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The Honorable Mariannette Miller-Meeks, MD
U.S. House of Representatives
1716 Longworth House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
U.S. House of Representatives
2202 Longworth House Office Building
Washington, DC 20515

The Honorable Mike Kelly
U.S. House of Representatives
1707 Rayburn House Office Building
Washington, DC 20515

Dear Representatives Miller-Meeks, Kelly, and Griffith:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide the following comments to questions posed by the Healthy Future Task Force Modernization Subcommittee. The AMA strongly supports Congressional efforts to ensure that Medicare beneficiaries have access to telehealth services and that the health care system is appropriately incorporating innovative digital technologies that have the potential to address patients' health needs while supporting physicians' work.

WEARABLE TECHNOLOGIES

The explosive growth of smartphone use, wearable fitness devices, and the ease by which apps can be built and integrated into the phones has made both receiving data and inputting data a norm in many consumers' daily habits. Users have grown accustomed to having the world at their fingertips via their phone. More and more, that world includes health-related data. As part of the recently rolled-out rules implementing the 21st Century Cures Act (Cures), patients also now have the right to access their own electronic health records (EHR) directly from their physician's EHR system in a form convenient for patients.

In today's environment—where bank accounts, work benefits, and utilities records can be accessed via smartphone in seconds—users want and expect their health information to be just as convenient and safe to access. Consumers are also using apps to aid in tracking their own health, from blood pressure to weight and mood. Because patients now expect health care facilities to protect their data as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which is further defined below, app users may assume that much of the health information collected and stored in apps will be kept private. However, in reality, most of the apps they are using are not subject to the same kinds of health privacy regulations as those that cover physician and health insurance company systems. The rules around what app and technology developers can do with that information are minimal and not well-defined.

When HIPAA came to be, the various kinds of electronic devices and applications that could be used to gather and house health information were limited and the future direction of such technology was not yet

anticipated. Today, some patients incorrectly believe that all health information is protected from disclosure by HIPAA. However, only information collected by covered entities (such as clinicians and health plans) is subject to HIPAA rules requiring privacy and security safeguards. While subsequent legislation (such as the California Consumer Privacy Act) has attempted to address some patient privacy concerns, more comprehensive data privacy rules have not been implemented at the federal level. In sum, while covered entities have obligations under HIPAA related to privacy and security of protected health information, there are many non-covered entities that collect and transmit that same data without restriction or specific requirements to protect it.

Physicians have an obligation—and a desire—to help their patients maintain privacy of their health data and are wary of personally recommending apps or devices that may seek to exploit their patient’s privacy. Clinicians look to trusted sources using guidelines specifically developed by their profession and seek to recommend apps that follow that guidance, such as the App Advisor from the American Psychiatric Association. For our part, in 2020 the AMA published a set of privacy principles, which build on long standing AMA policy developed by the physician members of its House of Delegates, to help guide the digital health information industry and regulators. The [AMA’s “Privacy Principles”](#) were born from the idea that third parties accessing an individual’s data should act as responsible stewards of that information. In addition, the AMA has developed [Privacy is Good Business: A case for privacy by design in app development](#), seeking to help developers and implementers of mobile health apps put the Privacy Principles into action—strengthening patient and physician trust in those apps.

Attestation Framework to Enhance Transparency for Health App Users

As the industry gets closer to building longitudinal health records from a variety of disparate sources, policymakers continue to face challenges in how to best balance access with privacy. Undoubtedly, both patients and clinicians are aware of the importance of an accurate, usable, and complete medical record for care coordination. The AMA supports this goal, as well as the principle that patients should be able to easily access their medical record. We are concerned, however, about the continued lack of safeguards from the Office of the National Coordinator for Health Information Technology (ONC) to ensure that patients understand what they are consenting to when they grant permission to an app to access their health information. We also believe that ONC has failed to appropriately embed the privacy protections Congress envisioned in Cures in the agency’s implementing regulations.

