October 5, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445–G  
200 Independence Avenue, SW  
Washington, DC  20201

Re: File Code CMS–1734–P. Medicare Program; CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Updates to the Quality Payment Program; Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Proposal to Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy Proposed Rule.

Dear Administrator Verma:

On behalf of the 50,000 physician and medical student members of the California Medical Association (CMA), I am writing to offer our comments to the Centers for Medicare and Medicaid Services (CMS) on the 2021 Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) proposed rule published in the Federal Register on August 4, 2020 (85 Fed. Reg. 50074). We support the comments submitted by the American Medical Association (AMA) and are providing additional comments to emphasize the priorities of California physicians.

Overall, the CMA supports and appreciates the new Evaluation and Management (E/M) codes, the simplified E/M documentation system, and the corresponding increase for primary care physicians, but we are strongly opposed to the budget neutrality adjustments that impose up to 11% payment cuts on physician specialists. Physicians cannot sustain such drastic payment cuts, particularly during the COVID-19 pandemic that has already caused severe revenue reductions. As we continue to combat the COVID-19 virus, we need viable physician practices to care for patients. We urge CMS to waive the budget neutrality requirements under the public health emergency or consider additional alternatives recommended by the AMA.
CMA Priority Issues

1. CMS payment policies must take into account the negative impact of the COVID-19 pandemic on physician practices and patient access to care.

Physicians in California and across the country immediately responded to the call to serve their communities during the COVID-19 outbreak. Physicians engaged in early mitigation public health strategies and education, and developed guidelines for prevention, care and more widespread testing. Physicians worked around the clock while facing workforce challenges and shortages of personal protective equipment, risked their lives to care for COVID patients in Emergency Departments and ICUs, volunteered in hot zones across California and the rest of the country, and worked tirelessly on the front lines while sleeping in cars and tents so as not to expose their families to the virus. Physicians supported social distancing and public health orders to stop providing non-essential care to reduce the spread of the virus even though it put their own medical practices in financial jeopardy. Physicians have led the fight against COVID-19 and worked to protect the health and well-being of their communities at great sacrifice. However, it has taken a toll on physician well-being and the financial health of our practices.

The viability of physician practices is under threat even with the modest assistance from the provider relief fund, the Paycheck Protection Program and the Medicare Advance payments. Physicians are experiencing unprecedented revenue losses in their practices from social distancing and public health orders to refrain from providing non-urgent surgeries, procedures, and care. At the same time, COVID-19 practice costs to purchase personal protective equipment (PPE), cleaning supplies and implement safety precautions has risen sharply. As practices and the economy begin to reopen, physicians report they will only be able to operate at 50% capacity.

A spring 2020 CMA survey of California physicians shows,

- 95% fear for their financial future;
- 64% average decline in revenue; 10-30% practice cost increases due to COVID-19;
- 11% have closed their practices;
- 49% have been forced to furlough staff and physicians; 35% imposed salary cuts to physicians and staff

Estimated Impact:

- 34% of Californians (13 million) are at-risk of losing their doctor
- $8.5 billion total revenue loss for all California physician practices March 1- June 1, 2020

Physician practices are also important to the economy. California physicians contribute to the health and economic well-being of their communities by supporting 1.2 million jobs, contributing $135 million in wages and benefits, and paying $11.2 million in state and local taxes.
The fall-out from this crisis threatens to fundamentally alter our nation’s health care delivery system—not just during the outbreak, but for years to come. The CMA calls upon CMS to help protect the financial viability of physician practices that form the backbone of our health care delivery system. Therefore, as CMS considers new payment-related policies, we urge you to take into account the negative impact the pandemic is having on physician practices and patient access to care. Ensuring patients have access to critical health care is our shared priority.

2. CMS policies must help to reduce health care disparities for patients.
CMA joins AMA in our concerns that some of the CMS proposals combined with the COVID-19 pandemic further widen the gap in health care disparities. Preliminary data shows that the virus has disproportionately affected African American, Latino, American Indian/Alaska Native—particularly in the Navajo Nation—Asian-American, and Pacific Islander communities. As CMS continues to address the nation’s health care needs, particularly during the pandemic, we urge, among other things, the dissemination of culturally appropriate public health care information to minority populations from health care professionals, and access to telehealth services, including audio, for underserved communities to increase access to care and move toward a more equitable health care system.

