AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable James Comer
Ranking Member
House Committee on Oversight and Reform
2157 House Office Building
Washington, DC 20515

Dear Ranking Member Comer:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on your examination of recent trends in regulation and regulatory reform. The AMA and its physician members across the nation are grateful for steps Congress has taken to address many of their most significant concerns, whether as frontline COVID-19 caregivers or as community-based providers. However, the pandemic's impact has been both broad and deep and, as you are aware, additional support will be needed to meet the nation's health care needs as physician practices plan for a successful transition back to full operation.

Outlined below is a comprehensive analysis of regulations and regulatory programs impacting our members and their patients, and recommendations on improvements that can be made. We are ready and able to provide further information or to develop solutions as Congress works toward the same goal and believe the efforts of the House Committee on Oversight and Reform will be vital to the process.

Permanent Expansion of Telehealth Services under Medicare

The AMA strongly supports the goals to increase access to services delivered through telecommunications technology, increase access to testing and services in a patient's home, and improve infection control and limit potential exposure to health care workers. While telemedicine is one of many tools in a physician's arsenal to treat patients, telehealth services have emerged as a critical component of our COVID-19 prevention and mitigation strategy. During the pandemic, telemedicine has allowed physicians to provide care to patients while supporting physical distancing efforts and reducing the spread of SARS-CoV-2 and other infectious diseases by avoiding unnecessary outpatient visits. Telehealth technologies allow physicians to increase continuity of care, extend access beyond normal clinic hours, and help overcome clinician shortages, especially in rural and other underserved populations. This ultimately helps health systems and physician practices focus more on chronic disease management, enhance patient wellness, improve efficiency, provide higher quality of care, and increase patient satisfaction. Many physicians are touting the expansion of telehealth during the COVID-19 public health emergency as a positive step for health care delivery due to increased provider/patient communication, greater provider/patient trust, and access to real-time information related to a patient's social determinants of health (i.e., a patient's physical living environment, economic stability, or food insecurity), which can lead to better health outcomes and reduced care costs.

The success of telehealth technology adoption during the COVID-19 public health emergency has made it abundantly clear that this technology should be available to all Medicare patients regardless of where they live or how they access telehealth services.

Recommendation

It is critically important that Medicare beneficiaries continue to be able to access telehealth services from their physicians without arbitrary restrictions throughout the COVID-19 public health emergency and beyond. Congress should provide this coverage by eliminating the 1834(m) statutory restrictions on originating site and geographic location, thereby ensuring Medicare coverage of telehealth services regardless of where the patient is located.

- The AMA strongly supports the permanent expansion for coverage and payment of telehealth to ensure increased access and use of these services after the COVID-19 pandemic.

Medicare Accelerated and Advance Payment Program

We greatly appreciate that the CARES Act expanded the Accelerated and Advance Payment Program for the duration of the COVID-19 public health emergency. The statute postpones the start of recoupment 120 days after initial payment and allows up to 210 days for repayment for physicians, and the Centers for Medicare & Medicaid Services (CMS) has worked quickly to provide flexibility to physicians who need financial assistance. It was a lifeline that many physician practices needed.

However, we have heard significant concerns from physicians about their ability to repay this amount of money as the COVID-19 crisis continues, and some statutory fixes are needed. The repayment terms of the Accelerated and Advance Payment program are harsh. Physicians are about to start having 100 percent of their Medicare claims withheld to repay the loans on a quick timeline, and after a few months any outstanding balances will be subject to a 10.25 percent interest rate. If Congress does not act, many physician practices will fail.

The policy changes outlined below will support the efforts of practices to stay open throughout the duration of the COVID-19 public health emergency and strengthen their ability to deliver services under a significantly impacted and altered environment. As the public gradually returns to physician offices to seek care, it is hoped that practices will reach their previous levels of service. The additional time before recoupment begins and the reduction in the amount recouped per claim will allow for a smoother transition for many practices.

Recommendations

- Resume the program for Part B entities;
- Postpone the recoupment of disbursed funds until 365 days after the advance payment has been issued to a physician practice;
- Reduce the per claim recoupment amount from 100 percent to 25 percent;
- Extend the repayment period for physicians to two years;
- Reduce the existing 10.25 percent interest rate accruing during the extended payment period to 1 percent; and
- Treat the payments through this program as if they were made from the General Fund of the U.S. Treasury.