The issue of transparency is critical because health care is built on trust and informed consent. Information flows at the speed of trust; the loss of trust will ultimately stall information exchange. We are very concerned data misuse will impact the trust between a patient and physician—negating any advances in data access and exchange gained by these proposals. We are all aware of recent articles that have exposed mobile apps, Facebook, and Google [harvesting](#), exchanging, and selling individuals’ personal information without their meaningful consent or in violation of a stated privacy policy. A recent [Morning Consultant national survey](#) showed that 94 percent of people feel privacy and security of their medical information is important. Additionally:

- Studies reported in the [BMJ](#) and [JAMA](#) have demonstrated that most apps do not share privacy policies with patients, and when they do, sometimes do not adhere to them;
- The [Washington Post](#) reported that a workplace wellness pregnancy-tracking app reports data to a woman’s employer, including the woman’s average age, number of children and current

trimester; the average time it took her to get pregnant; whether the pregnancy is high-risk, conceived after a stretch of infertility, a C-section or premature birth; and her return-to-work timing. The app's privacy notice is 6,000 words; and

- ProPublica and NPR [report](#) that insurers gather data from unknowing patients' medical devices to make coverage decisions.

Due to these types of privacy concerns, patient trust is already on the decline with [87 percent](#) of patients unwilling to share their complete medical information with their physician. While ONC's regulations have not caused this issue, they will increase the volume and velocity of data and further complicate data access and sharing rights and responsibilities—making data a tantalizing commodity while dramatically impacting patients' trust in the nation's health care system. Furthermore, an individual's health information often includes information about the individual's family history, resulting in the exposed information of multiple individuals. Additionally, HIPAA does not cover health data shared with apps and app developers, so there are almost no restrictions on how data can be used, disclosed, and sold.

Some stakeholders believe requiring a minimum level of privacy controls for patients is “paternalistic.” This characterization is perplexing given that patient privacy is a fundamental aspect of Cures, necessary for patients to safeguard themselves from data profiteering and discrimination, and promoted by the AMA *Code of Medical Ethics* and policy of our House of Delegates, which includes representation from state and territorial medical associations, national medical specialty societies, and the federal government. As you are aware, one of the purposes of Cures is to provide individuals with access to their health information without special effort. Most consumers would probably characterize multiple pages' worth of privacy practices, which may or may not be transparent, as requiring special effort. So why does the agency charged with implementing Cures dismiss concern over patient privacy with a “buyer beware” mentality? It is alarming that ONC appears to view its charge as merely providing access to data, and not meaningfully empowering the patient as the spirit of Cures intended.

ONC should create commonsense policies that give patients information about what apps do with the health data they receive. To help provide a minimal amount of transparency to patients about how a health app will use their health information, ONC should implement a basic privacy framework requiring certified EHR vendor APIs to check an app's “yes/no” attestations to:

- (1) *Industry-recognized development guidance* (e.g., [Xcertia's Privacy Guidelines/Privacy Is Good Business: a case for privacy by design in app development](#));
- (2) *transparency statements and best practices* (e.g., [Mobile Health App Developers: FTC Best Practices/CARIN Alliance Code of Conduct/AMA Privacy Principles](#)); and
- (3) *a model notice to patients* (e.g., [ONC's Model Privacy Notice](#)).

This is not regulation of apps and does not extend beyond ONC's authority; ONC would be implementing a new requirement for EHR Certification—an area clearly within ONC jurisdiction. Requiring an EHR's API to check for an app developer attestation would not be a significant burden on EHR vendors (which develop APIs) and apps would not be prevented from connecting to an EHR even if they attest “no” to the three checks. Accordingly, this framework is low-touch for EHR and app developers and does not require special effort by patients, yet it would provide some level of transparency to patients and physicians.

Furthermore, this framework would complement ongoing federal activity in this space: it would serve to assist the FTC in the event of an investigation or enforcement action of deceptive or unfair trade practices if the app strays from what it tells consumers. Additionally, CMS [requires payers](#) to provide educational resources on privacy and security to their beneficiaries accessing health information through APIs. Multiple “best practices” resources both allow and encourage questions about how an app will handle the individual’s data, and CMS specifically permits payers to implement an app attestation framework as noted on page three of its [“Best Practices for Payers and App Developers.”](#) These requirements are in addition to the curation of apps CMS selects for its Blue Button 2.0 initiative, each of which must meet privacy and security standards to be listed online. Implementing an ONC privacy framework would provide patients with tools to choose apps that align with their own privacy values that regardless of whether they seek health information from their payer or their clinician.

Groups representing app developers, past ONC Coordinators, patients, and HHS’ Healthcare Sector Coordinating Council have all recommended creating a privacy framework to accompany ONC’s regulation. Such a framework would help apps to establish a practice of transparency as Congress works on federal privacy legislation. Congress should direct ONC to immediately amend its information blocking regulations to require an attestation framework. It is possible to empower access while promoting privacy and transparency—we owe it to patients to give them both.

