committee

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