February 11, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

RE: Episode Group Comments

Dear Administrator Slavitt,

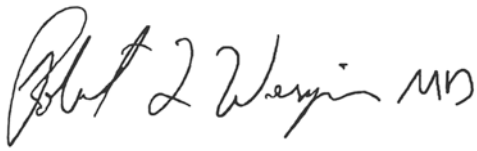
On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I am responding to the CMS request for information regarding implementation of the Episode Group as announced on November 11, 2015.

There are a couple of key points the AAFP would like to communicate to CMS regarding the use of episode groups for the purpose of measuring resource use:

- Because the Medicare Access and CHIP Reauthorization Act (MACRA) allows for the use of episode groups "as appropriate," the AAFP urges CMS to carefully consider how this is implemented and the eventual impact on physicians and their patients. If CMS finds it appropriate to implement episode groups, the AAFP recommends that CMS implement this form of resource measurement in a slow, phased-in approach.
- Family physicians also need access to sub-specialists' quality performance outcomes to make informed decisions with their patients when referral becomes necessary. Having both cost and quality information related to services furnished to their patients by other clinicians will enable family physicians and their patients to make fully informed decisions that take into account both cost and quality. It's crucial for a family physician to have this information before they will be responsible for a patient's total cost of care or episode-based costs.
- An increase in upfront, primary care costs that reduce downstream, more expensive costs, should not negatively impact how a family physician is evaluated under the use of episode groups or in the resource use category.

We thank you for the opportunity to provide these comments and suggestions regarding Episode Groups. We look forward to working with you and your colleagues during the upcoming year to further refine how CMS defines resource use and appropriately utilize our nation's limited financial resources. Please do not hesitate to call upon the AAFP for assistance. For additional information, please contact Robert Bennett, Federal Regulatory Manager at rbennett@aafp.org or (202) 232-9033, ext. 2522.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair

Enclosed: -AAFP response to the Request for Information Regarding Episode Groups

Care Episode and Patient Condition Groups

Within a specialty, a limited number of conditions and procedures account for the bulk of spending. Focusing on the top conditions and procedures for a specialty, what care episode groups and patient condition groups would you suggest?

The AAFP suggests that CMS carefully consider how episodes are deemed "as appropriate" for use to measure resource utilization. Because most of the conditions on the proposed list are applicable to the conditions commonly seen in a family physician's practice, the AAFP suggests a phased-in approach that initially begins with only two episode conditions such as urinary tract infections or some of the respiratory conditions. Family physicians commonly see these conditions in the outpatient setting, are the first line of care delivery, and have better control over these costs.

If CMS decides that the implementation of episode groups for measurement of primary care resource use is "appropriate," the AAFP urges CMS to gradually roll out the use of such episode groups. This will allow family physicians to adjust to episode groups as a form of resource measurement until it is better understood and issues are resolved.

What specific clinical criteria and patient characteristics should be used to classify patients into care episode groups and patient condition groups? What rules should be used to aggregate clinical care into an episode group? When should an episode be split into finer categories? Should multiple, simultaneous episodes be allowed?

Patients should be classified into a care episode group when the triggering event for that episode occurs. Similarly, when an EP diagnoses a patient with a specific condition that is defined within a patient condition group, that patient should be classified as a member of that condition group. Both the episodes and the patient condition groups should be defined with sufficient precision to allow CMS to make that determination automatically based on claims, and without additional involvement of the treating physician.

In general, the AAFP is comfortable using the diagnoses and services received by patient. This seems to be more administratively simple and less burdensome for family physicians. Episode grouper rules should be consistent with those for Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs).

Multiple chronic conditions are very commonly seen by family physicians, triggering the possibility of simultaneous episodes. This would cause a significant amount of administrative burden for the coding for multiple episodes, therefore the AAFP suggests that CMS implement a passive process where the physician does not have to actively trigger or end an episode through purposeful or additional coding.