TELEMEDICINE EXPANSION

The AMA believes that telehealth is a critical part of the future of effective, efficient, and equitable delivery of health care in the United States. Efforts must continue to build capacity and support access to care centered on where the patient is located to the greatest extent it is clinically efficacious and cost-effective, and to ensure physicians and other health professionals have the tools to optimize care delivery. The AMA has been a leader in advocating for expanded access to telehealth services for Americans because it believes that it has the capacity to improve access to care for many underserved populations and improve outcomes for at-risk patients, such as those with chronic disease and impairments.

Telehealth usage has expanded tremendously during the COVID-19 pandemic, helping Americans access health care services while maintaining physical distancing and reducing strain on hospitals and physician clinics. With this expansion of services has come recognition from patients, physicians, and others that telehealth services can be deployed to offer effective and convenient health care in many circumstances. Congress must act now to ensure that Medicare patients can continue to access telehealth services from wherever they are located after the pandemic ends by modernizing the Social Security Act to keep pace with our digital future.

CMS Flexibilities During the COVID-19 Pandemic Should be Made Permanent

Under section 1834(m) of the Social Security Act (SSA), Medicare is prohibited from covering and paying for telehealth services delivered via two-way audio-visual technology unless care is provided at an eligible site in a rural area.¹ This means that, in order to access telehealth services, patients must live in an eligible rural location, and must also travel to an eligible “originating site”—a qualified health care facility—to receive telehealth services, except in limited select cases where Congress has authorized

¹ Special Payment Rules for Particular Items and Services, 42 U.S.C. § 1395m(m), https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

provision of telehealth services in the home of an individual.² As a result, the 1834(m) restrictions bar the majority of Medicare beneficiaries from using widely available two-way audio-visual technologies to access covered telehealth services unless they live in a rural area, and with a few exceptions, even those in rural areas must travel to an eligible health care site.

Two-way audiovisual technology is the only communication modality on which Medicare places such a prohibition. Other communication technologies, including remote patient monitoring, do not meet the definition of a telehealth technology and services furnished via these technologies are not subject to the 1834(m) geographic and originating site restrictions and go through regular Medicare coverage and payment processes.

While these restrictions may have made sense given the limited technologies available when they were first instituted in the Balanced Budget Act of 1997,³ two-way audiovisual technology has become much more widely available and less expensive than it used to be.

In response to the COVID-19 public health emergency (PHE), Congress passed the CARES Act, which, among other things, provided the Centers for Medicare and Medicaid Services (CMS) the authority to waive the geographic origination requirement for the duration of the COVID-19 PHE, which CMS subsequently did.⁴ Telehealth usage among Medicare beneficiaries has since surged as patients could, for the first time, access telehealth services from wherever they are located, including their home, regardless of where they reside in the country. The AMA remains deeply grateful for these flexibilities, which have allowed Medicare patients across the country to receive care from their homes. With many physician offices closed, elective procedures postponed, and patients as well as many physicians, other health professionals, and practice staff required to stay at home for a long period of time, the ability to provide services directly to patients regardless of where they are located via telehealth has allowed many vital health care services to continue throughout the PHE. In addition to facilitating continuity of care for patients being treated for acute and chronic conditions, telehealth has also facilitated initial assessment of patients experiencing potential COVID-19 symptoms and those who have been in close contact with people diagnosed with COVID-19 to determine if referrals for testing or treatment are indicated while minimizing risks to patients, practice staff, and others.

However, without intervention from Congress, Americans that have come to rely on telehealth services during the PHE will abruptly lose access to these services. Congress must act now to remove the origination and geographic restrictions on telehealth coverage for Medicare patients. Continued access to telehealth services beyond the PHE is critical for patient populations that have come to rely on its availability.

The PHE Has Demonstrated the Value of Telehealth

The success of telehealth technology adoption during the COVID-19 public health emergency has made it abundantly clear that geographic and origination restrictions on accessing telehealth services are outdated

² For example, substance abuse disorder treatment delivered via telehealth is explicitly exempted from the geographic and origination restrictions.

³ Pub. L. No. 105-33, 111 STAT. 251, (1997).

