American Urological Association

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Submitted electronically via:
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March 1, 2016

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

Re: Request for Information Regarding Episode Groups

Dear Acting Administrator Slavitt:

On behalf of our nearly 15,000 members in the United States, the American Urological Association (AUA) welcomes the opportunity to submit comments to the Centers of Medicare & Medicaid Services (CMS) on the request for information (RFI) regarding episode groups developed by CMS and the future role of episode groups in resource use measurement. The AUA is a leading advocate for the specialty of urology, providing invaluable support to the urologic community as it pursues its mission of fostering the highest standards of urologic care through education, research and the formulation of health policy.

Patient Relationship Codes

The Medicare Access and CHIP Reauthorization Act of 2015 (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. MACRA further 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. CMS further notes that in developing classification codes to identify patient-physician relationship categories at the time of furnishing an item or service, the categories shall include different scenarios and combinations, such as a physician who:

- Considers them self to have primary responsibility for the general and ongoing care for the patient over an extended period of time;
- Considers them self to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
- Furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
- Furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
- Furnishes items and services only as ordered by another physician or practitioner.

The AUA commends CMS on its efforts to seek stakeholder input on how best to measure resource use based on patient relationships, and simultaneously promote care coordination and patient centrality. We realize there are challenges with developing an attribution method applicable to multiple provider types, and this holds particularly true with identifying resource use for specialists. We believe the establishment of patient relationship codes under the Merit-Based Incentive Payment System (MIPS) will effectively aid in implementing resource use measurement tools without having to apply an attribution methodology based on a plurality of primary care services, as used for the Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs), or engage in retrospective attribution methods.

The AUA would prefer that physician resource use be attributed on a prospective basis rather than retrospectively. While retrospective assessments are most represented in patient cohort designs, retrospective attribution is problematic for many physicians because they are often unaware of which patients they will be caring for and assuming accountability for the costs of all care associated with that patient until after health care services have been furnished. It is critical that each physician caring for a patient understand how their services contributed to the patient's total cost of care, but it is not necessarily appropriate to hold each physician accountable for that patient's total cost of care. Patient attribution will be a key element in accurately identifying physician resource use under MIPS. CMS must ensure that services attributed to a physician relate to those where the physician can influence resource utilization. Therefore, the AUA recommends that patient relationship codes be assigned for specific services in order to accurately allocate either the entire or partial costs associated with the delivery of that service.

To the extent possible, we believe patients should be able to self-select to the physician who will provide their health care. Certainly, collaboration and understanding among physicians serving in a variety of care delivery roles must be developed in order to gain adherence to treatment protocols, but such arrangement must allow flexibility if a patient's provider of choice is not fully integrated into the treatment plan. The AUA urges CMS to

adherence to treatment protocols, but such arrangement must allow flexibility if a patient's provider of choice is not fully integrated into the treatment plan. The AUA urges CMS to allow flexibility in implementing mechanisms to measure resource use across a variety of provider care delivery roles, particularly for specialists.

The AUA continues to have serious concerns about resource use and the underlying methodology used to evaluate costs in the current Value Modifier (VM) program. Since the resource use performance category will account for 30 percent of the performance composite score under MIPS, we wish to reiterate previous concerns regarding use of measures that do not provide a clear link between specialist resource use and patient quality of care, such as the Medicare Spending Per Beneficiary (MSPB) measure applied to the VM and for future use in the MIPS composite score.

It is critical that any cost measures utilized as part of the MIPS program have a more direct link to quality measures used to assess value. As previously stated, the AUA is opposed to use of the MSPB measure under the MIPS because of the reliability and validity of the group attribution methodology, given that beneficiaries are identified based on a plurality of primary care services. We are further opposed to use of the MSPB measure given the broad cost analyses that holds physicians accountable for care decisions beyond their control by assessing the total amount billed per patient and not the treatment of the individual physician. In instances where CMS may identify areas where patient relationship codes would be appropriate for development, but there are no corresponding quality measures relevant to that specific service, the AUA encourages CMS to consider creating patient relationship codes only in those areas where quality measures exist to ensure that patient care is not adversely affected by resource use assessment. In these cases, we suggest that CMS provide that data to the physician for educational purposes but not apply it to the resource use performance category under MIPS.

Episode Construction

In the RFI, CMS states that there is no "gold standard" for constructing episodes, and in fact there are many ways to define specific rules for each step of the development process. The AUA shares this belief, thus we encourage CMS to consider criteria that will incorporate clinical expertise directly from medical specialty societies regarding the conditions and procedures identified in the RFI, specifically for prostatectomy for prostate cancer, transurethral resection of the prostate (TURP) for benign prostatic hyperplasia, and kidney and urinary tract infection (UTI). Urologists that directly provide the type of care being bundled into these episode groups are best qualified to provide input on which services are appropriate for inclusion and exclusion, risk-adjustment based on severity, as well as feedback on how costs could be contained without compromising high quality health care. The AUA supports the aforementioned episode groups and corresponding construction steps developed by CMS and stand ready to work with CMS to review resources for appropriate allocation to these bundles.

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Conclusion

The AUA appreciates the opportunity to comment on the request for information regarding episode groups developed by CMS and the future role of episode groups in resource use measurement.

Sincerely,

David F. Penson, MD, MPH
Chair, Public Policy Council