February 11, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS Care Episode and Patient Condition Groups

Dear Acting Administrator Slavitt:

The American Academy of Neurology (AAN) is the premier national medical specialty society representing more than 30,000 neurologists and clinical neuroscience professionals and is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a physician with specialized training in diagnosing, treating, and managing disorders of the brain and nervous system such as Alzheimer’s disease, stroke, epilepsy, Parkinson’s disease, migraine, multiple sclerosis, and brain injury.

The AAN thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to provide feedback on care episode and patient condition groups. The AAN is concerned about the impact episode groups may have on physician utilization of services. We are especially worried that neurologists, and specialists in general, could be held accountable for services and care provided to patients with certain illnesses even when that care is out of their control. In particular, once a patient has had a stroke, a neurologist may be heavily involved, possibly serving as the primary physician responsible for the patient’s care. However, comorbid conditions treated by other physicians are likely factors that contributed to the occurrence of the stroke itself and could affect resource use after the stroke occurs. CMS must keep this in mind as it develops care episode and patient condition groups.

Care episode and patient condition groups

Within a specialty, a limited number of conditions and procedures account for the bulk of spending. Focusing on the top conditions and procedures for a specialty, what care episode groups and patient condition groups would you suggest?

AAN Response: The AAN has reviewed the CMS methods for creating the condition episodes for PD and stroke and we find that the methodology does
not produce episodes that are helpful to neurologists because we have evidence to show that much of the care for patients with these conditions is out of the control of the neurologist.¹

Many of the services identified in the episode groupings for Parkinson’s disease and stroke are performed by providers other than the neurologist. If specialists like neurologists are going to be held accountable and at risk for episode and patient condition groups, then those groups must be defined by services over which the specialists have control.

What specific clinical criteria and patient characteristics should be used to classify patients into care episode groups and patient condition groups? What rules should be used to aggregate clinical care into an episode group? When should an episode be split into finer categories? Should multiple, simultaneous episodes be allowed?

**AAN Response:** The AAN recognizes that this is a relatively new process. The first episodes of care that are developed for neurology should be simple and all associated services should be under the control of a specialist—the neurologist. The rules for aggregating care should follow clinical patterns. Some episodes of care might involve a diagnostic algorithm, while others could involve diagnosis and initial treatment. Additional episodes may aggregate care over a longer period of time such as a year. The first episodes will be simple and the AAN expects to eventually have to define subsequent episodes based on our experiences and lessons learned with developing initial episodes.

Medicare beneficiaries often have multiple co-morbidities. Recognizing the challenge of distinguishing the services furnished for any one condition in the care of patients with multiple chronic conditions, how should CMS approach development of patient condition groups for patients with multiple chronic care conditions?

**AAN Response:** The initial condition groups that CMS have developed are elegant and we appreciate the agency’s transparency, but what the episode groups currently lack is a separation of services that are under the control of the neurologic specialist. In further development of episodes, we encourage CMS to aggregate the diagnostic tests and treatment expenses that are under the control of the neurologist.

Additionally, we note that the way CMS currently aggregates episodes of care is relevant to large ACOs, but not to individual physician groups. Many neurologists are in small practices, with 18 percent working as solos.² This group’s future is in doubt as many are struggling to comply with increasing regulatory burdens and looming salary declines due to the loss of consultation codes, among other cuts.

Given that these co-morbidities are often inter-related, what approaches can be used to determine whether a service or claim should be included in an episode?


Co-morbidities should be analyzed for their relationship to the causal pathway. For instance, hypertension and diabetes management are not generally considered to be part of neurologist care, but are causative of cerebrovascular disease. In this formulation, treatment or non-treatment of these conditions would not be attributed to the neurologist, but downstream medical conditions owing to patient disability from neurological conditions, such as falls and fractures in Parkinson’s or stroke, aspiration pneumonia, and UTIs in Parkinson’s or MS, can be attributed.

What should be the duration of patient condition groups for chronic conditions (e.g., shorter or longer than a year)?

**AAN Response:** The duration of patient condition groups for chronic conditions will depend on the clinical circumstance for each disorder. Patient condition groups should recognize that for chronic disorders there may be several categories of patient care groups. For example, one for stable chronic disease and one for people with unexpected exacerbations—many of which may occur despite given optimal care—that could be quite costly.

The AAN supports subdividing episodes for chronic conditions. An arbitrary duration could reasonably be selected for a stable patient with a chronic condition. However, for those patients with episodic exacerbations, an arbitrary duration is not accurate. We also note that most general neurologists will have a relatively small percentage of their patients with any one specific chronic disorder. A general neurologist is not likely to have enough patients in any one category so as to make the data statistically relevant. A general neurologist may risk having one or several high-utilizing outlier patients for a particular disorder, which can give a false impression of having worse outcomes than a “typical” patient with the disorder.

