



September 7, 2018

The Honorable Paul Ryan
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Minority Leader
United States House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, DC 20510

Dear Speaker Ryan, Minority Leader Pelosi, Majority Leader McConnell and Minority Leader Schumer,

On behalf of the American College of Physicians, I am writing in reference to the proposed rule for the Medicare Physician Fee Schedule for 2019, which was released by the Centers for Medicare and Medicaid Services (CMS) on July 12th. In an effort to address numerous questions we have received from congressional offices, specifically in regards to the proposed changes to the Evaluation and Management (E/M) payment structure and documentation requirements, we would like to comment on these aspects of the rule recognizing that it may be helpful to Congress in its oversight role. Our views on these important issues will be reflected in greater detail in our comment letter to CMS, and we would be happy to share that with you as it may be helpful.

The American College of Physicians (ACP) is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Proposed E/M Payment Structure

CMS is proposing sweeping changes to the way the federal government would pay physicians under Medicare for the services they provide in their outpatient office setting. These changes would result in a radical departure from how physicians currently bill Medicare for E/M services by attempting to simplify the billing codes and associated clinical documentation requirements. Our detailed comment letter to the agency, which will be submitted soon, explains the rationale for our position not to support the coding changes, as currently proposed, while at the same time calling on CMS to proceed with its plan to simplify documentation requirements and decouple it from the E/M changes.

Flat Payment Rate with New Add-on Codes: Physicians currently bill Medicare for office visits using codes that are based on the differing levels of care and complexity of services provided to patients; level one refers to more straightforward clinical care, and levels increase in complexity to level five which is intended to reflect the most complex care. Each level typically requires differing clinical documentation requirements for billing purposes, most of which are not aligned with the needs of the patient or the clinical care team and thus create tremendous administrative burdens. Under this rule, CMS proposes to create a flat, single blended payment rate for levels two through five office visits and at the same time only require medical record documentation to support a level two visit under the new payment structure for any level of service two through five. In addition, CMS proposes two new add-on codes intended to reflect the additional care needed for more complex patients.

ACP has strong concerns that the proposed blended payment will have the unintended impact of undervaluing the work associated with caring for more complex and frail patients, even with the proposed add-on codes. The proposed rule would also incentivize shorter, more frequent visits and disincentivize the care of complex patients many of whom may be elders covered by Medicare. CMS's proposal may adversely impact patient care by favoring these unfortunate types of changes in patient mix, volume, and visit duration. A single flat fee minimizes the value of the care provided to all but the most straightforward clinical conditions. Therefore, ACP has concluded that the proposal to pay a single flat fee for E/M levels two through five does not reflect the true spectrum of care and strongly recommends that it not be implemented.

Proposed Changes to Clinical Documentation

Clinical documentation (CD) is the creation of a record detailing a medical treatment, medical trial, or clinical test and was developed to track a patient's condition. Over time, these documentation requirements have grown overly burdensome and have even moved away from their intended purpose of supporting direct patient care to reimbursement, billing and audit tools. ACP acknowledges and appreciates CMS working to address the significant problems with documentation of E/M visits via this proposed rule. CMS proposes to take major steps to reduce the documentation requirements associated with E/M services by allowing medical decision making to be the basis for documentation, requiring physicians to document only new information for established patients and to sign-off on basic information as documented by practice staff. ACP strongly supports these changes as they will better meet the needs of the patients and the clinical teams taking care of them, reduce the documentation burden on clinicians, limit redundant information in the medical record, and cut down on duplicative time spent on re-documenting existing information.

ACP does not concur with CMS's claim that it cannot reduce E/M documentation requirements unless it also implements a flat fee for E/M service levels two through five. While we understand CMS's concerns that changes in E/M documentation requirements, without changes in the underlying payment structure for E/M services, could create program integrity challenges, we believe that CMS should consider the testing of alternatives that would allow the agency to move forward on simplifying documentation, ensure program integrity, and preserve the overarching principle that more complex and time-consuming E/M services must be paid appropriately, that is, more than straightforward and less time-intensive services.

Conclusion

In summary, ACP believes that CMS should not move forward in implementing its proposed flat payment rate for E/M services and that the reduced documentation requirements should not be contingent on the flat payment rate being implemented. ACP supports CMS in finalizing the proposals related to simplified documentation including providing choice in documentation options with some improvements, reducing redundant documentation, and eliminating extra documentation for home visits for implementation on January 1, 2019. In addition, there are other components of the payment structure that have been proposed, including payment for prolonged services and for a number of technology-based and telehealth services, that ACP recommends CMS finalize for implementation in 2019. The proposed prolonged services code will help address a long-recognized challenge with the existing prolonged services CPT code due to the time thresholds that code requires. Further, the technology-based and other telehealth services were proposed as separate components of the rule from the E/M payment structure, and are important services that should be compensated and should be implemented immediately.

We appreciate this opportunity to provide input on this very important matter with the intent that it can help inform your work in the legislative space as you continue to monitor physician payment and administrative burden issues and exercise appropriate oversight of the administration's rulemaking on the issues discussed above. Should you have any further questions on these matters, please do not hesitate to contact Jonni McCrann at jmccrann@acponline.org.

Sincerely,



Ana María López, MD, MPH, FACP
President

CC: House Energy and Commerce Committee, House Ways and Means Committee, Senate Finance Committee