August 10, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244
patientrelationshipcodes@cms.hhs.gov

Dear Acting Administrator Slavitt:

The National Committee for Quality Assurance (NCQA) would like to thank you for the opportunity to comment on your draft list of Patient Relationship Categories and Codes. This work will lead to much-needed improvements to the assessment of Resource Use under the new Merit-Based Incentive Payment Systems (MIPS). We believe these improvements will contribute to more transparent, valid and reliable measurement that will in turn foster appropriate and accurate clinician accountability.

NCQA's comments are informed by over 25 years of experience developing quality measures. While we are encouraged to see measures integrated into the Medicare payment system for Part B clinicians, we believe it is critical that measures not only support joint accountability but are also fair to the clinicians being measured. We also believe it is important to make relationship-coding and attribution as simple as possible to minimize burden and make it easier for providers to understand which relationships they are responsible for managing.

To that end, we recommend CMS present the categories in a decision tree model to help determine options for efficiently selecting a relationship category. Done correctly, much of this process could be automated and thereby present clinicians and/or patients the ability to select the most appropriate relationship in the course of routine workflows. Ideally, the decision tree logic could be highly automated, embedded in existing health IT systems, and be based, in part, on routinely collected information such as clinician specialty, location of service, prior history of services rendered by the treating clinician, and CPT codes. While this approach may not resolve 100% of all attribution issues, it would address the vast majority. We would be happy to work with you to develop this decision tree.

You ask whether the draft categories are sufficiently clear to facilitate self-identification. We believe the draft categories are at this point too vague to be useful for clinicians (or their teams) to consistently and reliably self-identify an appropriate patient relationship for any given clinical situation. It is currently unclear what the "specifications" are for this decision – is it made at the point of care? Is it strictly the treating clinician who makes the determination or are others eligible such as practice managers or administrative staff?

As these relationships will be used for attribution of clinical quality and utilization measures, approaching this from a measurement framework might be helpful; you should detail specifications for how, when, where and by whom these decisions are made. Being more explicit and providing more illustrative examples will limit the gray area that exists between the draft categories.

You ask whether the categories "capture the majority of patient relationships for clinicians," but it might be more appropriate to consider the fraction of episodes which remain unclassified as these will be the most difficult to attribute. These episodes will require more nuanced categories and descriptions for providers to fairly and accurately self-identify the appropriate patient relationship. There should also be extensive testing to validate these assignments.

You ask whether or not you adequately capture Post-Acute Care clinicians. We do not believe that the category of Part B services delivered in a Part A facility is adequately addressed. However, as there are specific codes that indicate care is being provided in such facilities, automated functions might be able to fill in this gap. The relationship ideas should theoretically be parallel across care settings so more nuanced categories, complemented by automation, would capture these providers.

You ask what type of assistance would be helpful to clinicians. Continuing to do webinars, PowerPoints, tutorials and trainings at regular intervals is a great start. More robust and illustrative examples would also help, and these could even be included at the back of the CPT Standard Codebook.

For group (i), we believe you should add "preventative care" to the description. You should also include in this group primary care physicians who see patients in hospitals. For Acute Care Relationships, we believe it would be more appropriate to name these relationships "Episodic" instead of "Acute." Patients in continuing care can have acute care needs and defining these relationships as episodic would more clearly delineate when this category is appropriate to use.

We also have concerns that, when a clinician covers for another clinician for an isolated one-time service, coding issues could cause systems to misinterpret the patient relationship and result in inappropriate attribution to the covering clinician. Therefore, we recommend that CMS develop a separate code or modifier to indicate isolated, time limited interactions such as these. In the future, you might want to develop a system to ask beneficiaries who they consider to be their designated primary care clinician.

You ask whether it would be useful to include a category specific to non-patient facing clinicians. We believe this distinction is important as it may simplify self-identification for such providers.