3. California Medicare payment locality transition to Metropolitan Statistical Areas (MSAs)
CMA and California Medicare GPCI experts, Dr. Edward Bentley and Dr. Larry DeGhetaldi, have reviewed the Geographic Practice Cost Index (GPCI) calculations for the current phase of the California payment locality transition to Metropolitan Statistical Areas (MSAs) and confirm the accuracy of the calculations and adjustments for CY 2021. As we near final implementation, California physicians will be accurately reimbursed for the geographic differences in their practice costs and their payments will keep pace with local cost increases. Physicians practicing in California’s impacted urban areas have experienced appropriate rate increases and physicians practicing in rural regions have been protected. The new locality and payment structure has already improved access to physicians in several California counties. We appreciate CMS’ work to implement the California MSAs.

4. Physician Fee Schedule: E/M Changes, Budget Neutrality, Conversion Factor Payment Cuts

- CMA supports implementation of the new office visit Evaluation and Management (E/M) coding and relative value policy. We believe it will significantly reduce physician administrative documentation and reporting burdens and better describe office visits. We strongly support these long-overdue and much needed increases for primary care physicians who are the foundation of our health care system.

- However, CMA is opposed to CMS’ decision not to incorporate these revised office and outpatient E/M values in the global surgical codes, as this disrupts the relativity in services and treats the same physician work differently based on whether the service is a standalone or post-operative visit. We urge CMS to follow the RUC’s recommendations to include the E/M updates in the global surgical payment bundles.

- CMA is also strongly opposed to the hefty budget neutrality adjustment that is required to offset the proposed office visit and other payment increases. The proposed changes result in a drastic 11% reduction in the CY 2021 conversion factor at a time when MACRA is dictating a 0% annual
update in payments. Because of these policies, surgeons and anesthesiologists face a 7-8% cut while the non-patient facing specialties, such as pathology and radiology, would experience cuts up to 11%. The budget neutrality driven cuts also reduce the overall increase in office visit payments for primary care and oncology where office visits comprise most of their practice.

- Finally, we are seriously concerned that over the objections of the AMA RUC, CMS is proposing a $3.3 billion increase in spending for the new GPC1X primary care add-on code for complex services. This code accounts for over 30% of the payment reductions in the budget neutrality adjustment. We concur with the AMA RUC that this new code needs to be delayed, studied and more specifically defined before it is implemented. If this ambiguous code was postponed for further study, CMS could reduce the payment cuts to the specialists.

- These policies will further threaten the financial viability of physician practices and harm access to care at a time when we need physicians more than ever. As we stated earlier, the COVID-19 pandemic has placed an incredible financial strain on physician practices and these 2021 Medicare payment policies, while helping primary care practices, could further jeopardize specialty practices.

Therefore, CMA strongly supports the AMA’s proposed alternatives to mitigate the unnecessary payment cuts while protecting the primary care increases, including
  - waiving budget neutrality under the public health emergency authorities
  - postponing implementation of GPC1X until it is better defined
  - implementing GPC1X with no budget neutrality offset
  - using the 2020 utilization savings to lessen the budget neutrality adjustment
  - phasing-in the budget neutrality cuts over multiple years
  - adding the E/M changes to the global surgical codes

5. Other Physician Fee Schedule Policies

- **Telehealth**: CMA physicians greatly appreciate that CMS provided early flexibility for physicians to provide telehealth and audio-only services to patients during the pandemic. The provision of services via telehealth has been extremely successful in ensuring that high-risk elderly patients have access to care. We urge CMS to make telehealth services permanent, to remove the geographic and site of service barriers, and to ensure telehealth is reimbursed at in-person rates. These services should include audio-only visits for both the traditional Medicare program and Medicare Advantage.
- CMA supports an improved data collection process for physician practice expenses (pe). However, we urge CMS to maintain the current geographic adjustments for PE as rent and staff wages vary dramatically by geographic region. The Institute of Medicine, Urban Institute, and others have studied the geographic adjustments in Medicare payments and confirmed they are necessary and appropriate.
- CMA thanks CMS and strongly supports the plan to defer the requirement for electronic prescribing of controlled substances for Medicare Part D prescriptions until 2022.
• CMA supports the expansion of the monthly bundled payment codes to all substance use disorders and the payment of emergency physicians to stabilize patients with withdrawal symptoms.