⁴ Coronavirus, Relief, and Economic Security (CARES) Act, Pub L. No. 116-136, 134 Stat. 281 (2020), <https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf>.

and arbitrary given today's technology that allows for access to digital tools from anywhere. Physicians and patients have seen the value of telehealth services and should not be forced to stop using these tools when the PHE ends. Some have argued that statutory changes cannot be made without additional data on how telehealth services are used, however, this has the problem backwards. More data are not necessary to determine that the underlying policy needs to be permanent, but instead can help CMS determine which services ought to be covered permanently when provided via telehealth or not. In the meantime, the certainty that appropriate telehealth services will be covered would provide physicians confidence in investing in new technology and give patients peace of mind that they can continue to access the services in a way that works best for them.

The rapid and widespread adoption of telehealth by physicians during the PHE was one of the most significant improvements in health care delivery in decades. The new telehealth coverage and payment policies enabled physicians to deliver valuable services they previously could not afford to provide but that their patients needed. With legislative provisions such as the establishment of the CMS Innovation Center and Medicare's Quality Payment Program, Congress has sought for many years to support physician adoption of innovations in the delivery of care. The rapid and successful adoption of telehealth throughout the country demonstrated that, if the financial barriers are removed, physicians will adopt important innovations in the delivery of care that are necessary to improve their patients' health.

Telehealth technologies allow physicians to increase continuity of care, extend access beyond normal clinic hours, and help overcome clinician shortages, including those affecting rural and other underserved populations. This ultimately helps physician practices focus more on chronic disease management, enhance patient wellness, improve efficiency, provide higher quality of care, and increase patient satisfaction. Telehealth has helped increase physician/patient communication and trust. It also allows access to real-time information related to a patient's social determinants of health (i.e., physical living environment, economic stability, or food insecurity), which can lead to better health outcomes and improve health equity.

Telehealth services can also help patients avoid delaying care that can lead to expensive emergency department visits and hospitalizations. They cut down on trips to the office that may be difficult or risky for patients with functional or mobility impairments, frail elderly who need a caregiver to accompany them, and patients who are immunocompromised or vulnerable to infection. Providing access to telehealth services creates greater safety and efficiencies for both patients and physicians, delivering value to the Medicare program.

It is critical that access to telehealth services continues beyond the PHE. Besides their use to manage care for patients with respiratory and other symptoms that could reflect COVID-19, telehealth is being used for: patients with a variety of symptoms and acute and chronic conditions that can be evaluated and managed remotely; those who need hospice or palliative care; following up after surgery center, hospital, and emergency department services; behavioral health and substance use treatment; and pain management. Provision of telehealth services to patients in their home or other location is a huge advantage for patients with mobility or functional impairments or other problems that make travel difficult, and it is preferable for immunocompromised patients and those with communicable diseases. It allows physicians to see patients who have functional impairments in their usual living environment, instead of examining them after what may have been an arduous and stressful travel experience to obtain in-person care. In addition, it allows physicians to see patients with sporadic symptoms when these

symptoms occur and improves care for conditions where seeing the patient's living environment can inform treatment plans. Telehealth also facilitates team-based care by allowing other physicians, health professionals, caregivers, and family members to join patient visits from their own location.

Physician practices are ready to invest in the technology required to provide these services; however, it will be very difficult to invest in incorporating delivery of telehealth services into their workflows if the coverage is only temporary and its future uncertain. The removal of coverage and financial barriers has allowed the explosive growth in telehealth and certainty about future coverage is necessary for it to continue. It has allowed CMS to make more informed decisions about which services to cover, and, in fact, CMS has expanded coverage of telehealth services greatly during the PHE.⁵ While more data behind current telehealth usage trends may be valuable to gather evidence about which particular Current Procedural Terminology[®] (CPT[®]) codes need to stay on the Medicare telehealth list, that is a much different concern than whether nationwide coverage and ability to deliver care to patients wherever they are located should be available, and such determinations are appropriately made by CMS.

The data that have been collected thus far have reinforced that telehealth services are a vital tool in providing flexible and effective care to patients. The AMA has participated in several research studies to better understand how the wide availability of telehealth services during COVID-19 is affecting medical practice and patient care. This research is described in materials submitted to the [Agency for Healthcare Quality and Research](#) (AHRQ) Center for Evidence and Practice Improvement in July 2021 in response to its key questions on utilization and effectiveness of telehealth services during the pandemic. The AMA collaborated with other organizations on surveys of patients and physicians conducted by The Telehealth Initiative and in the COVID-19 Health Coalition Telehealth Impact Study. The AMA also partnered with Manatt Health on research to develop a "[Return on Health](#)" framework. The Return on Health research goes beyond examining telehealth services in isolation to articulate the value of digitally enabled care that combines virtual and in-person services to increase overall health and generate positive impacts for patients, physicians, payers, and society.