Family physicians treat a breadth of conditions, so multiple episodes will occur. Therefore CMS needs to carefully consider the documentation requirements to ensure they do not add additional burden on clinicians. Additionally, patients must be compared to those in similar episode groups. For example, if a patient has diabetes and coronary artery disease, resource use should be comparable to other patient's with the exact episode(s). Because of the complexity of multiple groups, among other issues, the AAFP strongly suggests slowly phasing in episode groups to alleviate these concerns.

An episode should contain with reasonable specificity, services (both amount and type) that can predictably be relied upon to treat that episode. If an episode contains subtypes that cause the calculation to vary widely, then the episode should be split into multiple categories. The episode

groups will not inspire confidence among physicians unless EPs view them as fairly predictable and consistent bundles of services associated with each defined episode of care.

CMS should also consider refining payment to support better care management and coordination services that are often provided in primary care, but not paid for prospectively in the current fee-for-service payment structure. As primary care physicians take on more responsibility for total cost of care and episode groups, payment for primary care needs to become more global and comprehensive. Additionally, prior authorizations, paperwork associated with justification of clinical decisions, and other hassles intended to control utilization need to be discontinued as they add administrative burden without improving patient care.

Medicare beneficiaries often have multiple co-morbidities. Recognizing the challenge of distinguishing the services furnished for any one condition in the care of patients with multiple chronic conditions, how should CMS approach development of patient condition groups for patients with multiple chronic care conditions?

CMS should consider developing unique patient condition groups to correspond with each potential combination of multiple co-morbidities. The purpose of patient condition groups is to compare resource use of EPs on similarly situated patients. It will be impossible to make such "apples-to-apples" comparisons unless performance in caring for a beneficiary with say, 4 co-morbid conditions, is compared to performance in caring for a beneficiary with the same 4 co-morbid conditions. If there is a sufficiently large sample size, CMS could further refine the patient condition groups with other criteria, to reflect population health criteria (e.g. age, gender, socioeconomic background).

While the methodology is not perfect, the AAFP suggests that CMS consider using the Hierarchical Category (HCC) Scoring that determines risk level when considering patients with chronic conditions. Because episode groups are designed to reduce or contain resource utilization, it would be appropriate to use this methodology as a starting point when considering patient condition groups.

Given that these co-morbidities are often inter-related, what approaches can be used to determine whether a service or claim should be included in an episode?

The AAFP suggests two options. For the first option, CMS could consider selecting the primary diagnosis code on a claim to determine which service should be in an episode. As a second option, CMS could consider all diagnosis codes on a claim to determine which service should be in an episode.

What should be the duration of patient condition groups for chronic conditions (e.g., shorter or longer than a year)?

Twelve months should be considered to allow for patient stabilization and to align with the Current Procedural Terminology© (CPT) definition of chronic care management code (99490). Additionally, a twelve month period will conform to current reporting periods for Physician Quality Reporting System and the Value-based Payment Modifier.

How can care coordination be addressed in measuring resource use?

With better coordination of services, some costs may increase in primary care in order to reduce more expensive, downstream costs and resource utilization. Primary care should not be penalized for increased resource use (e.g. more office visits) if the care coordination efforts are reducing unnecessary emergency department visits and admissions that occur downstream.

As EPs are incentivized to conserve Medicare resources, care coordination will be ever more important among all members of the care team. Although many care coordination activities are not paid for by CMS, the few that now are (TCM, CCM) have principally been designed to be coded by primary care physicians and therefore should not be counted toward a family physicians resource use. Specialists in particular will likely not bill for these care-coordination codes, even though they also will engage in care coordination with the beneficiary's primary care physician. If all members of the care team are performing the task of coordination, it would not be fair to attribute that activity only to the primary-care physician when measuring resource use.

CMS has received public comment encouraging CMS to align resource use measures (which utilize episode grouping) with clinical quality measures. How can episodes be designed to achieve this goal?

If measures included in the PCMH/ACO/Primary Care Core Measure Set developed by the Core Measures Collaborative are clinical topics that align with the clinical episode, they should be utilized. CMS should consider a way to report to clinicians both the quality of care and the cost related to the episode. Resource use should always include quality as a part of the evaluation; however, it should be carefully considered for performance and payment purposes. There could be unintended consequences if resource use is a sole driving factor in quality outcomes.

