MACRA's Patient Relationship Codes — Measuring Accountability for Costs

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The new patient relationship categories and codes may be one of the least known but most important provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As of January 1, 2018, clinicians may voluntarily submit these billing-code modifiers to help Medicare determine the extent to which they are responsible for various elements of a patient's care. Ultimately, this attribution of responsibility will be used to assess clinician performance, particularly with respect to resource utilization and cost, and will probably be tied to reimbursement.

Under MACRA, clinicians may elect to participate in the Merit-Based Incentive Payment System (MIPS), in which their achievement in several areas (use of electronic health records, engagement in practice improvement, and performance on a set of quality and cost measures) determines future payment adjustments. But assessing an individual clinician's performance on cost-related measures is challenging and requires a more granular understanding of the clinician's role in delivering care and his or her accountability for resources that are used. Although the Medicare Payment Advisory Commission has raised important concerns regarding the future of the MIPS,[1] it seems inevitable that payers will increasingly evaluate clinicians not only on patient outcomes, but also on the resources used and the costs incurred to achieve those outcomes. Thus, it will continue to be necessary to measure and attribute clinician responsibility for various aspects of care when assessing performance on cost-related measures under any new value-based payment program.

MACRA's patient relationship categories and codes aim to facilitate such measurement and attri-

Patient Relationship Codes and Categories.*

HCPCS Modifier	Patient Relationship Category	Description	Example
X1	Continuous and broad services	For reporting services by clinicians who provide the principal care for a patient, with no planned end to the relationship. Services in this category represent comprehensive care, dealing with the entire scope of patients' medical problems, either directly or in a care coordination role.	A primary care physician and specialists providing comprehensive care to patients in addition to specialty care
X2	Continuous and focused services	For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time.	A rheumatologist managing a patient's rheumatoid arthritis longitudinally but not providing general primary care services
X3	Episodic and broad services	For reporting services by clinicians who have broad responsibility for the comprehensive needs of a patient that is limited to a defined period and circumstance.	A hospitalist providing comprehensive and general care to a patient while the patient is admitted to the hospital
X4	Episodic and focused services	For reporting services by specialty-focused clinicians who provide time-limited care. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.	An orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period
X5	Only as ordered by another clinician	For reporting services by a clinician who furnishes care to the patient only as ordered by another clinician. This category is used for patient relationships that may not be adequately captured in the previous four categories.	A radiologist interpreting an imaging study that was ordered by another clinician

* Adapted from the Centers for Medicare and Medicaid Services.[2] HCPCS denotes Healthcare Common Procedure Coding System.

bution. The billing-code modifiers allow clinicians to report their relationship to the patient at a given point in time and for a particular service rendered. The codes characterize the relationship between clinicians and patients along two dimensions (see table): continuous versus episodic (anticipated longevity of the relationship) and broad versus focused (scope of the care provided).[2] For example, a patient with a new diagnosis of early-stage breast cancer might require multidisciplinary care from a surgeon, medical oncologist, radiation oncologist, pathologist, radiologist, and primary care physician. The patient's primary care physician would provide continuous and broad services longitudinally, whereas a breast surgeon would provide episodic and focused services during the perioperative period. A medical oncologist would provide episodic and focused services during a defined course of chemotherapy but might later provide ongoing monitoring and survivorship care, which could be reported as continuous and broad services. The codes therefore accommodate changes over time in a clinician's relationship to a given patient.

Each patient encounter would generate billing claims for services furnished as well as a clinician-reported patient relationship code modifier indicating the clinician's relationship to the patient at the time of the service. Once aggregated at the level of the care episode, these additional codes would tell a richer story of the way in which resources were used and would delineate the degree to which clinicians occupying various roles were responsible for costs incurred during the care episode.

