THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading change. Improving care for older adults.

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March 1, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Comments on CMS Episode Groups

Dear Mr. Slavitt:

The American Geriatrics Society ("AGS") appreciates the opportunity to comment on the CMS Episode Groups that will be used in the Merit-Based Incentive Payment System ("MIPS").

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. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the Medicare physician fee schedule ("PFS").

The new physician payment framework in MACRA must be implemented in a way that will facilitate and support significant improvements in the delivery of care for Medicare patients and more sustainable physician practices. We understand that the current RFI is the first of several opportunities for stakeholders to comment on the development of episode groups. The AGS welcomes feedback from the agency on steps that the physician community can take to assist in construction of episode groups and related provisions of MACRA. A participatory process will increase the likelihood that physicians will find them clinically relevant for their practices, administratively feasible, and helpful in achieving better care for patients with judicious use of resources while preserving and strengthening high-quality medical practices.

Comments on the Proposed Episode Groups in Appendix B

The AGS appreciates the complexity of developing the care episode groups, patient condition groups, and patient relationship categories required by MACRA, and that the timeline for implementing them is short. The AGS has reviewed the proposed Episode Groups listed in Appendix B and has several comments.

Overall, we believe that the proposed Episode Groups are a good first step. But we note that there are many episodes in some specialties (e.g. 13 cardiovascular episodes, 6 gastrointestinal episodes, and 6 musculoskeletal episodes) but few in others (e.g. 2 for infectious disease, 1 for neurology). Is this variability expected based on the distribution of Medicare payments across episodes? If so, wouldn't cancer and diabetes constitute episode groups?

Many of the episodes in Appendix B need significant modifications, however, and some of those designed to measure hospital resource use are not likely to ever be useful for measuring care of physicians who work primarily in ambulatory settings. MACRA gives CMS some latitude to apply new episodes as well as the current VBM measures "as appropriate." In our view, therefore, CMS has the flexibility to define new and refine old episode measures prior to moving full speed ahead with their implementation. **Initial efforts should focus on validity of the measures, not the volume of costs that are covered. Priority should be placed on a small set of measures that were developed for use in physician offices, not hospitals, and that have the support of the specialties that provide the key services within the episodes.**

The AGS also encourages CMS to ensure far greater involvement of physicians and the professional societies that represent them in future efforts to design, evaluate, and implement episode groups. The AGS recommends that CMS continue to use mathematical modeling to refine its methodology. We believe that episode groups require careful testing and consideration using experts and large databases. The AGS supports development of episodes that involve care of patients with chronic conditions. For those patients with multiple chronic conditions, we envision episodes that combine commonly co-occurring conditions but would continue to treat other less common chronic condition combinations separately. Involvement of the appropriate clinicians and specialty societies will be vital in determining which conditions could be combined and how that should occur.

Moreover, the AGS is concerned that there are no episode groups for geriatrics. Unfortunately, with the information provided AGS is unable to determine how our members would be affected by the use of the proposed episode groups, particularly given the need to account for patients with multiple chronic conditions. We recommend that CMS examine whether the Hierarchical Condition Categories model would be a more appropriate way to measure the resource use of geriatricians as it could better account for comorbidity and provide a mechanism for risk adjustment. The AGS also recommends that CMS specifically test the performance of the episode groups on patients with multiple chronic conditions. Additional variables, such as performance of activities of daily living and presence of dementia, should be assessed.

Finally, the AGS notes that there are no episode groups for several other specialties including anesthesiology, radiology, pathology, and oncology. Based upon the comments submitted by the affiliated medical specialty societies, provider types, and other groups, we understand that significant resources have been expended by many stakeholders to recommend episode groups to CMS, and believe those should be included in CMS' proposal or, if not included, CMS should explain why they were rejected.

As it seeks to supplement, refine, or replace current measures, CMS should focus on episodes designed specifically for use in physician settings. Repurposing hospital measures for use in smaller physician practices is generally inappropriate. Rather than expanding on this practice, CMS should replace current hospital-intended measures with episodes that were developed in cooperation with physicians' professional societies and designed for use in the setting where the particular services are most often delivered. **Potential sources for additional episodes include recommendations from the medical specialties, state Medicaid programs, Qualified Clinical Data Registries, and specialties' alternative payment model (APM) submissions to CMMI.** Private payer initiatives endorsed by relevant specialties could also be considered. CMS could hold meetings similar to those that were used to develop RBRVS PE units to hammer out elements of episodes.

While episodes of care defined in APM proposals can serve as a starting point and should be consistent with episodes associated with the MIPS program, some variation between the two types of episodes may be needed. For example, for services such as care coordination, which are not fully covered by Medicare, an episode of care covered in an APM may include specific care coordination activities that are not payable in fee-for-service (FFS) medicine and would not therefore be part of an episode used to measure resource use in FFS Medicare. In addition, to allow for legitimate differences between episodes used in MIPS and APMs, CMS will need to exercise some flexibility in application of the measures, such as in cases where a physician involved in APMs did not meet the threshold to be exempt from MIPS. If episodes are built on claims data and a lot of services physicians provide in an APM are not separately payable by FFS Medicare, they will be left out of the episode. For a stroke patient, for example, there may be claims from many different physicians and other professionals, but there will not be a claim for a team leader who is coordinating the overall care of the patient because Medicare does not pay for this service.