Prior Authorization and Utilization Management

According to an AMA survey of 1000 practicing physicians, a medical practice completes an average of 37 prior authorization (PA) requirements weekly per physician, taking a physician and their staff an average of 16 hours, or the equivalent of two business days, to process. In response to this waste of resources and the resulting delays in care, the AMA and more than 100 other organizations representing physicians, hospitals, pharmacists, medical groups, and patients have endorsed 21 Prior Authorization and Utilization Management Reform Principles that are intended to serve as best practices and reasonable reforms for utilization management (UM) programs. The AMA urges all entities engaged in UM to follow these principles.

One critical area addressed in the principles is PA process automation to improve efficiency and reduce costs for providers and payers by requiring payers to adopt the HIPAA-mandated transaction for medical services PA (X12 278) and the National Council for Prescription Drug Programs' (NCPDP) standard electronic transactions for pharmacy PA. Beyond the need for automation, UM requirements are overused and bluntly applied to all physicians, regardless of adherence to evidence-based guidelines. PA requirements now cover a wide range of services, including imaging, psychiatric hospital admissions, inpatient versus outpatient status and various surgical conditions. Rules may vary depending on whether the service is being provided on an inpatient versus an outpatient basis. Increasingly, tools intended as flexible guidelines instead are used as arbitrary standards, leading to denials for appropriate use. The problems are particularly pervasive in prescription drug coverage where physicians may be forced to rewrite prescriptions just to achieve a small, temporary discount from a particular company or to take advantage of a short-term strength-related discount on the same drug the patient is already taking at different strength. Patients' confusion over changes in their medications' appearance and directions can lead to significant and sometimes life-threatening clinical outcomes.

Recommendation

- Congress should pass H.R. 3107, the Improving Seniors' Timely Access to Care Act of 2019. This legislation would establish several prohibitions, requirements, and standards relating to prior authorization processes under Medicare Advantage (MA) plans.

  Specifically, the bill prohibits MA plans from instituting additional prior authorization requirements for surgeries (including related items) that are furnished to a patient during other surgeries for which prior authorization was not required or was already received.

  Additionally, MA plans must: (1) establish an electronic prior authorization program that meets specified standards, including the ability to provide real-time decisions in response to requests for items and services that are routinely approved; (2) annually publish specified prior authorization information, including the percentage of requests approved and the average response time; and (3) meet other standards, as set by CMS, relating to the quality and timeliness of PA determinations.

Infrastructure and Interoperability

The 21st Century Cures Act (Cures Act) included several important changes to the development, certification, and use of health information technology (health IT). The AMA appreciates the focus on physician burden reduction and attention to information blocking and emphasis on patient data access. While we will continue to work with the U.S. Department of Health and Human Services (HHS) on

implementing its information blocking Final Rule, there are specific missteps HHS took in its policies that are not in line with the goals of the Cures Act. The following recommendations will help refine and strengthen the original provisions in the Cures Act and help HHS make the necessary course corrections.

Recommendations

- **Stagger health IT development and implementation timelines:** Congress should direct HHS to ensure there is appropriate time for vendors to develop, test, and certify new health IT and for physicians to purchase, implement, train on and use updated EHR features (i.e., provide one timeline for development and a subsequent timeline for clinician adoption). HHS' current policy will exacerbate physician burden and will be compounded by physician practices' long-term recovery post COVID-19.

- **Revisit information blocking:** HHS' information blocking regulations are complex, confusing, and unworkable for physicians to implement—especially while recovering from the COVID-19 pandemic. Congress should direct HHS to use discretion in its initial enforcement of the data blocking provisions, prioritizing education and corrective action plans over penalties. Physicians and other health care providers should be provided enforcement discretion for no less than one year after the Information Blocking Final Rule's (i.e., 45 CFR 171) effective date.

- **Expand HITAC representation to include small physician practices:** The Health Information Technology Advisory Committee (HITAC) provides important direction and insight on HHS' health IT policy efforts. However, the committee does not represent the experiences and needs of resource-limited medical practices. Congress should require that HITAC membership includes representation from practicing physicians, including both small and rural clinics.