To address some additional issues, NCQA suggests that CMS consider Dr. Christopher Forrest's work on the typology of specialists. We believe this can help inform the development of a framework that more closely aligns with clinical roles and related responsibilities[1] than those outlined in the RFI. These are the five categories of referrals by primary care physicians to specialists described by Dr. Forrest:

1. Cognitive Consultation: provide diagnostic or therapeutic advice to reduce clinical uncertainty
2. Procedural Consultation: perform a technical procedure to aid diagnosis, cure a condition, identify and prevent new conditions, or palliate symptoms
3. Co-manager with Shared Care: share long-term management with a primary care physician for a patient's referred health problem
4. Co-manager with Principal Care: assume total responsibility for long-term management of a referred health problem
5. Primary Care clinician: provides a medical home for a group of patients

[1] Forrest CB. A typology of specialists' clinical roles. *Arch Intern Med*. 2009;169(11):1062-1068.

The RFI proposes a draft list of patient relationship categories divided as follows:

- Continuing Care Relationships
- Acute Care Relationships
- Acute Care or Continuing Care Relationships

The Table below builds upon Dr. Forrest's typology and the CMS-proposed relationship categories to outline eight (8) categories that we believe help clarify the potential patient/clinician relationships.

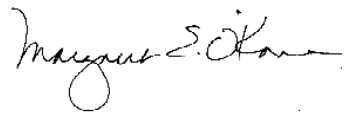
CMS Proposed Category	**Crosswalk to Forrest Typology of Specialist Referrals**	**NCQA Recommended Categories**	**Comments**
Continuing Care Relationships (Primary Care)	N/A	**[1] Primary Care Clinician** (defined by specialty: e.g., IM, FP, Ped)	NCQA recommends that primary care clinicians have a separate category given that continuing care relationships can be defined by either specialty or by comprehensive services provided by a specialist as in Category 5 of Dr. Forrest's typology.
Continuing Care Relationships (Non-primary care specialist)	Category 3 Category 4 Category 5	**[2] Specialist Providing Principal Care** (i.e., nephrologist managing patient with end-stage renal disease on dialysis, oncologist caring for patient in active treatment for malignancy) **[3] Co-Manager of Care in Collaboration with Primary Care Specialist** (i.e., cardiologist managing congestive heart failure in collaboration internist; infectious	NCQA recommends that specialists providing longitudinal care in collaboration with a primary care clinician be specifically identified; this could support appropriate attribution models for accountability.

CMS Proposed Category	Crosswalk to Forrest Typology of Specialist Referrals	NCQA Recommended Categories	Comments
		disease specialist managing HIV in collaboration with family physician)	
Acute Care Relationships (overall health care responsibility during an acute episode) Acute Care Relationships (clinician who is a consultant during the acute episode)	Category 1 Category 2	Separate out the examples in the RFI as follows: **[4] Procedural Consultation with Time-Limited Ongoing Care** (i.e., orthopedic surgeon performing hip replacement, cardiovascular surgeon performing CABG)) **[5] Procedural Consultation without Ongoing Care** (i.e., screening colonoscopy, cardiac catheterization, interventional radiology, dermatologic procedure) **[6] Cognitive Consultation +/- Minor Procedures with Time-Limited Ongoing Care** (i.e., rheumatologist evaluating referral for swollen joints, nutritionist providing support to an ICU patient, infectious disease consultant	These two CMS-proposed categories include too many different, disparate relationships to be useful in attribution and accountability modeling. NCQA recommends further differentiation based on the Forrest Typology.

CMS Proposed Category	Crosswalk to Forrest Typology of Specialist Referrals	NCQA Recommended Categories	Comments
		supporting inpatient management of sepsis) **[7] Cognitive Consultation +/- Minor Procedures without Ongoing Care** (i.e., emergency room clinician, urgent care clinician treating patient with influenza, gastroenterologist performing upper endoscopy in patient as part of diagnostic evaluation)	
Acute Care or Continuing Care Relationship -as defined by CMS, this category includes non-patient facing clinicians such as radiologists, pathologists and others who have very little or no relationship with a patient	Category 1	**[8] Cognitive Consultation without Patient Contact** (i.e., radiologist interpreting images, dermatologist reviewing images, pathologist reviewing slides)	NCQA recommends that the original category proposed be modified to specifically indicate that it is for consultations without patient contact.

Thank you for the opportunity to comment on this proposal. Please contact Joe Castiglione, Federal Affairs, at (202) 955-1725 or castiglione@ncqa.org with any questions.

Sincerely,



Margaret O'Kane,
President