The definition of the trigger for the start of an episode is an important aspect of episode construction. For example, for a patient who comes to the emergency department, is kept under observation for a day, and later is admitted as an inpatient, would the episode start with the emergency visit, the observation visit, or the hospital admission? Similarly, tests may be ordered for purposes of establishing a diagnosis and for ruling out other diagnoses. It will be important for CMS to consider whether any of these tests trigger assignment to an episode or whether the episodes begin after a diagnosis has been established.

To minimize new administrative and reporting burdens for physicians, CMS should consider what information is already collected on claims that can be used to assign patients to episode groups. For example, site of service information is already collected on claims and can be used to identify

patients who are in a hospital, nursing home, or other facility without requiring the physician to separately report it. Physicians should therefore not need to place a new patient condition code that merely identifies where they received services on the claim form.

CMS also must consider how to address attribution issues with a much greater degree of validity than used in its various pay-for-performance initiatives to date. If a reliable and valid set of patient relationship codes is developed, these could be of great assistance in the attribution process. The AGS has some questions/reservations regarding the particular relationship codes defined in MACRA, and would also like to ensure that the codes do not create yet another administrative burden for physicians. We also agree that accurate attribution requires the identification of physician relationships that are not considered in current CMS methodologies. For example, CMS will need to consider relationships that physicians cannot currently code due to Medicare payment policies, such as indicating that they are a consulting or referral physician providing a report back to another physician. As also mentioned above, there should be some mechanism, at least in the APM setting, for physicians to indicate that they are the leader of a multi-physician team, or are advising the patient's primary care physician, or are managing the patient's recovery following an acute episode.

Comments on CMS' Proposed Methodology

In the Request for Information that was recently released by CMS, the AGS noted that there was no discussion of making changes to the Value Modifier program. The proposed Episode Groups fail to address a number of fundamental concerns with the methods for measuring and comparing resource use, and the AGS remains concerned that the MIPS will not be successful without addressing them.

The initial weight (10 percent) assigned to the resource category as well as the section requiring CMS to develop new tools for measuring resource use are evidence that Congress did not regard the measures in the VBM as an adequate way to make fair and accurate comparisons of physician resource use. While the AGS believes that more work is needed prior to implementation of the 44 episodes linked to this RFI, we agree that the measures used in the VBM are seriously flawed. CMS needs to devote significant data analysis and resources to this effort in order *to replace, not expand,* the current VBM cost and resource use measures. Simply layering new episode-based measures on the current system is unacceptable. CMS should also not transfer the existing VBM cost and resource use measures to the quality category, as suggested in CMS' Quality Measure Development Plan Request for Information.

In addition to their other flaws, VBM measures today are irrelevant for many physicians—either because no patients get attributed to them, or because the services provided are only a small percentage of total costs, and hence the physician had little or no opportunity to influence these expenses. Shortcomings in the attribution and risk adjustment methodology can also exacerbate the problem. If properly selected and designed, clinical quality measures aligned with episodes of care could increase the relevance, validity, reliability, and value of resource use measures and make physician feedback reports more actionable. This would also offer an opportunity to adapt risk adjustment and attribution methodologies to the individual condition or service being measured. However, it is likely

that episode groups will never cover all physicians. CMS will need to think carefully and consult with the physician community on how to ensure that these physicians are not disadvantaged in the scoring process.

The Medicare Payment Advisory Committee (MedPAC) in its comments on the 2015 Proposed Rule for the Physician Fee Schedule highlighted three concerns with the Value Modifier that, in the AGS' view, still exist and should be addressed to the extent possible in the design of the Resource Use category in the MIPS:

1. …[T]he complexity of the PQRS and the value modifier are clear signals of the many challenges in assessing performance at the individual clinician level. First, there is a trade-off between the type of quality measures Medicare can deploy (outcome measures versus process measures) and the statistical accuracy (i.e., reliability) of the different kinds of measures at the clinician level. Process measures may be less meaningful to patients as quality indicators, but they are more reliable to measure at the individual clinician level; whereas more meaningful outcome measures, such as potentially preventable admissions/readmissions and mortality, are less reliable when measured at the individual clinician level. This means that the measures that can be most important and meaningful to patients—a provider's performance on the outcomes of care—often are not statistically reliable when measured at the individual clinician level.

2. Second, while CMS and physician specialties have worked to increase the number of PQRS measures, it may be difficult to define clinically meaningful and statistically reliable quality measures for some specialties… [and] the default assumption Medicare will make is that the quality of each clinician's performance is no different than average. But this assumption renders moot a policy to adjust or redistribute some portion of payments on the basis of variations in quality across providers...

3. Third, a payment signal that is not transparent or understandable by clinicians is unlikely to improve care in the way it is designed. The value modifier, despite CMS's effort to be transparent and clearly implement the statute, is highly complex. The complexity derives from the inherent difficulty in measuring individual clinician performance. If clinicians do not know what to do to improve their value modifier result, they are unlikely to devote resources effectively to improving the quality and increasing the efficiency of the care they provide.

