August 15, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS Patient Relationship Categories and Codes Request for Information

Dear Mr. Slavitt:

The American Society of Cataract and Refractive Surgery (ASCRS) is a medical specialty society representing nearly 9,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care.

Thank you for the opportunity to provide comments on CMS’ patient relationship categories. While ASCRS has long opposed CMS’ current patient attribution methods based on E/M codes, which potentially hold physicians responsible for care they did not provide, we urge CMS to ensure the final patient relationship categories accurately reflect all practice types, particularly specialists such as ophthalmologists.

Our key recommendation is for CMS to develop a system for measuring resource use that accurately aligns the cost of the care provided by a physician with the type of relationship he or she reports to have with a particular patient. We request that CMS make available additional information regarding how these codes will be used to determine resource use, especially as they relate to CMS’ proposed episode groups. Physicians must understand what costs they will be responsible for, and CMS must only attribute the costs of care that would be in a physician’s control based on the relationship reported. In addition, the resource use measures must reflect the severity of the disease being treated and be risk adjusted to account for other factors outside the physician’s control, such as patient compliance and socioeconomic conditions, which may ultimately affect the cost of treating a particular patient.

In response to CMS’ request for information, we have provided general comments on the patient relationship categories, guided by the questions posed by CMS. In addition to our recommendations regarding the development of the resource use framework, we focus our comments on the following issues:

- In alignment with the Medicare Access and CHIP Reauthorization Act (MACRA) statute, which raises the possibility of a combination of relationships applicable for a particular patient, we recommend that CMS develop relationship categories to reflect specialty practices that provide
both continuing and acute care to a patient, or clarify how the agency intends to determine which relationship or code should be reported when both types of a relationship apply.

- Ensure the relationship categories adequately address that ophthalmologists do not typically coordinate care with primary care physicians, but do frequently with other ophthalmologists or optometrists.

- In addition, the categories must reflect that the severity of a patient’s disease affects the type of relationship a physician has with a patient and may impact how the physician manages the care with other providers—and ultimately the cost of care.

- To ensure the patient relationship codes proposed accurately reflect the care provided by specialists, such as ophthalmologists, we recommend extensive testing through pilot programs before all physicians are required to comply with this requirement.

- Urge CMS to consider the administrative burden that coding for patient relationships may place on physicians and practices who are already inundated with other regulatory burdens. CMS must consider as a whole the burden its proposals for implementing the programs included in the MACRA statute may place on physicians and practices. We urge CMS to ensure the method for reporting patient relationships can be easily integrated with reporting for other elements of MACRA, including the Merit-Based Incentive Payment System (MIPS.)

- Urge CMS to provide adequate training and technical assistance for providers implementing the new codes.

**METHODOLOGY FOR DETERMINING RESOURCE USE**

As part of MACRA, CMS is required to develop a system of patient relationship categories and codes to determine resource use. ASCRS has long opposed CMS’ existing policies for attributing patients—first as part of the Value-Based Payment Modifier (VBPM) and as proposed to continue in the MIPS program—because the measures are primary care-based and potentially hold certain physicians, particularly specialists such as ophthalmologists, responsible for care they did not provide. Under CMS’ current two-step attribution process, beneficiaries who remain unassigned to a primary care provider are assigned to a non-primary care provider who billed the most evaluation and management services for the patient during the reporting period. Because ophthalmologists often bill evaluation and management codes, they are particularly at risk for being held responsible for care they did not provide. Further, the current resource use methodology does not incorporate appropriate risk adjustment for factors outside the physician’s control, such as patient compliance and socioeconomic status.

Patient relationship categories and codes have the potential to more accurately identify what physician is responsible for a patient’s care. Since the current methodology for determining cost is not effective, it is imperative that CMS ensures these categories and codes are tested and developed in a way that accurately holds physicians, particularly specialists such as ophthalmologists, accountable for the cost of the care they provide and control. In addition, when developing the relationship codes that correspond to the overarching categories, we urge CMS to include a method for reporting the severity of a particular disease, which will impact the cost of the care provided. The categories and codes should also be risk adjusted, and since we are not aware of any current model that provides adequate risk adjustment, we
urge CMS to develop an appropriate methodology that accounts for factors outside the physician’s control.

- When designing a framework for how patient relationship codes will be used to determine a physician’s resource use, ASCRS urges CMS to develop a proposal that does not hold physicians who report specific patient relationship codes accountable for the costs of care they did not provide and cannot control. Similar to the current resource use attribution method, it is possible that an ophthalmologist might be the only physician a patient sees in a particular year or performance period who claims a relationship of leading the management of care for a chronic disease or acute episode. However, if a patient is treated for another disease or acute episode unrelated to the care the ophthalmologist provides, and no other physician claims to have the overall management of that unrelated care, the ophthalmologist should not be attributed the cost for all of the care provided to the patient—which is out of an ophthalmologist’s control.

