**COALITION LETTERHEAD**

DATE

Ms. Seema Verma VIA ELECTRONIC SUBMISSION

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1693-P

Mail Stop C4-26-05

7500 Security Blvd.

Baltimore, MD 21244-1850

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program; Proposed Rule

Dear Administrator Verma:

The Coalition of State Medical Societies — a group of 10 state medical associations representing more than 180,000 physician and medical student members from coast to coast — urges you to reconsider the collapsing of evaluation and management (E/M) payments proposed under this rule. We believe this would damage significantly access to care for Medicare beneficiaries, especially those with chronic and/or complex medical problems.

Like many other health care organizations, many or all of the coalition’s member societies will submit their own detailed comments and recommendations regarding this wide-ranging proposed rule. We are sending this comment collectively, however, because we are extremely concerned about how this particular proposal would hurt our member physicians and their patients.

Individually and collectively, we have long urged the Centers for Medicare & Medicaid Services (CMS), commercial insurance companies, and other payers to reduce drastically the administrative tasks ⎯ especially, the overwhelming documentation requirements ⎯ associated with the services our member physicians provide. We therefore applaud your proposal to simplify the outdated, unnecessary, and duplicative E/M documentation requirements. This would allow our member physicians to refocus their attention back to medical decision making and what is needed for appropriate patient care.

**We strongly oppose, however, CMS’ proposal to flatten payment for E/M visits in connection with the relief in the E/M documentation burden.**

This proposed flattening, with significant cuts in payment for complex (levels 3-5) visits, erroneously assumes that the greater documentation requirement is the only justification for the larger payments currently provided for those visits. This is an extension of the thinking that transformed the medical record from an essential clinical tool into a billing-support document. Regardless of any payers’ requirements, physicians will continue to use the medical record to document their clinical findings, assessment, and plans. Regardless of any payers’ requirements, the amount of time, expertise, and skill used with the patient will not change. This proposal, therefore, significantly devalues the work physicians perform and the services they provide.

Removing the payment differential for the visit levels will:

* Eliminate incentives for physicians to care for complex or complicated patients including those with disabilities and those with serious or terminal illnesses;
* Make treating patients covered by Medicare even more financially challenging for physicians, leading more physicians to limit the number of Medicare patients they see or to opt out of the program entirely; and
* Translate into similar changes by commercial insurance companies that tend to follow CMS’ lead on payment matters.

We appreciate that CMS is proposing new “add-on” codes to increase payment for more complex visits. However, these codes do not provide enough compensation to offset the cuts created by flattening payment for level 2 through 5 visits.

In fact, use of these add-on codes would make existing administrative requirements even more complex. It would transform a uniformly accepted approach to E/M coding and billing into one system for Medicare and a different one for all other payers.

Further, the proposed rule provides little guidance regarding the use of and required documentation for these codes. We can, therefore, expect that many physicians will avoid these codes – even when appropriate – fearing a rash of new audits and payment denials.

Finally, we remain dismayed that physicians’ Medicare rate increases promised in the Medicare Access and CHIP Reauthorization Act (MACRA) will once again not be forthcoming. In an environment where many of the savings to Part A of Medicare have resulted because the service is now being performed more timely and safely under Part B, it makes no sense to keep the funding mechanisms separate. Our members’ operating costs continue to increase, but – unlike hospitals, nursing homes, and other facilities – their Medicare payment rates have not kept pace, and have stagnated for the better part of the past two decades. Physicians’ Medicare fees measured in real dollars have decreased by 25 percent since 2001. This is one more disincentive for physicians to participate in the Medicare program.

We understand that the agency has no authority to override congressional decisions that control base Medicare payment rates. But we urge you to examine closely how your proposal to flatten the E/M payments ⎯ coupled with no significant rate increase for years ⎯ is systematically driving physicians away from the program. Medicare beneficiaries who cannot access outpatient physician care will increasingly seek care in emergency rooms, driving total Medicare cost higher.

**In closing, we recommend that the administration:**

1. **Move forward with the proposed simplification in E/M documentation guidelines and continue to work to relieve physicians of the administrative burdens created by outdated, excessive, and overwhelming E/M documentation guidelines;**
2. **Neither reduce payment for E/M visits nor tie any reduction in payment to a reduction in administrative documentation burden;**
3. **Convene an expert workgroup of physicians and other health professionals to recommend a physician payment structure that is accurate, fair, and adequate;**
4. **Continue to make every possible effort in all rulemaking to decrease administrative cost burdens for physicians to offset the adverse impact of inadequate fees; and**
5. **Examine the payment silos within Medicare and propose revisions so that the money more closely tracks where care is being provided to the patient.**

Our leaders, members, and staff stand ready to assist you and your agency in this critical task. The proposed changes are too important and too wide-ranging and – unfortunately – too flawed to be permitted to take effect in 2019.

Sincerely,

Coalition of State Medical Societies

These state medical associations comprise the Coalition of State Medical Societies:

Arizona Medical Association  California Medical Association  Florida Medical Association  Louisiana State Medical Society  Medical Society of New Jersey  Medical Society of the State of New York  North Carolina Medical Society  Oklahoma State Medical Association South Carolina Medical Association  Texas Medical Association