The proposed methodology for constructing Episode Groups does not address patients with multiple chronic conditions. Further, the methodology is so complicated that it is virtually incomprehensible to most physicians who do not possess a PhD in economics or similar training. Without a more straightforward way for physicians to understand how their resource use measures are constructed and what changes in practice would move them up or down, it will be difficult to improve the quality and value of care. Further, without adequate risk adjustment, physicians who treat the sickest patients will be penalized.

Recommendations for Valuing Collaborative Care for Patients with Chronic Conditions

Congress' intent in creating MIPS was to improve the quality and value of care for Medicare beneficiaries. Measuring resource use within episodes of care and using those measures to adjust payments for individual physicians has inherent limitations. Further, such measures of resource use could miss the mark altogether.

By looking retrospectively at patients who had costly cases, it is possible to determine why a patient had high costs (such as an inpatient stay) but less clear what interventions could have prevented the inpatient stay in the first place. Sometimes the patient's entry into the hospital could have been prevented through better care coordination, but neither care coordination, nor the lack thereof, can be deduced by analyzing Medicare claims.

For this reason, the AGS believes that it is imperative that CMS provide more explicit incentives for individual physicians to coordinate care amongst themselves. Moreover, new codes are needed to adequately identify and value the cognitive services and collaborative work that go into modern medicine. The AGS, along with support from the American Psychiatric Association (APA) and the American Academy of Neurology (AAN) developed a new CPT code that would address issues related to caring for patients with cognitive impairment such as dementia, management of symptoms, assessment of decision-making capacity, addressing caregiver stress, and other factors important to providing competent and comprehensive care. We urge CMS to adopt payment for such a service as described below.

Comprehensive assessment of and care planning for the patient with cognitive impairment, office or other outpatient, home or domiciliary or rest home, requiring an independent historian, with the following required elements:

- Comprehensive Cognition- focused evaluation including a pertinent history and examination
- Medical decision making of moderate or high complexity
- Functional assessment (e.g., Basic and Instrumental Activities of Daily Living), including decision-making capacity
- Use of standardized instruments for stage dementia
- Medication reconciliation and review for high-risk medications
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized instrument(s)
- Evaluation of safety (e.g., home), including motor vehicle operation
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks
- Advance care planning and addressing palliative care needs
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (e.g., adult day programs, support groups) shared with the patient and/or caregiver with initial education and support

Additionally, the AGS supports CMS' prior decision to pay for chronic care management (CCM) and transitional care management (TCM) services. The AGS also strongly supports the need for a high-severity chronic care management code. We urge CMS to recognize CPT code 99487 (complex chronic care manage services, at least 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with specified required elements) in addition to 99490.

CMS should establish relative value units (RVUs) for CPT Code 99487 based on the RUC's recommendations to CMS for physician work and practice expense inputs. If CMS adopts these recommendations, payment will be appropriate for the requirements of each code. The 20 minutes of clinical staff time in the chronic care management code currently reimbursed by Medicare is inadequate given the needs of the chronically ill Medicare population potentially eligible for this service. We note that the CPT manual includes guidelines for reporting complex care management services based on the total duration of staff time.

CMS should also adopt the requirements for billing codes 99490 and 99487 as described in the CPT manual:

> *"Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline…*
>
> *Complex chronic care management services are provided during a calendar month that includes criteria for chronic care management services as well as establishment or substantial revision of a comprehensive care plan; medical, functional, and/or psychosocial problems requiring medical decision making of moderate or high complexity…*
>
> *Physicians or other qualified health care professionals may not report complex chronic care management services if the care plan is unchanged or requires minimal change (e.g. only a medication is changed or an adjustment in a treatment modality is ordered.) Medical decision making as defined in the Evaluation and Management (E/M) guidelines is determined by the problems addressed by the reporting individual during the month.*
>
> *Patients who require complex chronic care management services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, and/or repeat admissions or emergency department visits. Typical adult patients who receive complex chronic care management services are treated with three or more prescription medications and may be receiving other types of therapeutic interventions (e.g. physical therapy, occupational therapy)…*

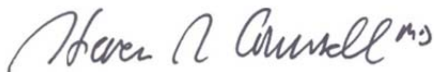
All patients have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline. Typical patients have complex diseases and morbidities and, as a result, demonstrate one or more of the following:

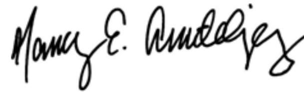
- *Need for the coordination of a number of specialties and services;*
- *Inability to perform activities of daily living and / or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver;*
- *Psychiatric and other medical comorbidities… and/or*
- *Social support requirements or difficulty with access to care."*[1]

* * * * *

The AGS greatly appreciates the opportunity to comment on proposals to improve the care of individuals with chronic and often complex conditions. Please do not hesitate to contact us, agoldstein@americangeriatrics.org, if we can provide any additional information or assistance.

Sincerely,





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[1] American Medical Association, CPT Code Manual, 2015.