AMERICAN OSTEOPATHIC ASSOCIATION

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April 24, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Verma:

On behalf of the American Osteopathic Association (AOA) and the nearly 130,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) *Episode-Based Cost Measure Development for the Quality Payment Program*.

The osteopathic profession strongly supported passage of the Medicare Access and CHIP Reauthorization Act (MACRA), and remains optimistic as we move towards a system that aligns well with the osteopathic philosophy of care – treating the whole person with a strong focus on prevention, wellness, and quality. During the law's development, the AOA was especially supportive of MACRA's focus on the value of care provided over volume. To further support these efforts, we offer the following comments on the questions posed by CMS.

Episode Group Selection
We support that use of the episode's share of Medicare expenditures; clinician coverage; and the opportunity for improvement in acute, chronic, and procedural care settings are considerations when developing an episode group. We would add that episodes must also have parameters for included services that are reasonable and likely for patient care. These parameters are not easily set; variation in patients' needs will undoubtedly generate a multitude of care scenarios. We caution that where this variation exists to a greater degree, CMS should reconsider the development of an episode group.

Further, we appreciate that CMS is compelled to create episode groups to address cost measurement under MACRA. However, we urge CMS to take a stepwise approach to this effort by creating and testing fewer episode groups, and adding to that list only when existing episode groups have been proven to reflect actual care. This approach will ensure CMS has a manageable set of episode groups which it can refine, and in doing so, perfect its methodology, before extending episode groups to other conditions.

Acute Inpatient Medical Condition Episode Groups
We appreciate CMS' efforts to identify acute inpatient episode groups. We agree that there may be overlap between some acute inpatient episode groups and chronic condition episode groups. For example, CMS lists an inpatient episode group for diabetes as well as a chronic condition group for it. As CMS has aligned "inpatient" and "acute" it is unclear on how acute care in an outpatient setting would be considered. For example, a diabetic patient may present in the hospital emergency room and have their medical needs addressed there rather than as an admitted patient to the hospital. Based on CMS' approach, proposed categories for episode groups are insufficient to account for this care. We appreciate CMS' recognition of these challenges and its consideration of a single acute episode group category. The approach would better distinguish between ongoing care for chronic conditions and acute care that may be provided in a variety of locations including at a physician's office or acute care clinic.

Chronic Condition Episode Groups
We recognize challenges in assigning a patient with multiple chronic conditions to a single episode group. From a clinical point of view, many chronic conditions impact each other and the patient's health. As such, it is nearly impossible to attribute specific aspects of a patient's health to a single condition for patients with multiple chronic conditions. Therefore, we offer the following approach to assigning these patients. First, peer-reviewed literature should be consulted to determine conditions that co-occur more than 50 percent of the time. Next, these conditions should be included in a single episode group identified by the predominant condition. Should the predominant condition change, the episode group also would change. This change in episode groups could occur as frequently as quarterly. However, billing for care under the episode group could occur on a more frequent basis, such as monthly. An illustration of this approach can be done with a diabetic patient. A high percentage of Type 2 diabetic patients have hypertension, hyperlipidemia, obesity, renal disease, and cardiovascular disease. In fact, practice guidelines require that these conditions be monitored and addressed in the diabetic patient, so the 'diabetic condition' episode should be constructed to include monitoring and treating all these conditions. If the patient develops cardiovascular disease, for example, the dominant condition would change to cardiovascular disease and the episode group also will change to reflect that. This change can be made in the first reporting quarter after the renal failure diagnosis is made.

We also appreciate that current definitions of disease are too broad to capture clinical variation in disease severity or staging. For example, breast cancer alone does not identify the patient's condition or likely treatment pathway sufficiently to anticipate services in an episode group. Such an episode group should be informed by the stage of cancer at minimum. We suggest that a modifier be introduced so that claims can track this information and ensure an appropriate episode group is assigned. While this measure will aid in identifying a more appropriate episode group, we note that additional significant detail will still be illusive. For example, knowledge that a patient has Stage 2 breast cancer does not also provide information on the patient's known genetic information on the type of breast cancer which will also determine the patient's treatment pathway. In addition to a cancer staging modifier, we offer that disease severity modifiers may be useful in relation to chronic disease and we would support appropriate modifiers for these uses.

