[September XX, 2018]

VIA ELECTRONIC SUBMISSION

Administrator Seema Verma

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1693-P

P.O. Box 8011

Baltimore, MD 21244-1850

**RE: CMS-1693-P: 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**

Dear Administrator Verma:

Thank you for the opportunity to comment on the proposed changes to the FY 2019 Physician Fee Schedule, Medicare Shared Savings Program, Quality Payment Program, and Medicaid Promoting Interoperability Program.

[Introduce yourself/your organization—highlighting your experience with/expertise on Medicare]

In the CY 2019 physician fee schedule proposed rule, the Centers for Medicare & Medicaid Services (CMS) is seeking a number of significant changes to the documentation and billing requirements for Medicare’s Evaluation & Management (E/M) services. I/We appreciate CMS’s recognition that there are longstanding problems with the current system and applaud the agency for revisiting this issue.

However, I/we cannot support the agency’s recommended approach. The new payment policy CMS has put forth could have devastating—if unintended—consequences for people with Medicare. Of particular concern is the proposal to consolidate the billing codes for physician E/M services. This would result in a flat payment rate for all office visits, regardless of the visit’s length or the complexity of the beneficiary’s condition. Such a shift would effectively cut rates for time-intensive visits that are currently reimbursed at higher levels, penalizing Medicare providers who treat people with complicated health issues.

To offset this reimbursement cut, many providers would likely seek to maximize revenue by reducing the length and narrowing the scope of office visits, asking beneficiaries to make additional visits to address additional issues. This would increase the financial, emotional, and physical burdens on older adults, people with disabilities, and their caregivers: more trips to the doctor would mean more copayments, more travel, more time spent in waiting rooms, and more stress for all involved.

I am/We are also concerned that this proposal could incentivize providers to cherry-pick healthier patients to avoid financial losses. People who are dually eligible for Medicare and Medicaid would be at particular risk. Compared to non-duals, they are more likely to be in worse health, to face provider access and transportation issues, and to need longer, comprehensive office visits.

Though well-intended to reduce documentation and reporting burdens on providers, collapsing the E/M codes would have detrimental and lasting effects on people with Medicare and their families. I/We urge CMS not to finalize this proposed rule, and to instead work with stakeholders to identify ways to reduce the administrative burden on providers without jeopardizing the health and economic security of people with Medicare. Thank you for your consideration.

Sincerely,

[Name/Organization]