How can care coordination be addressed in measuring resource use?

**AAN Response:** The AAN does not have enough information about the topic at this time to make recommendations and we do not believe that CMS has enough information. Thus, we believe that it is premature for CMS to make recommendations about this topic. Please provide more information to specialty societies before moving forward on this issue.

CMS has received public comment encouraging CMS to align resource use measures (which utilize episode grouping) with clinical quality measures. How can episodes be designed to achieve this goal?

**AAN Response:** See above.

Information that is not in the claims data may be needed to create a more reliable episode. For example, the stage of a cancer and responsiveness history may be useful in defining cancer episodes. How can the validity of an episode be maximized without such clinical information?

**AAN Response:** One method would be to create a predictive model based on the expenditures or utilization of the previous year. This would be an indicator of severity and be able to identify high-utilizing outliers.
How can complications, severity of illness, potentially avoidable occurrences and other consequences of care be addressed in measuring resource use?

**AAN Response:** Defining the causal pathway for each major condition of chronic illness along with its complications and associated health conditions to relevant avoidable acute health care utilization would be very helpful in addressing resource use. This may also help to pinpoint severity so that as severity level increases, we would expect to see more healthcare utilization.

Reliability of resource use measures are impacted by sample size. How should low volume patient condition groups and care episodes be handled?

**AAN Response:** While physicians who appear to be outliers on any particular measures might be requested to explain circumstances that account for it before the data are considered to be a reliable measure of resource use, any outlier should be evaluated for potential clinical explanations. For example, one physician might act as a referral center for difficult cases, and we are aware that severity may be difficult to measure. Another physician’s ratings may be impacted by a small number of extreme, outlier cases.

**Patient relationship codes**

Episode Groups have traditionally considered a patient’s course of care as a unit; including in it all care relevant to the course regardless of the specific provider. Section 101(f) of the 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. While CMS will seek additional public comment on patient relationship codes in the future, we seek stakeholder input on how to simultaneously measure resource use based upon patient relationship while promoting care coordination and patient centrality.

**AAN Response:** The AAN does not see an alternative to the patient needing to designate a primary care provider. We believe that specific providers other than the primary care provider should be held accountable, but only for those diagnostic procedures and therapies within their control. Initially, there will be relatively little data at the provider level until CMS can build up episodes of care at the specialist level.

Individual physician data should be inputted on a timely basis and there should be an opportunity for the physician to comment on the data, especially on potential outliers. For physician-to-physician interactions that occur 25 times or more per year, these physicians should be given the information about the other on a timely basis. Primary care providers ought to know which specialists are more effective, and vice-versa. Giving the primary care provider the opportunity to determine which specialists are most effective allows them to specify care combinations for each patient.

*Section 101(c) of the MACRA 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. Are there specific issues that should be considered when developing resource use measures which apply to these professionals?

**AAN Response:** Neurologists frequently perform unpaid non-face-to-face services for patients. As a result, a number of neurologists are now declining to perform these cost-efficient services. The AAN continues to encourage CMS to pay for non-face-to-face services that are currently outlined in a variety of existing CPT codes.

**Additional AAN considerations**

The AAN offers additional considerations to those raised by CMS. We would like to know how resources should be reported for an episode that is truncated (cut short, likely resulting in a resource usage reduction) by death or the onset of another related episode. Should assigned values be used to add resources to the truncated episode for comparison purposes?

Additionally, as physicians begin this process, CMS should assign the physician at the beginning of the episode. The attributed physician should be required to sign off on anything that will be attributed to them. We want to stress that episodes of care need to include only services that are under the physician’s direct control. Some neurologists may only provide care in the inpatient setting, others only in the outpatient setting, and certain neurologists will take patients through an entire illness. There must be separate episodes for each circumstance.

Finally, regarding attribution, data should be collected at the individual physician level because that data may be useful to a large group of physicians. However, if a large group of physicians such as an ACO wish to be evaluated as an entity, the AAN believes it is acceptable and promotes patient care.

**Conclusion**

We greatly appreciate this opportunity to share the views of the AAN in response to the questions raised by CMS. If you have any questions regarding this letter, please contact Daniel Spirn, Regulatory Counsel for the AAN, at dspirn@aan.com or (202) 525-2018.

Sincerely,

Terrence L. Cascino, MD, FAAN
President, American Academy of Neurology