September 10, 2018

Seema Verma, Administrator
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Quality Payment Program; Federal Register July 27, 2018 (83 Fed. Reg. 35704); CMS 1693-P;

Dear Administrator Verma:

On behalf of the more than 43,000 physician and medical student members of the California Medical Association (CMA), I would like to thank you for the opportunity to provide comments on the proposed 2019 Medicare Physician Fee Schedule and the Quality Payment Program.

CMA appreciates CMS’ proposal to reduce the Evaluation and Management (E&M) documentation requirements so that physicians can devote more time to their patients and we urge its immediate adoption.

However, the CMA is strongly opposed to the proposal to restructure payment and coding for E&M office visits. It would result in significant payment cuts that would harm physicians in specialties that treat the sickest patients, as well as those who provide comprehensive primary care. It jeopardizes access to care for the chronically ill and patients with complex conditions. We are also opposed to the payment cut for multiple services provided on the same day as it has already been factored into prior RVU valuations via the RUC process. Therefore, we urge CMS to withdraw both of these proposals and work with the CMA and the AMA work group of practicing physicians who have expertise in valuing codes, to develop alternative solutions to update and simplify payment for cognitive services while reducing documentation burdens.

The California Medical Association fully supports the comments submitted by the AMA. We are providing additional comments to emphasize the priorities of California physicians. A summary of our recommendations are listed below.
**Physician Fee Schedule Comments**

**Year 3 California Geographic Payment Updates and Transition to MSAs: Support**

In 2017, CMS began the six-year transition to fully updated and accurate geographic payments in California pursuant to the “Protecting Access to Medicare Act of 2014” (PAMA). CMS implemented the new Metropolitan Statistical Area (MSA) payment localities and aligned the Medicare Part A and Part B regions. CY 2019 will be the third year of the implementation. Our physician analysts, Edward Bentley, MD and Larry DeGhetaldi, MD, have reviewed and verified the implementation methodology and calculations and we want to thank CMS for the thorough work to implement the changes. CMA continues to strongly support the implementation plan. For the first time in decades, California physicians will be paid more accurately based on their local costs to provide care as full implementation continues. This important reform will help to maintain access to care in the impacted California regions.

**New Payments for Technology-Based and Telehealth Services: Support**

CMA strongly supports the proposed payments for technology-enabled virtual care services, such as virtual check-ins, remote consults of patient videos and photographs, on-line consultations with other physicians, and chronic care remote physiologic monitoring and management codes. We also applaud the expansion of coverage for telehealth services and removing limitations relating to geography and patient setting, including for end-stage renal disease home dialysis evaluation.

**Evaluation and Management (E&M) Documentation Reduction: Support**

CMA greatly appreciates the proposed reduction in documentation requirements for E&M services. The proposal will streamline documentation, improve overall physician workflow, and reduce the “note bloat” that makes it difficult to locate the most pertinent medical information in patient medical records. Specifically, CMA supports

- Allowing the required documentation to focus only on the interval history and physical exam since the patient’s last visit.
- Eliminating the requirement for physicians to re-document information regarding chief complaint and history that has already been recorded in the patient’s medical record by practice staff or the patient.
- Removing the requirement to justify a home visit versus an office visit.

CMA urges immediate 2019 adoption of this proposal. We do not believe, however, that revisions made to the E&M documentation guidelines should result in a revaluation of the entire E&M coding and payment system.
New Evaluation and Management (E&M) Payment Structure: Oppose
CMA strongly opposes the proposed collapse of the E&M office visit codes from eight to two for both new and established patients. According to a detailed analysis by the AMA (see attached), this change would result in significant payment cuts of 4-20% that would harm physicians in specialties that treat the sickest patients, as well as those who provide comprehensive primary care. It jeopardizes access to care for the chronically ill and patients with complex conditions – those most in need of comprehensive care management. Even with the proposed add-on payments for primary care, designated specialties, and prolonged visit services, most California physicians report to CMA that they will still experience inappropriate payment cuts and potentially, increased documentation burdens. Valuing the services provided to more complex patients the same as those provided to much less complex patients is fundamentally flawed and inconsistent with the Resource-Based Relative Value Scale foundation of the Physician Fee Schedule.

Most California physicians are seeing an increase in an aging patient population with multiple chronic conditions. In some California counties, Medicare-Medicaid dual eligible patients represent 30-40% of the total Medicare population. Under this proposal, physicians will not be incentivized to treat complex, costly patients. Many physicians will stop participating in Medicare altogether and access to care will suffer for the millions of California seniors.