CMS Already Makes Coverage Determinations on Telehealth Services

CMS currently has all the tools necessary at its disposal to make determinations about which telehealth services it should cover. For the duration of the COVID-19 PHE, CMS has added many services to the list that Medicare pays for when they are provided via telehealth. The newly covered services include emergency department visits, observation care, hospital and nursing facility admission and discharge services, critical care, and home care, as well as services like ventilator management that have been especially necessary for COVID-19 patients. The interim services have greatly assisted physicians during the PHE when both patients and health professionals needed to maintain physical distance from others as much as possible. Through telehealth communications, for example, an emergency physician, potentially assisted by members of the patient's household, can diagnose, and treat emergency conditions without sick patients having to endure difficult travel and expose themselves and others to SARS-CoV-2 and other dangers. In all, CMS added interim Medicare coverage for more than 150 services during the COVID-19 PHE. The agency has now extended the interim coverage for many of these services through 2023 to allow time to help gather more evidence of how the services are used when provided via telehealth outside the context of a pandemic.

⁵ Medicare Physician Fee Schedule 2021, 85 Fed. Reg. 84,472 (Dec. 28, 2020), <https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf>.

The only thing holding CMS back from expanding access to appropriate telehealth services to its beneficiaries are the outdated restrictions currently in the statute.

Telehealth Helps Provide Access to Health Care to Underserved Communities

Access to telehealth services can help reduce inequalities in care for underserved communities by providing access to services for patients regardless of where they are located. Patients in rural areas or underserved urban communities often have to travel long distances to access care, especially specialty services including emergency and critical care. Telehealth also can help eliminate commutes to physician offices for those with mobility or transportation difficulties.

In conjunction with expanded access to telehealth services, the AMA supports Congressional efforts to expand high-speed broadband internet access to underserved communities. Patients cannot take advantage of telehealth services if they do not have the requisite internet connection to access them. Solving this requires enhanced funding for broadband internet infrastructure in rural areas and support for underserved urban communities and households to gain access to affordable internet access.

Concerns About Fraud and Abuse and Overutilization Are Misplaced

Some have raised concerns that expanded coverage of telehealth services could lead to greater fraud and abuse or duplication of medical services. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication are of particular concern for telehealth services. Therefore, Congress should not create artificial barriers to telehealth by defining an established doctor-patient relationship inconsistently with the standard of care or otherwise creating unique and burdensome fraud and abuse requirements that would stifle access to telehealth services.

CMS and the Office of Inspector General (OIG) at HHS already have sufficient Medicare coverage and payment and fraud and abuse authorities to monitor telehealth service compliance just as they do other Medicare services. Additional restrictions do not currently apply under the Medicare Advantage, the Center for Medicare and Medicaid Innovation, section 1116 waiver authorities, the existing Medicare telehealth coverage authority, or other technologies such as phone, text, or remote patient monitoring.

Data analyses since the start of the PHE show that fears of overutilization are overblown. For example, AMA analyses of Medicare claims data from 2020 through the first half of 2021 show that only 3 to 4 percent of telehealth spending is for new patient office visits. Moreover, nothing in the data or anecdotal evidence suggests that telehealth services have been duplicative of in person services rather than being used as an alternative or in addition to in person care. The AMA will continue to monitor and analyze the data as it becomes available, but this suggests that there is no reason to think better access to telehealth will lead to an explosion in unnecessary services.

As a result, Congress should refrain from imposing new and discriminatory restrictions on the use of audio-visual communications technologies, such as restrictions on how a physician-patient relationship can be established. AMA policy, established in 2014, states that a valid physician-patient relationship may be established virtually face-to-face via real-time audio and video technology, if appropriate for the

service being furnished.⁶ It also allows for the relationship to be established in a variety of other ways such as meeting standards of care set by a major specialty society. All 50 states and the territories allow a physician-patient relationship to be established virtually or through other means. The exact parameters vary by state; however, many state laws are based on an AMA model law. Congress should not impose a one-size-fits-all requirement on services furnished via telehealth technology that are in direct conflict with standards of care and that do not exist for other technologies.