Information that is not in the claims data may be needed to create a more reliable episode. For example, the stage of a cancer and responsiveness history may be useful in defining cancer episodes. How can the validity of an episode be maximized without such clinical information?

Information related to social determinates of health can often impact access, severity, and exacerbate barriers, but is not included in claims data to inform an episode. The AAFP urges CMS to consider collecting and using data related to social determinates of health to further inform an episode of care. The current work of the National Quality Forum's Risk Adjustment for Sociodemographic Factors Project can advise this process. That said, it must be noted that documentation to support this could increase administrative burden on physicians, so it is important to balance the need for data collection and the impact on those collecting it.

How can complications, severity of illness, potentially avoidable occurrences and other consequences of care be addressed in measuring resource use?

Good risk adjustment methodology should include severity of illness which should include complications... The AAFP suggests CMS start with the Hierarchical Condition Category (HCC) methodology, further refine the process over time and with experience, and perhaps consider ICD-10 specificity. Also, much of this information related to complications can be collected from claims data such as length of stay, additional procedures, etc.

Potentially avoidable occurrences seem to impact the inpatient setting more so than a primary care outpatient office. Because of this, resource use due to these factors should not be passed on to the primary care physician.

Reliability of resource use measures are impacted by sample size. How should low volume patient condition groups and care episodes be handled?

In terms of a minimum threshold for resource use measures, the AAFP prefers the use of a minimum reliability threshold instead of a minimum patient threshold. As highlighted in our Guiding Principles on Physician Profiling, we believe that the validity, accuracy, reliability, and limitations of data used are important when reporting on performance and profiling results. Case

minimum thresholds should be different for each measure, so using a minimum reliability threshold can help mitigate the variation between measure types.

Unusually complex patients, patients with rare diseases, and other outliers can be classified outside the MACRA resource-use methodology under subsection 1848(r). CMS has great flexibility under subsection (r) to implement episode groups and patient condition groups "as appropriate."

Patient Relationship Codes

Episode Groups have traditionally considered a patient's course of care as a unit; including in it all care relevant to the course regardless of the specific provider. Section 11 101(f) of the MACRA requires CMS to distinguish the relationship and responsibility of physicians and practitioners during the course of caring for a patient and to allow the resources used in furnishing care to be attributed (in whole or in part) to physicians serving in a variety of care delivery roles. While CMS will seek additional public comment on patient relationship codes in the future, we seek stakeholder input on how to simultaneously measure resource use based upon patient relationship while promoting care coordination and patient centrality.

The AAFP supports multiple provider attribution and sees great value in this approach. The AAFP believes that CMS should consider the valuation of services when assigning responsibility of patients. It is only appropriate that specific aspects of an episode are attributed to clinicians who provide that service. In other words, the clinician who was paid for rendering the service should be primarily responsible for the resource use. At this point in time and given how payment is structured, we suggest to link accountability to RVUs. A post-review should be completed to ensure the accuracy of the attribution.

Section 101(c) of the MACRA requires CMS to give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient. Are there specific issues that should be considered when developing resource use measures which apply to these professionals?

If attribution is based on RVUs or services provided, then it would be appropriate to include those clinicians who are not involved in face-to-face interaction with the patient in the attribution process. There is some responsibility for the patient's outcomes based on their involvement even though it is not a face-to-face interaction.

How should the resources be reported for an episode that is truncated (cut short, likely resulting in a resource usage reduction) by death or the onset of another related episode? Should imputed values be used to add resources to the truncated episode (for comparison purposes)?

Episodes that end in death should be valued separately from a similar episode within that condition. Additionally, episodes resulting in death should be compared to other episodes for the same condition also resulting in death. Family Physicians are often faced with balancing evidence-based care with patient and family wishes. CMS needs to carefully consider how the cost of episodes that are shortened by death are evaluated for resource use. The AAFP believes there should be simultaneous episodes allowed to occur, with the understanding that administrative burden of documentation would not fall to the provider.