For the last two decades, Medicare payments have failed to keep pace with the rising costs to operate a medical practice. Measured in real dollars, Medicare physician payments have decreased by 25% since 2001. These declining payments have forced many physicians to reduce the number of Medicare patients they can accept. The E&M restructuring proposal will exacerbate physicians’ ability to appropriately care for their patients.

Moreover, while CMS has given relatively favorable value to the collapsed initial and follow-up codes, we are concerned that private payers will adopt the coding changes without commensurate valuation.

CMA strongly recommends that CMS not finalize the E&M payment proposal but work with the state and national physician organizations through the AMA work group to develop alternative solutions.
Multiple Procedure Payment Reduction (MPPR): Oppose
CMA opposes the proposed multiple procedure payment reduction. This proposal would reduce payments for E&M services billed with CPT modifier 25 when reported with a minor surgical procedure. Allowing physicians to be paid fully for unscheduled, same-day, medically necessary care, modifier 25 supports prompt diagnosis and streamlined treatment – which in turn promotes efficient, high-quality, and patient-centric care. This proposal represents a substantial pay cut (up to 70%) for physicians in California across all medical specialties. It also places an added burden on patients by forcing them to schedule multiple visits, with additional copayments, to receive necessary care. And finally, this proposal is inappropriate because overlapping elements of physician work and practice expenses have already been eliminated from CPT codes typically reported together by the RUC’s practice expense committee. These issues have already been factored into prior valuations of the impacted codes. The CMS proposal would result in duplicative reductions.

Reimbursement Reduction for New Drugs Administered in Physician Offices: Oppose
CMA opposes the proposal to reduce Medicare reimbursement for new drugs from Wholesale Acquisition Cost (WAC) + 6% to WAC + 3%. The current formula misrepresents prices available to small physician practices and therefore, distorts the overall costs. This is a significant payment reduction that would limit the use of new medications in physician offices and reduce access to new and innovative therapies that are more effective and less debilitating than existing drugs. Many physicians will not be able to afford to administer these medications in their offices, shifting patients to outpatient hospital facilities where costs are much higher.

Reporting Expansion for Physician Office Labs: Oppose
CMA opposes the expansion of the number of physician office labs required to report payment data as part of the clinical lab fee schedule calculations. The Office of Inspector General (OIG) has already determined that this data will not alter the payment amounts, and it will impose substantial regulatory burdens on physician offices. As part of the “Patients Over Paperwork” initiative, we urge CMS to rescind this requirement. It is extremely costly, time-consuming and burdensome for physician practices.

Eliminating Extra Documentation Requirements for Home Visits: Support
CMA supports the proposal to reduce the required documentation related to providing home-based care and we appreciate CMS recognizing this issue as a challenge for physicians who are working to provide the best care for their patients in the most appropriate setting.
Eliminating the prohibition on billing for same-day visits by physicians in the same group or medical specialty: Support
CMA strongly supports elimination of this unnecessary burden for both physicians and patients. This important reform would allow physicians or a group of physicians to more appropriately serve the patient’s needs at a time that works best for the patient – rather than requiring a patient return to the office on a different day.

MACRA Quality Payment Program (QPP) Comments

CMA Urges CMS to Further Reduce the Number of Measures and Simplify the Program
Overall, CMA was extremely disappointed that CMS did not reduce the reporting burdens in the MIPS program in a more meaningful way. We certainly appreciate the reductions in the EHR-Promoting Interoperability Category process measures but we would like to request simple Yes/No attestations for the entire category. We oppose the confusing new scoring tiers (gold, silver and bronze) and urge CMS to simplify and overhaul the complex MIPS scoring system consistent with the AMA recommendations. Specifically, we urge CMS to:

- **Significantly reduce the number of Quality measures;** restore the topped-out quality measures to give physicians a sufficient number of measures to report; reduce the threshold on patients from 60-50%; and only require 90 days of reporting.
- **Eliminate the requirement for physicians to report all-payer data.**
- **Only require Yes/No attestations in the EHR Promoting Interoperability Category** and allow physicians to choose from a larger menu of measures applicable to their practice.
- **Enforce EHR vendor interoperability and accountability;** require vendors, not physicians, to report on CEHRT functionality and to bear the costs for interoperability updates.
- **Restore the Small Practice Bonus to the overall MIPS score** – do not restrict the bonus to the Quality category.
- **Reduce the barriers to participation in virtual groups.**

Retention of the complex patient bonus: Support
CMA appreciates CMS’ maintaining the complex patient bonus. This is crucial for protecting access to care by ensuring that physicians are incentivized to treat chronically ill, complex patients, such as Medicare-Medicaid dual eligible patients.

