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SUBMITTED ELECTRONICALLY
patientrelationshipcodes@cms.hhs.gov

Andy Slavitt
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5517-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS Patient Relationship Categories and Codes

Dear Administrator Slavitt:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed patient relationship categories and codes.

The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (NPPs) who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our vision for the future is that every older American will receive high quality patient-centered care. In order to achieve this vision, we strive to help guide the development of public policies that support improved health and health care for seniors.

The AGS shares CMS' commitment to the overall goal of reforming Medicare payment structures to improve patient outcomes and the quality of care provided. The society continues to support implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), which includes section 101(f) that requires the establishment and use of patient relationship categories and codes. We believe that the patient relationship categories and codes are an important component of the Merit-based Incentive Payment System (MIPS) program under MACRA, as they will aid in evaluating the resources used to treat patients and ultimately, provide a more effective method for attributing costs to physicians. However, the specifics of how these methodologies are implemented are critical to their success and may produce unintended and undesirable outcomes unless they are designed and evaluated in a careful and deliberate manner.

We believe, as a general matter, that evaluations at the individual clinician level will result in flawed conclusions and if statute requires such evaluation, CMS must proceed with caution. We are particularly concerned for professionals that are in shortest supply and/or care for more challenging patients.

The intended use of these codes will affect reporting. It will be helpful if the use is consistent across programs (e.g. attribution for an Accountable Care Organization (ACO) and attribution for costs in MIPS). Ambiguity in definitions coupled with significant impact on value based payment modification is likely to result in inconsistent reporting of similar relationships by different providers.

CMS needs to ensure that there is a common, hopefully, universal understanding and use of the patient relationship categories and codes. If the categories and codes are not used and applied consistently by all physicians of all specialties across all geographic areas (e.g., there is known variation in use of consultants and roles of primary care practitioners (PCPs) in different parts of the country), then the quality, and more importantly, the validity of the information captured by these proposed categories and codes will not only be minimal but could be counterproductive because it could lead to inappropriate attribution of cost and quality of care. Even more problematic would be the use of these categories and codes to manipulate the attribution of costs and savings in both MIPS and Advanced Alternative Payment Models (APMs). The AGS is very concerned about this and recommends that (1) CMS develop and implement extensive education, in conjunction with medical specialty societies and the American Medical Association (AMA) on the categories and codes; (2) that CMS audit the use of the codes to ensure correct reporting; and (3) that CMS develop criteria for outliers or physicians who use the categories and codes inconsistently, in order to focus investigations so that large numbers of clinicians would not need audit.

We urge CMS to continue to work closely with medical specialty societies and other key stakeholders as the agency further develops the patient relationship categories and codes to ensure that they are implemented in a way that minimizes the reporting burden on physicians and their staff, allows for consistent and accurate reporting, and leads to better outcomes of care when they are launched in 2018.

Comments Regarding Specific Questions:

1. Are the draft categories clear enough to enable clinicians to consistently and reliably self-identify an appropriate patient relationship category for a given clinical situation?

No. The AGS believes that the draft categories are not clear enough and that there could be a substantial amount of variation in categorization as currently defined. We urge CMS to add additional FAQs and examples across different clinical scenarios to help providers and those submitting claims on behalf of providers better understand and select the appropriate patient relationship categories and codes. CMS should avoid the use of undefined terms such as “principal care” by either not using the term or defining it.

For example, we seek clarification regarding how consultant geriatricians—who are *not* their patient’s PCP but have significant involvement in their care—would report their patient relationship. Would they fall under the “continuous/broad” category or the “continuous/focused” category? The demarcation between the degree of focus may vary by visit, while the context of care may not. For example, the primary reason for participation in care may be to address dementia care related

issues, but this is considered in the context of the patient's status globally. If a single visit is more limited in scope is that visit focused because of the visit content or broad because of the relationship context? In some cases, consultants stand-by for a continuous relationship based upon the need of the PCP. In such a case, is the relationship continuous based upon the potential or episodic based upon the actual next scheduled visit?

If there is a need to identify the primary physician, which seems likely, then a specific category should be created. As a general matter, we believe clinicians typically understand their role as PCP or consultant/co-manager. In our examples above, we believe that most geriatricians would either be PCPs or have "continuous/broad" relationships, but the two roles are not always the same.

We also seek clarification regarding the billing and claims process for the fifth category, "only as ordered by another clinician." For example, if a physician orders a colonoscopy for his/her patient, there is often no evaluation and management (E/M) service performed or if so, it may be limited to assessing the safety of the procedure. Would the physician performing the colonoscopy fall under the "episodic/focused" or the "only as ordered by another clinician" category? CMS sought to avoid the issue of "patient facing" as certain specialties may predominantly perform test interpretation but also perform other services, but for a specific service, that demarcation may be useful.

It will be important to define the reporting rules for covering clinicians or care teams. For example, a covering physician with another tax identification perhaps could use episodic, whereas the same service by a clinician in the same group may be advised to use continuous. We especially wish to be sure the rules are clear for nurse practitioners and physicians assistants who are not in designated specialties in the same manner as physicians.

Finally, it is not stated whether these modifiers would be used on all services or just on certain services such as E/M or once on any service per claim submittal. The required use, may affect categorization clarity. Requiring every service to be labelled, when multiple services are performed by the same provider creates additional administrative burden.

2. As clinicians furnishing care to Medicare beneficiaries practice in a wide variety of care settings, do the draft categories capture the majority of patient relationships for clinicians? If not, what is missing?

Overall, the AGS believes that the draft categories capture the majority of patient relationships for clinicians.

However, as noted above, we seek clarification on some relationships. When CMS provides additional information, we will be better able to determine whether new categories should be created to more clearly distinguish these different types of relationship between patients and physicians.

3. Are HCPCS modifiers a viable mechanism for CMS to use to operationalize this work to include the patient relationship category on the Medicare claim? If not, what other options should CMS consider and why?

The AGS agrees that the use of Healthcare Common Procedure Coding System (HCPCS) modifiers appears to be a viable mechanism for CMS to operationalize this work, but urges the agency to be aware of the administrative burden to physicians and their staff. It is also essential that technical assessments be done with those familiar with claims formats. For example, if modifier fields are limited, what proportion of claims received are already at the maximum field range?

We believe that CMS should not deny claims if there is no modifier. If a modifier is required for a particular line item or claim, CMS needs to create a mechanism for instances when the modifier is missing which will result in a modifier being added to the line item to ensure that the claim is not denied for this reason.

Further, we ask CMS to clarify whether all specialties will be required to report and which codes/services will require HCPCS modifiers. In some cases the relationship may be self-evident.

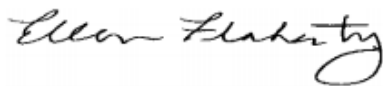
General Comments:

We strongly urge CMS to implement an evaluation process to determine whether the data is valuable, useful, a reasonable administrative burden, and how it will impact Medicare reimbursement over time.

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Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Anna Mikhailovich, amikhailovich@americangeriatrics.org.

Sincerely,



Ellen Flaherty, PhD, APRN, AGSF
President



Nancy E. Lundebjerg, MPA
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