• CMA joins our teaching institutions in support of permanently allowing the supervision of residents in teaching settings through audio/video real-time communications technology, the virtual presence of teaching physicians during Medicare telehealth services and we urge these changes to be made permanent.

• CMA continues to oppose the potential payment cuts for clinical testing services paid on the Clinical Laboratory Fee Schedule.

• CMA opposes the transition of the Medicare Shared Savings Program (MSSP) quality measures from the GPRO web-interface to the MIPS Alternative Payment Model (APM) Performance Pathway, particularly during the pandemic.

• CMA urges CMS not to require physicians to use 2015 Edition Cures EHRs before January 1, 2023 and we ask CMS to limit unnecessary burdens that could impede physicians’ adopting, testing, training, and use of new EHRs.

• CMA supports the flexibilities that CMS has provided for Medicare Diabetes Prevention Program (MDPP) suppliers during the COVID-19 PHE and we urge these changes to be made permanent.

6. Updates to the Quality Payment Program (QPP)

CMA urges an overhaul of the QPP to provide meaningful reporting relief to physicians

The CMA appreciates CMS’ stated commitment to the “Patients Over Paperwork” initiative that was intended to reform the health care delivery system by focusing on patient-centered care and working with physicians to reduce the administrative regulatory burdens that are contributing to physician burnout and reduced access to care. We believe that providing long over-due regulatory relief to physicians will decrease costs, improve quality of care, increase access to physicians, and allow physicians to spend more time with their patients. Patients care about timely access to a doctor and getting enough time with their physician to answer their questions. This is the one of the basic standards of quality care and none of it is actually measured in the QPP program.

The increasing administrative workload forced upon physicians adds unnecessary costs to physician practices and the Medicare program. Unnecessary administrative tasks undercut the patient-physician relationship. For example, studies have documented lower patient satisfaction when physicians spend more time looking at the computer and performing clerical tasks.\(^1\) Moreover, for every hour of face-to-face time with patients, physicians spend nearly two additional hours on administrative tasks.

throughout the day. The increase in administrative work is unsustainable, diverts time and focus away from patient care, and leads to additional stress and burnout among physicians.

The greatest negative impact has been the loss of physicians in the workforce. If physicians continue to withdraw from Medicare or retire early, all Californians will experience difficulty finding a doctor. California is experiencing physician shortages, at a time when the baby boomers are flooding onto Medicare. Simplifying the practice environment will make an enormous difference in maintaining access to physicians.

The MIPS Quality Payment Program (QPP) continues to be extremely burdensome. The cost category imposes penalties on physicians for expenditures beyond their control and discourages physicians from treating sicker patients. The quality measures are not relevant to most specialties and meaningful to patient care. And at this stage in physicians’ high-rate of HIT-adoption, a simple attestation that physicians have engaged such systems and are using them should be satisfactory rather than more reporting. Finally, the budget neutral nature of the bonus pool is problematic as the penalties fund the bonuses. Many California physicians received high performance scores on QPP but will receive an extremely small bonus payment because of the underfunded performance pool. As intended, the bonus payments are not helping physicians recoup their investment in reporting systems. This will eventually cause many physicians to withdraw from Medicare. Moreover, physicians will not be receiving a MACRA payment update in CY 2021.

By reducing administrative burden, CMS can maintain physician participation in Medicare, support the physician-patient relationship and let physicians focus on an individual patient’s welfare and, more broadly, on protecting public health.

To advance these goals, CMA physicians have prioritized the following regulatory relief proposals for the QPP program. We have also listed our responses to specific proposals in the proposed CY 2021 QPP.

- CMA strongly urges CMS to extend the extreme and uncontrollable circumstances hardship exception flexibilities due to the COVID-19 public health emergency (PHE) through at least 2021.