- Patient relationship codes have the potential to more accurately determine which physician is responsible for the cost of care for particular beneficiaries, provided CMS develops a framework that does not penalize physicians for care they did not provide and factors out of their control. As episode-based payment models that seek to account for the full cost of treating a specific condition or episode of care are developed, patient relationship codes give physicians the ability to identify to CMS how they view their role in treating the patient. In some cases, cataract surgery patients’ care may be comanaged. If, for example, an ophthalmologist reports to be providing postoperative care to a cataract surgery patient, but did not perform the actual surgery, and accurately reports that relationship as being in a consulting role during the acute episode, he or she should only be attributed for the cost of the post-operative care.

- CMS must clearly define how costs will be attributed to specific physicians based on the relationship they report. We urge CMS to provide additional information regarding how these patient relationship codes will be used in determining resource use for episode groups. Given the example above of an ophthalmologist or optometrist providing postoperative care to a cataract surgery patient, physicians should know in advance what costs they are responsible for based on the type of relationship they are claiming. In addition, physicians claiming to have the ultimate responsibility for the patient should know what costs will be included in the episode, and have the opportunity to indicate what costs within the episode are within their control, so they are not held accountable for the cost of care unrelated to the disease or acute episode or from other providers. Physicians should also not be attributed the extra costs for particular treatments required due to other care the patient is receiving from other physicians. For instance, if a cataract patient is prescribed Tamsulosin by a primary care physician, that patient will likely require the use of iris retractors, leading to the use of the complex cataract surgery code 66982, reimbursed at a higher value than cataract surgery, 66984. It is not currently possible to determine how those costs would be attributed from the patient relationship categories request for information or the proposed episode groups.

- The framework for determining resource use should also take into account the severity of the patient’s disease, which impacts the type and cost of care a physician may provide. Treating patients with diabetic retinopathy, for example, may involve several different courses depending on severity. Patients with well-controlled blood sugar may not have a severe case of
diabetic retinopathy and not require more than annual exams. However, patients with severe cases may require extensive intravitreal injections to curb the progression of the disease. If the injections are not sufficient to curb the progression of the disease, laser treatment or surgery may be required to prevent the patient from losing their sight completely. Treating the more severe case would become much more expensive than a mild or moderate case. In addition, the presence of certain co-morbidities may impact the complexity of cataract surgery, and may lead to complications during surgery.

- Physicians should not be held accountable for care they, or other physicians, are required to provide due to issues, such as patient compliance or socioeconomic factors, that are beyond their control. For instance, glaucoma patients will never fully regain their vision, but preventing further progression of the disease generally depends on the patient’s use of prescribed drops and following up with the ophthalmologist’s office for regular eye pressure checks and other glaucoma-related testing. Patient compliance can have an impact on the progression of their disease, and ultimately the cost of their care. If a patient cannot make his or her regularly scheduled appointments, or does not regularly use prescribed drops, it may require costlier treatment, such as surgical intervention. In addition, older patients with glaucoma may have difficulty withstanding visual field testing in both eyes in one visit and may require additional visits. Patients with severe diabetic retinopathy must come to the physician’s office for regular intravitreal injections. If a patient misses several appointments, the treatment cannot simply be re-started, and may require surgery. The ophthalmologist treating this type of patient should not be penalized for having to provide the more expensive care when the patient could not comply with the original course of treatment. There are also a variety of socioeconomic factors that impact overall care for certain patients. For example, lower income patients or patients in rural areas may have difficulty making regularly scheduled appointments if they do not have access to reliable transportation or must travel longer distances. In general, ophthalmologists tend to treat older Medicare patients, who may not have the manual dexterity required to administer their drops. In addition, older patients have mobility issues and rely on other caregivers to bring them to the physician’s office. All of these factors can impact their ability to receive regular care or the ultimate cost of the care.

ADDITIONAL TESTING REQUIRED

ASCRS recommends that CMS conduct rigorous testing on the relationship codes before requiring all physicians to comply. We recommend a pilot program be developed and implemented in several practices of varying size, specialty, and location to determine how well they capture the myriad types of relationships physicians may have with patients, and the administrative burden the proposed system may place on practices. We realize that under MACRA, physicians must report the codes beginning in 2018, and therefore, we urge CMS to begin the pilot program immediately.