Gains made in access to telehealth will be greatly hampered if unique and arbitrary barriers are erected around the use of telehealth services. Such barriers will have dramatic and negative impacts on patients seeking care.

States Must Continue to Play a Central Role in Licensing Physicians

State medical boards play a pivotal role in protecting the safety of patients through physician licensure, regulations, and disciplinary action. At the start of the COVID-19 pandemic, there was some concern that state licensing requirements would limit physicians' ability to quickly move into those areas hardest hit by COVID-19 and meet the workforce demands on the ground and via telehealth. In response to this concern, the states acted quickly to temporarily allow physicians to practice across state lines by waiving licensure or creating a streamlined licensure or registration processes in response to the COVID-19 emergency.

The AMA believes that it is essential to ensure that physicians and other health care providers are licensed in the state where the patient is located to provide telemedicine services in a secure environment. The AMA opposes proposals that would change which state is responsible for overseeing the physician from the state where the patient is located to the state where the physician is located. Proposals to change which state is responsible for overseeing the physician from the state where the patient is located to the physician's home state would likewise change which state's medical practice and scope laws apply to the care rendered. Such proposals would interfere with states' investigative and disciplinary authorities and also raise enforcement concerns since states are generally unable to investigate incidents that happen in another state. Similarly, states cannot take action against the license of a physician in another state. This is inconsistent with AMA policy.

Instead, AMA believes efforts should be made to increase membership in the Interstate Medical Licensure Compact (IMLC), a one stop shop for physicians who are in good standing with their state medical boards to seek a license to practice in multiple jurisdictions in an expedited process. In 2017, the IMLC established a faster pathway to licensure for qualifying physicians seeking to practice in multiple states. By 2021, 33 states, the District of Columbia and the Territory of Guam had become members of the Compact, with IMLC authorizing legislation pending in several other states. More than 21,000 licenses have been issued by the IMLC although physicians practicing in non-Compact states are unable to apply for expedited licenses through the Compact. Ultimately, the IMLC maintains state-based licensure and the ability of state medical boards to protect the safety of patients, while allowing for greater sharing of information between states and expediting the licensure process for physicians who want to move between states or practice in more than one jurisdiction.

⁶ American Medical Association, H-480.496: Coverage of and Payment for Telemedicine, <https://policysearch.ama-assn.org/policyfinder/detail/telemedicine?uri=%2FAMADoc%2FHOD.xml-0-4347.xml> (last modified, 2019).

Artificial Intelligence in Health Care

The AMA appreciates that the Subcommittee takes the importance of payment for AI seriously and is actively engaged in gathering information from stakeholders to better understand its impact on the future of health care. The AMA recognizes that considerations around AI delivery are complex and not always adequately understood. For example, applications may change our very understanding of “work done by machines” in complicated ways. At the same time AI applications offer medical advancements and innovation to serve as an additional tool in the overall toolkit of physicians and other health care professionals to improve patient care and outcomes. AI is transforming quality, efficiency, accessibility, and patient, as well as physician, experience within the health care system. It is gaining traction in everyday practice and physicians should be compensated appropriately for the expense of applying AI to enhance patient care.

The AMA believes that, when designed appropriately, AI tools can help increase access to health care and improve health equity. AMA policy supports the development of thoughtfully designed, high-quality, clinically validated health care AI that:

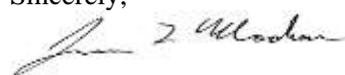
- is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
- is transparent;
- conforms to leading standards for reproducibility;
- identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
- safeguards patients’ and other individuals’ privacy interests and preserves the security and integrity of personal information.⁷

When developed with these principles in mind and incorporated into clinical practice appropriately, we believe that innovative technology including products incorporating AI can help improve quality of care and increase health equity.

However, we note that many of these products are novel and not yet in widespread use so their impact on quality of care or health equity is not yet entirely clear. While we believe these products can be used to provide higher quality of care to a greater number of patients, we strongly support CMS and other regulators interest in gathering the data necessary to calculate the performance and impact of innovative technology moving forward. Given that the approaches to design and implementation, as well as the underlying data provenance, will vary by necessity, it will be important to gather additional evidence on the development and impact of the use of specific technologies.

Thank you for your consideration of our comments.

Sincerely,



James L. Madara, MD

⁷ <https://www.ama-assn.org/system/files/2019-01/augmented-intelligence-policy-report.pdf>