- **Protect and promote privacy and security:** Improving data access and exchange must include strengthening privacy and security precautions. HHS' implementation of the Cures Act undervalues patient privacy. While Congress works on national privacy legislation, near-term protections must be included in HHS' health IT regulations. Congress should direct HHS to reevaluate its current data privacy stance and implement a privacy attestation framework, incentivize adoption of segmentation standards/technology, and strengthen policies around vetting consumer-facing applications. This may require additional rulemaking or could be accomplished through work already underway at standard development organizations like Health Level Seven (HL7).

EHR Reporting Programs

Physicians have endured the unfortunate byproduct of federal policy dictating certified EHR use and development for nearly a decade. While the EHR reporting program's name has changed several times (i.e., Meaningful Use to Advancing Care Information to Promoting Interoperability), the program remains fundamentally flawed, linking "success" to measuring keyboard clicks and tracking physicians in a certified EHR. Certified EHRs are therefore "one size fits all" and specifically built for federal reporting purposes. Documentation "noise" is added to office notes simply to justify federal measures and requirements. This noise hides important clinical facts from patients, detracts from care coordination, and increases physician cognitive burden, burnout and a loss of productivity. Furthermore, innovative tools that are not certified by ONC but nonetheless help physicians improve patient care are not eligible for inclusion in CMS' evaluations of how physicians use technology.

Recommendations

- **Allow physicians to use non-certified health IT:** HHS continues to tie all its reporting programs (e.g., Quality Payment Program) to the use of certified EHRs. This linkage negatively impacts EHR usability, patient safety, and interoperability. Congress should remove the certified EHR limitations in the HITECH Act and direct HHS to solicit feedback from stakeholders that identifies additional types of non-certified health IT to count toward federal reporting programs. Doing so will promote adoption of emerging technology that makes sense for a physician's specialty and patient population in addition to the certified EHR technology that over 85 percent of practices have already adopted.

- **Direct HHS to accept physician attestations:** HHS' EHR reporting program still counts the number of clicks physicians take to document a patient's visit. This drives EHR design by forcing developers to continue to focus on the same functionalities already in use and capturing information in a way that can be measured by clicks rather than by what is intuitive and logical for the physician's workflow, contributing to physician burden and burnout. Originally designed to capture "meaningful use" of certified EHR, prescriptive measurement-based reporting is antiquated. Congress should explicitly direct HHS to accept a physician's "yes" attestation as successfully meeting any and all EHR reporting requirements. This complies with MACRA's requirement that EHR reporting credit be granted based on subsection (o)(2) of HITECH to be considered a meaningful user, while also utilizing the Secretary's discretion allowed under HITECH's subsection (o)(2)(C)(i)(I) to allow a professional to satisfy demonstration of meaningful use through attestation. This will also create new opportunities for EHR design and development.

Advanced Alternative Payment Models (APMs)

As discussions on the next phase of our response to the pandemic continue, value-based care providers remain among those on the front lines of defense until we develop and disseminate a vaccine for COVID-19. Participants in value-based care models such as accountable care organizations (ACOs) and other alternative payment model (APM) participants have long used care coordination tools that have become even more important in the context of patient care during COVID-19.

We encourage the House to take action to ensure that value-based care organizations continue to provide these vital services by modifying the Qualifying APM Participant (QP) thresholds included in the Medicare Access and CHIP Reauthorization Act (MACRA). With overwhelming bipartisan support, Congress passed MACRA in 2015 to shift Medicare away from fee-for-service by providing incentives to health care providers for participating in risk-bearing or Advanced APMs. As a result of this effort, recent survey data shows over a third of health care spending is through value-based payments, but this transition is threatened because the law's thresholds for providers to qualify for incentives is set to increase to unrealistic levels in 2021.

It has become clear that COVID-19 will make it more challenging for many APM participants to meet the law's current thresholds due to shifts in care. According to data recently released by the Centers for Medicare & Medicaid Services (CMS), on average, providers missed even the current QP threshold (50 percent) and are nowhere near the heightened threshold (75 percent) required by statute in 2021.