DRAFT PATIENT RELATIONSHIP CATEGORIES

The two main draft relationship categories—Continuing Care Relationships and Acute Care Relationships—do not reflect all of the types of care ophthalmologists provide. We recommend creating additional categories for specialists that reflect specialty surgical care, specialty chronic care, and a category for when specialists treat the same patient for both chronic disease and acute...
episodes, such as surgery. Ophthalmology is one of the few specialties that provides both ongoing chronic care and performs surgery. For example, treatment of glaucoma would be considered a continuing relationship since the disease is chronic, but oftentimes, treatment may incorporate some acute care, such as surgical interventions. These alternative categories will more accurately reflect the range of services that specialists, such as ophthalmologists, provide to patients. As noted in this request for information, Section 1848(r)(3)(B) requires CMS to establish categories to reflect different types of relationships between the physician and patient, “(and the codes may reflect combinations of such categories.)” We recommend that CMS either create another category of relationship that incorporates both types of care, or clarify how physicians should report overlapping relationships. We urge CMS to provide clear guidance on how reporting each type of relationship will impact how a provider’s resource use is measured.

We are also concerned that the draft relationship categories rely on the term “primary health care provider” to describe a physician with a lead role in a patient’s care. As our members do not consider themselves primary care physicians, the term “primary” may cause confusion, and specialists may not select the correct relationship category for a particular patient. We recommend the description of the relationship use the term “principle health care provider” or similar to avoid confusion.

**Specialty Chronic Care Relationships**

- Specialists provide continuing specialized chronic care to patients for a specific disease or organ system over an extended period of time, similar to the examples noted in the proposal. Ophthalmologists would be able to characterize a significant portion of their relationships with patients in this category, since, in addition to the surgical procedures they perform, they can care for patients with chronic diseases, such as glaucoma and age-related macular degeneration. Because there is no cure for these chronic diseases, treatment is limited to managing the progression of the disease to ensure patients do not lose their eyesight completely. However, that treatment may include surgical procedures, such as glaucoma surgery or cataract surgery, which may fall into the surgical care relationship category. We recommend creating a specialty chronic care relationship category to avoid potential attribution of costs for primary care or other diseases to specialists who are only managing the care of specific diseases.

- When developing the codes for each of the different types of relationship categories, CMS must also provide a way for classifying the severity of the patient’s disease. The type and severity of a disease will determine what type of treatment is appropriate for the patient, and thus the relationship that patient will have with the physician or physicians providing the care. For patients with diabetic retinopathy, for example, an ophthalmologist may be providing ongoing care to the patient, but if the disease is not severe, the patient’s primary care physician or endocrinologist—who is treating the overall diabetes—would have the lead relationship with the patient. For severe cases, which can require an extensive and concentrated course of intravitreal injections, and if necessary, laser treatments and surgery, the ophthalmologist may be the provider who is responsible for most of the patient’s care. **Within each of the categories, there must be flexibility to choose codes that reflect the severity of a patient’s disease, and how it may change over time. The severity of the disease determines the relationship they have with the provider.**
**Specialty Surgical Care Relationships**

- We recommend that CMS create a category for specialty surgical care for acute episodes. Ophthalmologists take responsibility for providing or coordinating the care of the patient relating to an acute surgical episode of care, such as cataract surgery. However, they do not provide or coordinate care for the total health care of the patient. Similar to our recommendations to create a specialty chronic care category, the specialty surgical care relationship would also prevent attribution of the cost of unrelated care.

- In addition, ophthalmologists may co-manage postoperative care with other ophthalmologists or optometrists—at the request and/or consent of the patient. Under CMS’ proposed categories, the co-managing physician’s relationship to the patient would likely fall into the category, “clinician who is a consultant during the acute episode.”

**Overlapping Relationships**

ASCRS urges CMS to develop an additional relationship category for specialty physicians who provide both continuing care for chronic disease and acute episodes to the same patient, in accordance with the MACRA statute. CMS has inquired if any additional categories are necessary; and in response, we request another category incorporating both ongoing chronic care treatment with acute episodes, such as when surgical interventions are needed as part of ongoing treatment of glaucoma. This new category would reflect a significant portion of ophthalmologists’ relationships with their patients. Alternatively, CMS should clarify how it intends to address this type of relationship through its proposed categories.

- Patients suffering from glaucoma are the most likely to need continuing care and occasional surgical procedures. There is no cure for glaucoma; however, there are surgical procedures, such as Selective Laser Trabeculoplasty (SLT), which may be performed at the outset of glaucoma treatment or if drops are either not adequately lowering intraocular pressure or causing side-effects. In addition, glaucoma surgery is often performed at the same time as cataract surgery. Despite these acute surgical interventions, glaucoma patients continue to need ongoing care.