Cost Measure Development
We appreciate CMS' acknowledgement that several important variables should be considered when using episode groups to develop cost measures.

Regarding risk adjustment, we offer that patient classification should be based on at least two components:

1. Clinical factors including age, gender, condition, etc., as well as for non-clinical factors such as socioeconomic status and access to care, which can significantly impact clinical outcomes; and
2. Presence of multiple chronic conditions or co-morbidities, which merits further differentiation based on patient compliance with treatment, and disease management and improvement status (example: well-controlled and improving).

Chronic conditions can impact patient health differently based on risk factors (age, gender, etc.) and disease management (controlled and stable, or uncontrolled and unstable), so both of these should be considerations moving forward.

Regarding attribution, we offer that robust methodology is needed to ensure appropriate pairings of providers and services, or proportions of services, in the episode group. This is particularly challenging as multiple physicians and other health care providers may be involved in the care of a patient with multiple co-morbidities. As such, claims may be generated for multiple providers for a single patient with multiple co-morbidities. We offer that a care coordination team can aid in managing patient care and is of particular value for patients with multiple co-morbidities. As most health care providers will determine basic information, such as blood pressure, about a patient in their care, these patient interactions provide opportunities to collaborate and coordinate care across providers. To facilitate this coordinated care, we support the primary care provider as the lead of the care team, and offer that the patient-centered medical home (PCMH) model provides an appropriate context for this care coordination. Additionally, in identifying and assigning claims related to patient care for patients with multiple co-morbidities, it will be likely that some claims will be missed or misassigned. We appreciate that even with well-coordinated care, other gaps may impact the attribution of claims. We seek insight from CMS as to the processes that will be set forth for providers to appropriately appeal any errors in assigning claims to episode groups.

Regarding the degree of responsibility of attributed services, we offer that proportions may change over time as the patient's condition improves or progresses. For example, a diabetic patient may be stable in the first quarter of the year, and have a precipitating event in the second quarter of the year that necessitates intervention by other care team members for the same illness. As such, a single and continuous attribution of services to providers would not be appropriate in this scenario. Any degree of responsibility of attributed services must provide enough flexibility to mirror real world care. We offer that for chronic diseases, annual adjustments are too infrequent and that quarterly changes to the degree of responsibility of attributed services are preferable.

Regarding subgroups, we support that they should be developed to align patient care with resource use. For example, for a knee replacement surgery, follow-up care will be different for a patient without complications than one who does have complications. In the latter case, additional resources and care will be needed to ensure the patient receives appropriate treatment. As such, the care episode split into the finer category of "with complications" ensures additional relevant resources and services are included in the episode.

We also appreciate CMS' consideration of the use of cost measures in MIPS and the potential adverse impact this may have for physicians who assume the care of complex patients. We share these concerns and urge CMS to ensure appropriate risk stratification of all measures. In addition, we urge particular attention to ensure that chronic care measures appropriately reflect the resources

used to care for patients. These resources may not be captured in current CPT codes, and therefore, be unaccounted for on claims. We urge CMS to ensure that care coordination is included in all episode groups for chronic disease.

We appreciate CMS' desire to include all costs in an episode, including prescription drug costs. However, we urge CMS to first establish a foundation of operational episode groups based on sound methodology. CMS may then consider analytics that test the incorporation of Medicare Part D costs into episode groups, and share the findings of that assessment with physicians' association and other key stakeholders who can make recommendations on the methodology. Only after these episode groups have proven to reflect actual care should CMS consider incorporating Medicare Part D costs into episode groups. At this early stage, we believe the incorporation of drug costs into episode groups will add undue complexity.

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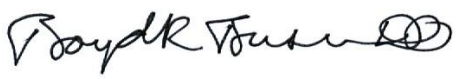
We appreciate the opportunity to share these comments and would be pleased to provide additional insight as you develop this program. To do so, or for additional information, please contact Laura Wooster, Senior Vice President for Public Policy, at lwooster@osteopathic.org, or (202) 349-8747.

Sincerely,



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President