It is critical for seniors that APMs continue in 2021 and beyond. Physicians participating in APMs are conducting care coordination strategies that are needed now more than ever. Many seniors and vulnerable patients have been isolating themselves for months while they wait for a vaccine. ACOs and other APM providers are making sure their beneficiaries are accessing food and medications while they isolate. These are the exact kind of non-medical interventions our seniors will depend on until a vaccine becomes available.

Recommendation

- In the next COVID-19 response package we urge you to include a provision to address the QP cliff. The impending QP threshold jump in 2021 will derail the shift to value-based care right when seniors need it the most.

Merit-based Incentive Payment System (MIPS)

Since the enactment of MACRA, physician organizations have worked closely with both Congress and the CMS to promote a smooth implementation of the law. Additional refinements are needed to improve the program and ensure physicians can be successful moving forward.

- Provide scoring flexibility to CMS to ensure the MIPS Value Pathways are successful

In the 2020 Medicare Physician Payment Schedule final rule, CMS outlined the MIPS Value Pathways (MVPs) approach, which has the potential to reduce administrative complexity, improve value to patients, and be a bridge between MIPS and alternative payment models by holding physicians accountable for quality, cost, health IT, and improvement around an episode of care, condition, or public health priority. To successfully implement MVPs, CMS should have the authority to establish a transition period, allow for innovation in health IT use and experimentation with new measures, and provide opportunities for physicians to receive incentive payments when they improve quality or reduce costs through an MVP.

CMS should have explicit flexibility to base scoring on multi-category measures to make MIPS more clinically meaningful, reduce silos between each of the four MIPS categories, and create a more unified program. This provision could also include the ability for CMS to award bonus points at the composite score level, which would allow for a simplified scoring methodology. This could be accomplished by adding language to Social Security Act § 1848(q)(2)(B)(v) stating "If a measure or activity satisfies multiple performance categories, an eligible clinician shall receive credit in each category for the measure or activity."

- Update the Promoting Interoperability performance category

Physicians should be allowed to use certified EHR technology (CEHRT), technology that interacts with CEHRT to be considered a meaningful user, or a qualified clinical data registry to participate in PI. Doing so would engage clinicians who are non-patient facing that are currently exempt from the category (e.g., radiologists who use imaging equipment, but not EHRs). It would also reward physicians who seek to utilize emerging health IT for patient care or contribute data for aggregation and quality analysis purposes. This would require a new clause in 1848(o)(2)(A):

> (iv) ADDITIONAL TECHNOLOGY – The eligible professional may choose whether to use certified EHR technology, technology that interacts with certified EHR technology, or may participate in a qualified clinical data registry (or a combination of all three technologies), to be considered a meaningful EHR user.

Congress should direct CMS to utilize the authority it granted to the Secretary through HITECH to permit reporting in PI through yes/no attestation. Doing so would add value to the PI program because physicians would tell CMS which EHR activities are truly useful in practice as opposed to those performed simply to meet reporting program requirements. In turn, health IT developers can prioritize innovation rather than functions of little clinical importance. This can be accomplished by adding the following to 1848(q)(2)(B)(iv): "For the performance category described in (A)(iv), the requirements shall be met via attestation or other less burdensome means."

- Allow pay-for-reporting on new measures, when significant refinements to a measure or composite have been made or due to data being impacted by the COVID-19 pandemic

CMS should have the flexibility to allow pay-for-reporting for the first two years a measure is introduced into the program and when significant refinements to the measure have been made, such as scientific evidence has changed. In addition, the flexibility to allow pay-for-reporting due to data being impacted by the pandemic. Data from 2019, 2020 and 2021 and potentially future years are not a representative sample and should not be used for setting benchmarks or risk-adjustment models. Precedent already exists for allowing pay-for-reporting in other value-based purchasing programs. This would also incentivize reporting and developing new measures and continued participation in MIPS.

