AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

December 21, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Patient Relationship Categories and Codes

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write in response to the patient relationship categories and codes document posted on the Centers for Medicare & Medicaid Services (CMS) website in December of 2016.

While the AAFP continues to support implementation of the *Medicare Access and CHIP Reauthorization Act* (MACRA), which includes section 101(f) requiring establishment and use of patient relationship categories and codes, we continue to have grave concerns that this reporting requirement will significantly increase the administrative burden that Medicare participating physicians already experience. As articulated in our August 12, 2016, letter to CMS on patient relationship categories and codes, we urge CMS to provide additional information on how these patient relationship categories and codes will be used to attribute cost and patient outcomes to physicians and also how this information will be used with episode groups. The AAFP calls on CMS to thoroughly pilot test these patient relationship categories before their use impacts payments. CMS must minimize the reporting burden for physicians and for the agency through pilot testing to address logistical issues and possible unintended consequences, especially for small practices.

AAFP Responses to CMS Questions for Consideration

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?
Yes, the categories are clear enough to enable most physicians in most situations to accurately describe their relationship to the patient. These new categories are a vast improvement compared to what CMS originally suggested, and we think the dual axis of “continuous/episodic” and “broad/focused” are more useful than the original false dichotomy of “continuing/acute.”

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Family physicians will typically recognize themselves having a “continuous/broad” relationship with their patients. The AAFP urges CMS to further define and thoroughly educate physicians and their staff about these coding changes before these new codes are required.

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?

As noted above, AAFP supports classifying relationships using the dual axis of “continuous/episodic” and “broad/focused.” While family physicians will typically recognize themselves as being in the position of having a “continuous/broad” relationship with their patients, the draft categories accommodate other patient relationship categories family physicians address. For instance, family physicians serving as hospitalists can appropriately classify their relationship with a patient as “Episodic/broad,” while family physicians covering the emergency department may recognize their relationships with patients as “Episodic/focused.” We caution, however, that while conceptually the relationship classifications outlined by CMS in the MACRA final rule provide greater clarity and minimize the previously fuzzy and discontinuous borders associated with the initially proposed relationship categories, we continue to urge that CMS pilot test the finalized relationship categories. Pilot testing utilizing these relationship categories should involve physicians from all specialties providing care across a variety of care settings because these relationship categories will impact analysis of physician resource use and cost within value-based payment reimbursement models. CMS is attempting to undertake landmark progress toward accurate and responsible attribution. As such, CMS should establish an adequate pilot using these relationship categories with disclosure of the attribution logic and methodologies intended, and a fully representative sample population of physicians and providers.

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?

Yes, HCPCS modifiers are a viable mechanism. As we noted in our August 12, 2016, letter, family physicians are familiar with this approach, given their experience with the A1 modifier, which CMS recommended in 2010 when consultation codes were discontinued from the Medicare Physician Fee Schedule. Family physicians use this modifier on inpatient claims to “identify the physician who oversees the patient’s care from all other physicians who may be furnishing specialty care.” Family physicians will quickly learn to use new modifiers for reporting patient relationship categories.

Nevertheless, CMS must notify and educate physicians well in advance of when these new HCPCS modifiers are required. The relationship should be denoted with the claim to simplify the process and decrease disruption to clinical workflow. However, physicians will need to have personnel very well trained to carry out this modifier assignment. Should HCPCS modifiers be the route chosen, we would encourage CMS to provide not only the modifier and descriptor, but also detailed vignettes for appropriate application. It will be imperative to equate the definitions of new and established patients, chronic and acute problems under CPT guidelines with the HCPCS and CMS applications of continuous, episodic, broad, and focused.

We appreciate the opportunity to further comment on patient relationship categories and make ourselves available for any questions you might have. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Wanda D. Filer, MD, MBA, FAAFP
Board Chair

CC: Kristin Borowski
Dr. Theodore Long