Creation of Sub-Groups: Support with Amendments
CMS is asking for feedback on creating sub-group options for reporting. The CMA has consistently requested that large medical groups be provided the option to report through their
sub-tax ID numbers based on the Medicare physician fee schedule are or the hospital payment area in which they provide services. Currently, CMS only allows physicians to report individually or as a group through one TIN. However, many California medical groups are large and provide care across several Medicare geographic payment regions with substantially different practice costs and payment rates. These medical groups have requested the option to report to CMS through their sub-tax ID numbers. We urge CMS to provide such an option.

**Cost Category Weight Increased from 10% to 15%: Oppose; Retain at 10%**
CMA strongly urges CMS to maintain the 10 percent weight of the cost category. Vast methodology improvements should be made to the cost category before its weighting is increased. Otherwise, physicians will be disincented from treating the sickest and most vulnerable patients and access to care will be jeopardized. We urge CMS to make adjustments for the following: 1) physician expenditure comparisons should be made at the subspecialty level; 2) geographic costs should be factored-in to account for physicians practicing in high cost areas; and 3) socioeconomic status of the patient, including race, ethnicity, income, previous insurance coverage, and other social determinants of health. In addition, the total per capita cost and the Medicare spending per beneficiary (MSPB) measures for individual physicians should be removed until better measures are developed. However, we support the transition to episode-based cost measures that have been appropriately tested. We also request a delay in the new attribution methods for the inpatient condition measures. And finally, high-performing physicians within 1-2 standard deviations of the national average should be rewarded and the all-or-nothing criteria removed.

**Expansion of the MIPS Quality Payment Program (QPP) Low-volume Exemption.**
*Establishing a voluntary exemption for small practices that want to participate and be eligible for bonuses: Support*
CMA specifically supports CMS’ proposal to allow small practices that want to participate in MIPS on a voluntary basis to do so. From 2019-2024, physicians will not be provided an automatic Medicare fee schedule payment update, and therefore, many practices may want to participate in the MIPS bonus pool.

**Alternative Payment Models (APMs): Support Additional Physician-Led Models**
The CMA continues to strongly urge CMS to expand the number and types of innovative physician-led alternative payment models and to remove the current administrative and financial barriers to participation. We also urge CMS to approve the numerous physician payment models that have been recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). And finally, we urge CMS to provide more accurate and timely data to physicians with improved risk-adjustment and benchmarking methods, lower
financial risk requirements and consideration of start-up costs. CMA supports the proposal to maintain the revenue-based financial risk requirement at no more than 8% of total revenue for an additional four years.

California physicians have been innovators in health care delivery and we cannot emphasize more strongly the need to move forward with more innovative physician-led models. APMs can address the shortcomings of a fee-for-service system that fails to incentivize high value services, such as chronic care case management or palliative care – services that reduce spending and improve care.

**Future Physician Participation in the QPP**

CMA has heard from numerous physicians across the state, in all specialties, from solo practice to large sophisticated medical groups, who made substantial investments in order to participate in the MIPS program. Most of these physicians received high to perfect performance scores for 2017 but have now been told by CMS that they will only receive a 0.2-0.3% bonus for 2017 – if they receive a bonus at all. Physicians are extremely frustrated with the program right now. We understand that CMS is not responsible for the budget neutrality requirements of MACRA but CMS needs to be aware that the limited return on investment has discouraged many physicians to the point of withdrawing from MIPS and Medicare altogether. Moreover, the Alternative Payment Models are so limited that these physicians cannot participate in the APM track either. Physicians are left without sustainable payment options and few resources to improve the quality of care. We urge CMS to seriously consider these issues and work with CMA and AMA to address them.

We thank you for the opportunity to comment on the proposed rule. Detailed AMA comments are attached. We look forward to working with you as partners to address these important issues and improve the Medicare program for physicians and their patients. The CMA contact is Elizabeth McNeil, Vice President, Federal Government Relations at emcneil@cmadocs.net.

Sincerely,

Theodore M. Mazer, MD
President