- Improve the cost performance category

To allow CMS to prioritize cost measures that are valid and actionable, Congress should remove the requirement that episode-based cost measures account for half of all expenditures under Parts A and B. CMS should focus on episodes of care with high variability and potential high impact for change at the physician level. This could be accomplished by changing Social Security Act § 1848(r)(2)(D)(i) to read "(I) Establish care episode groups and patient condition groups~~, which account for a target of an estimated ½ of expenditures under Parts A and B.~~"

In addition, we recommend removing the total cost of care measure requirement. The Total Per Capita Cost measure did not receive endorsement by the National Quality Forum (NQF) in 2013 for use in physician cost measurement. Problems with the measure were linked to validity, patient attribution, and holding physicians accountable for costs over which the physician has no control. This change would also eliminate double counting of the same patient costs under multiple measures and move toward scoring measures that have stronger correlation between costs and the physicians' influence over those costs.

- Provide flexibility to CMS to set multiple performance thresholds

The mean and median scores to date illustrate the need to set the performance threshold lower for several more years while CMS determines how to assist small practices and enable those groups to be successful in MIPS. Because the first and second years of MIPS were transition years, nearly all physicians were successful. The national mean score for all participants in 2018 was 87 and the national median score for all participants was 100. However, the scores varied significantly by practice size and location.

- For large practices, the mean score was 92 and the median score was 100.
- For rural practices, the mean score was 86 and the median score was 99.
- For small practices, the mean score was 66 and the median score was 81.
- For small and rural practices, the mean score was 67 and the median score was 81.

Thus, given this stark contrast between practice types, CMS should be provided additional flexibility. As opposed to a pre-set formula, CMS may be in a better position to determine each year whether physicians are ready to move to an increased performance threshold given that the agency has access to all the previous year's performance data. CMS may also decide to establish different thresholds for small and large practices. Providing CMS with additional flexibility to set the performance thresholds would maintain budget neutrality in MIPS.

- Align comparisons in the MIPS Quality performance category and Physician Compare

Physicians are currently evaluated on two different standards for a single quality measure. One for the Physician Compare program and another for the Quality performance category of MIPS. Congress should align the legislative language around the Quality performance category and Physician Compare to reduce physician burden of having to understand two separate benchmarking methodologies.

Reduce Quality Data Completeness Threshold back to 50 percent

Starting in 2020, CMS increased the quality measure data completion threshold to 70 percent from 60 percent in 2019. Originally, the threshold was 50 percent of all-payer patients, regardless of payer. If a physician fails to meet the data completeness threshold they only receive one point (three for small practices) for reporting on the measure. While increasing the data completeness threshold may increase the sample size of data, returning the threshold at a minimum of 50 percent does not prohibit physicians or practices from submitting more data. Changing the threshold level while physicians are still learning the complex requirements for successful Merit-Based Incentive Payment System (MIPS) participation is premature and ignores the burden associated with increased reporting thresholds. It also disadvantages certain specialties because their practice patterns require them to practice in multiple sites and do not always have access to the data across sites and/or sites of service.

Increasing the threshold will also disincentive physicians from reporting on certain high priority measures due to the large administrative burden and cost associated with collecting information and reporting on all-payer data using a Qualified Clinical Data Registry (QCDR), registry, electronic health record (EHR) or web-interface reporting mechanism. Increasing the threshold, coupled with the requirement of reporting on all-payer data, is especially burdensome for small practices that do not have the resources to hire an employee to collect and document such information. Even if the practice has an EHR, much of the information that supports the high priority measure is not captured within the EHR system but is collected through surveys and manual key entry.

The AMA strongly disagrees with the notion that a 50 percent threshold could lead to possible gaming. In addition, a 50 percent threshold still requires reporting on a majority of patients, which prevents cherry picking. A 50 percent threshold is simply a more realistic reporting level that acknowledges potential problems that may arise prior to or during the reporting period, such as the following:

- A vendor that fails to update measure specifications at the start of the reporting period.
- A delay in publication of CMS' approved qualified registries or QCDR list. Historically, CMS has not finalized the approved list until late spring or early summer of the reporting period.
- A delay in a practice determining their reporting status (low volume threshold, non-patient facing or facility-based).
- A practice switching EHR vendors.
- Power outages, inaccurate coding, or natural disaster.