Quality Measures

- CMA supports CMS’ proposal to reduce the 2021 MIPS performance threshold from 60-50 points because of the COVID-19 pandemic.

CMA urges CMS to:

- Reduce the number of quality measures from six to three and engage with the specialty societies to ensure that there are measures relevant to each specialty. We urge CMS to focus on fewer quality measures that are more appropriate for each specialty and meaningful to their patients’ conditions.
- Maintain the existing, topped-out measures until an overhaul of all measures can be done pursuant to the recommendation above for three relevant, specialty-specific measures.
• Remove the difficult, time-consuming and unnecessary requirement to report all-payer data.
• Eliminate the global and population health administrative claims measures specifically the All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions in the Quality category.
• Focus opioid related Quality measures or Promoting Interoperability (PI) measures on how well patients’ pain is controlled, whether functional improvement goals are met, and therapies used, rather than the current approach of only focusing on preventing and/or reducing opioid use.
• Continue to work to conform the quality measures with those in the Medicare Advantage Program and ultimately among all public and private payers.
• Improve large group reporting accuracy by allowing the use of sub-group tax ID numbers.

Cost Category

• CMA strongly urges CMS to maintain the weight of the cost category at 15% and the quality category at 45% of the final MIPS score for the 2021 performance year because of the unknown impact of the COVID-19 public health emergency on physician expenditures and other factors. Moreover, a higher cost category weight will further discourage physicians from caring for sicker patients, particularly during the COVID-19 pandemic.

• CMA recommends that CMS remove the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures that hold physicians accountable for costs beyond their control. Individual physicians cannot control total costs of care for inpatient care, other specialty care, or prescription drug costs.

Promoting Interoperability (PI) Category

• CMA strongly supports the new CY 2021 proposal to allow physicians to report on the HIE Bi-Directional Exchange measure by a yes/no attestation. We continue to urge CMS to provide broad categories of PI to allow physicians to provide a simple yes/no attestation for all measures tied to CEHRT use and beyond to reduce reporting burden.

CMA urges CMS to:

• Eliminate the additional electronic data collection that does not align with a physician’s clinical workflow or relate to clinical practice and patient improvement.
• Hold EHR vendors and hospitals more accountable for HIT interoperability.

Improvement Activities (IA) Category

• CMA urges CMS to include more activities related to the management of patients with COVID-19, including screening, testing, diagnosis, and treatment, whether in-person or via telemedicine.
Alternative Payment Models (APMs)

- We cannot emphasize enough the need to promote and implement more physician-led APMs.
- Reform the address change and communication system for physicians participating in APMs. For the second year in a row, more than 20,000 physicians will not receive their 5% APM bonuses because CMS cannot locate them.

7. CMA Opposes Supervision of Diagnostic Tests by Certain Non-Physician Practitioners

California law does not allow any of the practitioners to whom the proposed rule would apply to supervise diagnostic procedures. Though California has new law establishing different categories of nurse practitioners, each with different ways of interacting with physicians, California law still does not expand authority to any category of nurse practitioner to supervise diagnostic procedures. Permanent implementation of the rule will represent an inappropriate expansion of authority for a certain subset of nurse practitioners to supervise diagnostic procedures with limited physician engagement. CMA urges CMS not to expand the authority of nurse practitioners or other non-physicians to supervise non-physician practitioners performing diagnostic procedures. Nurse practitioners do not have the education and training to perform all diagnostic procedures, as broadly defined in the rule, or to provide clinical supervision for non-physician practitioners performing diagnostic procedures. Granting this broad expansion of scope of practice will cause confusion and harm patients who will have difficulty determining whether a nurse practitioner performing and supervising diagnostic procedures actually has the education and training to provide that care.

We fully concur with the detailed comments submitted by the AMA on the scope of practice issues.

We thank you for the opportunity to comment on the proposed rule. If you have any questions or need additional information, the CMA contact is Elizabeth McNeil, Vice President, Federal Government Relations, at emcneil@cmadocs.org or 415 310 2877.

Sincerely,

Peter N. Bretan, Jr, MD
President