Administrators at the Centers for Medicare and Medicaid Services (CMS) have recognized that codifying the relationship between clinicians and patients is a new and vexing challenge for value-based payment and have solicited input on implementation of the provision from multiple stakeholders. Since posting an initial set of codes in 2016, CMS has gathered feedback from three public comment periods to establish the current set of codes. Reporting of these billing-code modifiers is voluntary for now, and CMS plans to collect more data before making reporting mandatory and using clinician-reported code modifiers to attribute costs to providers participating in the MIPS. The timetable for mandating reporting remains uncertain.

We believe that several potential consequences associated with implementing patient relationship codes warrant consideration. First, clinician self-reporting creates a moral hazard — or worse, could be subject to gamesmanship — in that clinicians may forgo responsibility in especially complex cases or report exaggerated responsibility in straightforward ones. Put another way, attribution is a double-edged sword, since increasing ownership of a care episode is likely to translate into increasing financial risk under value-based payment models. Indeed, the patient relationship category delineating the provision of services "only as ordered by another clinician," which most likely implies less ownership, has already engendered debate among members of potentially affected subspecialties.[3] But the alternative to self-reporting — relying on a claims-based algorithm — is also fraught with problems; although such a system might be more objective, it would probably be less accurate.

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Second, the rollout of an additional billing-code modifier risks adding to the administrative load of an already overburdened clinician workforce. CMS has purposefully developed a relatively simple classification code set in order to limit the additional burden placed on clinicians. Nevertheless, the usefulness and reliability of patient relationship codes will depend on seamless, accurate reporting in routine care, and to the extent that these codes are seen as a cumbersome addition to clinician workflows, they will not realize their full potential.

Third, because CMS has tried to make the codes as simple as possible, there is a risk that they will not meaningfully distinguish the roles and responsibilities of certain clinicians in the course of caring for a patient. For example, one patient might have a costly complication while under the

care of a specialist, whereas another might benefit from remedial specialty care for a complication resulting from inadequate primary care. Although the specialists in both of these cases might report an episodic and focused relationship to the patient, the attribution of costs — and, ultimately, the assessment of each provider's performance on cost-related measures and the resulting payment adjustment — would be expected to be very different.

CMS's deliberate pace in rolling out the patient relationship codes affords an opportunity to anticipate and address these potential consequences. First, we believe the codes should be validated to verify their accuracy and reliability in routine use, with periodic auditing to help minimize the potential for moral hazard among clinicians. The resulting attribution of costs should also be validated, most likely by reviewing clinical charts. It will also be important that the use of patient relationship codes by providers who care for patients with particularly complex conditions or people of low socioeconomic status receive additional scrutiny to ensure that the codes do not inadvertently penalize such providers. Finally, we believe that the codes should be tested in conjunction with recently finalized care episode and patient-condition groups and codes,[5] thereby leveraging the opportunity to attribute the care episode itself, in whole or in part, to clinicians who are part of a multidisciplinary team. To explore these issues, CMS might consider mandating reporting in a limited geographic area, paying physicians to participate but not holding them financially liable for results. The CMS Innovation Center would be well positioned to run such a test. Underlying all these recommendations is the critical need for clinician participation during the voluntary reporting period — including communication of feedback to CMS.[4]

The relationship between clinicians and patients is central to the practice of medicine, and attempts to codify it must be approached with care. At the same time, the evolution of health care payment models toward rewarding value over volume necessitates an objective determination of the roles of various clinicians — and, ultimately, their shared accountability for costs — in the course of caring for a patient. The patient relationship categories and codes implemented under MACRA represent a first step toward this goal. Now our task should be to vet, validate, and iterate on this approach.

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Disclosing Prescription-Drug Prices in Advertisements — Legal and Public Health Issues

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On October 15, 2018, the Centers for Medicare and Medicaid Services (CMS) proposed a rule requiring television advertisements for prescription drugs and biologic products to disclose the product's price.[1] The advertisements must state in legible text the wholesale acquisition cost (WAC) for a 30-day supply or a typical course of treatment.

The rulemaking follows an un-