Modernize Stark and Anti-kickback Restrictions

Physicians are barred from participating in innovative and cost-saving care models due to outdated regulations, including Anti-Kickback and complicated Stark prohibitions. These models may require the use of EHR software and technology in order to be viable and effective. While safe harbors exist in this area, they are temporary and limited in scope. In addition, physicians are inadvertently subjected to large fines or penalties for Stark technical violations (e.g., missing or out-of-date paperwork).

Recommendations

- Create new statutory exceptions or safe harbors for Stark and Anti-kickback to facilitate coordinated care and promote cost reductions and extend existing waivers from the Medicare Shared Savings Program's ACOs to other individuals and entities implementing alternative payment models outside this program;
- Require HHS to amend and revise the definition of "fair market value" to account for new payment models that are based on value and outcomes rather than productivity (e.g., allowing incentive payments for efficient and better care rather than on the number of hours or RVUs worked);
- Codify and amend the existing regulatory safe harbor for EHR software and technologies and should broaden the definition of "electronic health record" beyond clinical diagnosis and treatment. The definition should include such things like information sharing and cybersecurity and allow for flexibility as technology evolves; and
- Codify existing technical noncompliance Stark language (e.g., documentation and signature requirements) and provide CMS broad authority to waive the nonpayment sanction under Stark for minor and technical violations or from violations stemming from non-abusive arrangements.

Physician Focused Payment Model Technical Advisory Committee (PTAC) - Legislative

On August 4, 2017, PTAC Chair Jeffrey Bailet, MD, wrote then-HHS Secretary Tom Price, MD, in response to a request to share "lessons learned" from the first physician-focused payment models submitted. Dr. Bailet made the following observation:

> Committee members have been impressed by the number of practicing physicians and specialty groups that have developed and submitted PFPM proposals to us. Some of the proposals submitted by practicing physicians provide a clear description for the care delivery model that would be supported by a change in payment, but the detailed description of the actual payment model that would support the new approach to care delivery is underdeveloped. This is not surprising, since physicians' expertise is in delivering care, not designing payment models. In many cases the proposal submitters could address these gaps if they had access to assistance from individuals with expertise in payment model design. In addition, PTAC could be helpful triaging good ideas by identifying those that warrant a payment model versus those that would benefit from other intervention such as a new code or change in payment amount.
> A Technical Advisory Program for submitters could include:
>
> - Periodic public workshops explaining the key building blocks of payment models and describing optional ways of addressing issues such as risk adjustment, performance measurement, cost estimations and other elements of payment models.
> - Help for model developers in determining when good ideas could be addressed using current payment methods versus needing new payment models and helping applicants discern options for closing specific gaps in a PFPM proposal.
> - Assistance for model developers in interpreting and meeting the Secretarial criterion on "Health Information Technology – Encourage use of health information technology to inform care" and helping submitters implement the HIT-enabled data sharing elements of their model as proposed, if the PTAC finds that the proposed PFPM has sufficient merit otherwise.

Recommendation

We concur with Dr. Bailet's analysis and recommend that Congress adopt the following language to provide the necessary authority for the provision of technical assistance prior to the time a proposal is selected for implementation:

SEC. __ . AUTHORITY OF PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE TO PROVIDE TECHNICAL ASSISTANCE.

Section 1868(c) of the Social Security Act (42 U.S.C. 1395ee(c)) is amended—

(1) in paragraph (1)(D), by inserting before the period the following: ", and to provide technical assistance as described in paragraph (2)(B)"; and

(2) in paragraph (2)(B), by adding at the end the following: "The Committee may provide technical assistance with respect to the development of such proposals, **[**subject to any criteria established by the Secretary regarding the extent to which the resources of the Committee may be allocated for such technical assistance**]**."

Physician Ownership of Hospitals

The Affordable Care Act (ACA) effectively bans physicians from acquiring ownership of hospitals by not allowing such facilities to participate in the Medicare program. Physician-owned hospitals that were under development or under construction were subsequently forced to halt their work because of a punitive grandfathering date that accompanied the ban.

The ACA also penalizes physician-owned hospitals that were already participating in Medicare by prohibiting them from adding a single bed, operating room or procedure room unless they meet a complicated and unrealistic set of criteria as part of the application process. As a result of these restrictions, only seven of the nearly 250 physician-owned hospitals will ever be eligible to expand under the current criteria for "applicable hospital" or "high Medicaid facility."