- In some cases, the physician who provides continuing care for managing the chronic disease may not be the surgeon performing the cataract or glaucoma surgery, so each physician would each be able to claim a relationship he or she has with the patient under the proposed categories. However, if the same physician provides all care to the patient, it is unclear how these categories should be applied. We suggest that the creation of an additional category incorporating both chronic and acute care would help ophthalmologists treating a patient with glaucoma or other diseases to more accurately describe the type of care he or she is providing to a particular patient.

- CMS’ proposed definition of an acute episode includes “a disease exacerbation for a given clinical issue.” Glaucoma not adequately managed with drops and requiring surgery could qualify under that definition of an acute condition, but would ongoing care provided after the global period for the procedure revert to the specialty chronic care category?
To reiterate, ASCRS urges CMS to create a new category addressing a patient relationship that involves both continuing and acute surgical care and to provide clear guidance to providers for how they should categorize these types of interactions.

**Duplicate Relationships**

ASCRS also urges CMS to clarify how it will determine resource costs if two physicians claim the same category of relationship for the same patient. For instance, since Medicare allows beneficiaries to see the physician of their choice, a patient could be seen by two or more physicians for the same disease. Similarly, a patient could choose to change providers mid-year and have costs of his or her care equally split between two physicians. Further, there is the potential for the physicians to independently characterize their relationship as a consulting provider and with neither claiming the ultimate responsibility for the acute episode. Therefore, **CMS must clarify how it will distribute costs of care when these possible duplications arise so physicians are not held accountable for the cost of care they did not provide.**

**MINIMIZING THE BURDEN ON PHYSICIANS AND PRACTICES**

ASCRS is concerned that requiring physicians to indicate patient relationships on every claim will be overly burdensome and add to already significant administrative requirements. CMS should allow providers to indicate once, or yearly, their relationship to a particular patient, and require a new relationship code only if the relationship category changes. CMS should also consider allowing for default relationships that would be presumed to be the correct relationship based on the diagnosis, but could be easily editable by the physician as needed, such as if the severity of the disease changes.

- **Ensuring EHR systems are equipped to incorporate these codes is a key component in limiting the burden on physicians and practices.** New regulations, or changes to existing regulations, require updates to information technology (IT), and oftentimes, practices are disadvantaged by delays from EHR vendors. We encourage CMS to provide sufficient time and technical assistance to ensure Health IT systems are capable of capturing and reporting the relationship codes.

- In addition to requiring providers to indicate their relationship to the patient on every claim, CMS is also proposing in the CY 2016 Medicare Physician Fee Schedule Proposed Rule to require all physicians furnishing services with a 10- or 90-day global period to report data on postoperative care. **ASCRS and the surgical community oppose this proposal due to the burden it will place on providers and because it is not in line with the MACRA statute, which requires CMS to collect data on the global packages from a “representative sample.”** Requiring all physicians to code all encounters is in no way a sample.

- **Given the extreme burden requiring patient relationship codes and codes on all services related to global surgical bundles would place on physicians and practices, ASCRS recommends CMS simplify how providers would report relationship codes and modify the proposal to collect data on the global periods to be a true sampling, as required by MACRA.**

**TECHNICAL ASSISTANCE REQUIRED**
ASCRS urges CMS to provide clear guidance and training for physicians and practices well in advance of the implementation of the patient relationship codes.

- Physicians are already confronted with the significant task of implementing MIPS or alternative payment models into their practices, and must have sufficient time to become familiar with the new requirements and develop administrative processes to comply with the policy. We have already urged CMS to modify the start date of programs under MACRA to later in 2017, and we caution against requiring patient relationship codes to be included on claims without providing enough time and training for practices to be ready.

- Due to the potential for overlap between continuing and acute care in what type of relationship a physician may have with a particular patient, we urge CMS to provide clear guidance to providers for how these relationships should be reported and how costs will be attributed based on them.

CONCLUSION

In summary, ASCRS urges CMS to consider our comments closely and, of foremost importance, develop a system for measuring resource use that does not hold physicians responsible for care they did not provide or based on factors beyond their control. In addition, we urge CMS to add new relationship categories for specialty surgical care, specialty chronic care, and a category that reflects the overlap between continuing and surgical care for the same patient. We recommend extensive testing of the codes before they are implemented so as not to overly burden physicians and practices, and that CMS provide adequate notice and training prior to the implementation.

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Thank you for providing our organization with the opportunity to present our comments on the request for information. Should you have any questions regarding our comments, please do not hesitate to contact Allison Madson, Manager of Regulatory Affairs, at amadson@ascrs.org or 703-591-2220.

Sincerely,

Kerry D. Solomon, MD
President, ASCRS