The inability of physician-owned hospitals to meet their communities' fast-growing demand for high-quality health care services is bad for patients, in particular those on Medicare and Medicaid. Physician-owned hospitals are widely and consistently recognized as some of the highest quality, lowest cost providers in the country. Current law is forcing these centers of excellence to consider forgoing their participation in Medicare in order to add desperately needed capacity and remain accessible to patients.

Recommendation

Congress should pass Representative Michael Burgess' H.R. 3062, the "Patient Access to Higher Quality Health Care Act of 2019." This legislation would level the playing field, allowing physician-owned hospitals to remain competitive, continue their solid record of providing the highest quality health care to patients, and contribute significantly to the communities they serve.

Costs of Interpretation and Translation Services

The AMA supports access to quality care for all individuals and encourages physicians to make their offices accessible to patients with disabilities and limited English proficiency (LEP). Moreover, the AMA strongly believes that clear, direct communication and understanding is the bedrock of the patient-physician relationship and is very important in ensuring the provision of quality medical care to all patients. However, we believe that the financial burden of medical interpretive services and translation should not fall entirely on physician practices.

As with interpreters or other auxiliary aids or services for individuals with hearing impairments, language interpretive services should be a covered benefit for all health plans, which are in a much better position to pass on the costs of these federally-mandated services as a business expense.

Relatedly, AMA members have reported to the AMA that individuals with LEP often bring trusted adults with them to an appointment to facilitate communication. Current regulations states that a physician may rely on an adult accompanying an individual with LEP to interpret or facilitate communication only if reliance on that adult for such assistance is "appropriate under the circumstances." This standard remains unclear to physicians, causing them to take on the additional burden and expense of interpreters out of an abundance of caution when it may not be always necessary to do so. For example, when a physician sees an adult male patient presenting with flu-like symptoms, who is accompanied by his adult brother, and the patient requests that his brother translate, a physician may find this request appropriate under the circumstances. Conversely, if a female patient presenting with a broken arm is accompanied by her husband, the physician may have concerns about domestic abuse. In this case, it may be inappropriate to rely on the husband to provide accurate interpretation services.

Recommendation

The AMA urges HHS to clarify the circumstances in which a physician may rely on an adult accompanying a patient to interpret or facilitate communication. We welcome the opportunity to assist the agency with guidance.

Medicare Advantage Star Ratings

As the Star Ratings program has expanded and plays a larger financial role on health plans' bottom lines, the administrative demand has simultaneously increased on physicians and impeding clinical care and thus does not provide a beneficiary benefit. A large percentage of the measures within the MA Star Ratings program are based completely on physician action and compliance. In order for health plans to increase their HEDIS scores and earn greater incentives from CMS, plans are requiring practices as part of their clinical data submission requirements to submit data on all patient lab results and tests and the plans state it is due to the Star Ratings HEDIS requirements. Many of the measures, particularly the HEDIS *Effectiveness of Care* measures, have more to do with physician quality than assessment of a health plan. The *Effectiveness of Care* measures are really targeting clinical quality, which is a physician or facility issue—and therefore physicians and facilities have the data. Without a better focus the MA ratings program is just one more burden on physicians and does not provide beneficiaries with the best information they need to determine the most appropriate and high-quality MA or drug plan.

Recommendations

- CMS should refine Star Ratings to better measure the quality of plans and things over which the plan has control and the supporting data (for example, access);
- CMS should require health plans to allow practices to respond *at-will* at a time of their choosing, at a minimum allow for at least 90 days to respond, support use of electronic methods of data submission, and adequately compensate physicians for the time and burden;
- CMS should allow for more general exclusions for patients with specific conditions, comorbidities or allergies from measures to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making; and
- Denominators of quality measures should be appropriately defined to ensure patients for whom the treatment may not be appropriate are excluded from measurement.

The AMA appreciates the opportunity to provide our input and recommendations, and we look forward to continuing to work with you and members of the House Committee on Oversight and Reform on regulatory developments that will be important over the course of the next several years.

Sincerely,

James L. Madara, MD

cc: The Honorable Carolyn B. Maloney, Chairwoman
Committee on Oversight and Reform