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**Association of
American Medical Colleges**
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

August 12, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W Room 445-G
Washington, DC 20201
CMS-6082-NC

RE: Comments on the Request for Information on Reducing Administrative Burden To Put Patients Over Paperwork [CMS-6082-NC]

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the Request for Information “Reducing Administrative Burden to Put Patients Over Paperwork,” 84 *Fed. Reg.* 27070 (June 11, 2019) issued by the Centers for Medicare & Medicaid Services (CMS).

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Together, these institutions and individuals are the American academic medicine community.

The AAMC appreciates CMS’s commitment to transforming the health care delivery system by focusing on patient- centered care, innovation, and outcomes. The AAMC supports CMS’s efforts to reduce burden for hospitals, physicians and patients and to allow providers to devote more time to patient care. Many regulations were developed decades ago when reimbursement was strictly fee -for- service and delivery models did not rely on team-based care and other innovations.

CMS has already provided some significant regulatory relief to hospitals and physicians, which we appreciate. Yet, there is still a need for more relief. We commend CMS for soliciting additional public comment on ideas for regulatory, sub-regulatory, policy and procedural changes that reduce unnecessary administrative burdens for clinicians, providers, patients, and

families. Below are some actions that the AAMC hopes CMS will take to reduce the regulatory burden on hospitals, physicians, and the patients that they serve.

QUALITY

Suspend Faulty Hospital Star Ratings Until Flaws are Addressed

The AAMC appreciates the CMS dedication of time and work on improving Star Ratings through its request for comment on potential improvements to the ratings methodology. We remain very concerned, however, with the flawed methodology used to determine the Ratings posted on Hospital Compare and believe them to be both inaccurate and misleading to patients and consumers seeking hospital care. The AAMC urges CMS to remove the publication of the Star Ratings from the *Hospital Compare* website until CMS is able to address significant concerns with the methodology. We request that prior to re-releasing Star Ratings, CMS take sufficient time to examine the feedback provided and make modifications to the methodology to ensure that the Ratings are accurate. In addition to the comments regarding issues with methodology we remain extremely concerned about potential consequences for patients that could result from an overly simplistic picture of hospital quality with a single overall rating. In addition to considering the comments received on potential improvements to the ratings methodology, it is imperative that CMS contract with independent outside experts to review the overall methodology and verify its accuracy before further public implementation.

The AAMC also strongly recommends that CMS continue ongoing review for areas of improvement in future releases of the Ratings and convene stakeholders regularly to review the appropriateness of the current methodology.

Take Additional Steps to Account for Sociodemographic Status (SDS) Factors in Quality Measurement

The AAMC strongly supports the movement from volume to value. Academic medical centers are leaders in the area of providing quality health care, and in creating and implementing innovative care delivery models. There are numerous inpatient and outpatient quality programs under Medicare that link payment to quality. CMS has stated that outcome measures and cost measures are a priority in these programs. However, most outcome measures, particularly readmission measures, are affected by Sociodemographic Status Factors (SDS), which are beyond the control of the physician or hospital. The nation's teaching hospitals and physicians, which provide superior patient care and disproportionately treat disadvantaged and vulnerable patient populations, are unfairly penalized by the performance and penalty programs in part due to the lack of adequate SDS adjustment. The AAMC recommends that the Administration use its authority to implement SDS adjustments across all affected Medicare quality programs where appropriate.

Align Quality Measures Across Payers and Use Only Measures That Truly Matter

The number of quality measures that providers must report to CMS and other payers is increasing rapidly in the inpatient and outpatient quality programs. To the extent possible, CMS should work with other payers to align the measures used by the Medicare and Medicaid programs as well as commercial payers to reduce burden and prevent confusion. A key step would be development of a national core measure set, with measures that apply across health settings and across payers. CMS should focus on measures that are critical to driving the best possible outcomes for patients. We urge CMS to work with a variety of stakeholders, including the AAMC, to identify critical indicators of quality and safety that are meaningful to patients.

Reduce Clinician Burden and Complexity in the Quality Payment Programs (MACRA)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new physician payment system that took effect with physician reporting beginning January 1, 2017. The program features two pathways for physicians who treat Medicare beneficiaries: the Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). Both pathways require major operational changes for physician practices. The AAMC believes it is important for CMS to reduce clinician burden and complexity of the program and to ensure that the program is more meaningful for physicians and their patients.

The AAMC is pleased that for the 2017, 2018, and 2019 performance years, CMS used its discretion to lower the weight for the cost performance category under MACRA. For 2019, the cost performance category has a weight of 15%. In the 2020 proposed physician fee schedule rule, CMS proposes to increase the cost weight to 20% for 2020, 25% for 2021, and 30% for 2022. Prior to increasing the weight of the cost category, it is important to address concerns with risk adjustment (e.g. clinical severity, sociodemographic factors) and attribution associated with the cost measures.

Starting in 2021, a clinician may achieve status as a qualified participant of an APM through the All-Payer Combination Option. Thresholds under this option can be met by combining payments or patients from Other Payer Advanced APMs with those from Medicare Advanced APMs. These processes involve either the payer or the eligible clinician submitting detailed information to CMS for a determination that would be made at the individual clinician level. The AAMC has significant concerns with the approach to the All Payer combination. It presents major operational challenges for eligible clinicians as compared to the Medicare option. Reporting the information to CMS would be extremely burdensome for the eligible clinicians. CMS needs to work with stakeholders to develop mechanisms to simplify determination of this threshold.

Electronic Health Record (EHR) Use Reporting

In 2019, CMS made significant changes to the program requirements for the Promoting Interoperability category (PI) in MIPS and the Medicare Promoting Interoperability Program for hospitals. These changes included aligning the MIPS and hospital programs and changing the

scoring methodology for the programs. The AAMC commends CMS for aligning the programs, which has helped to reduce provider burden and increase the focus on interoperability and for its efforts to reduce the complexity of the scoring methodology. However, we remain concerned about a number of aspects of the Promoting Interoperability Programs and encourage additional refinements to further improve flexibility and reduce burden. Specifically, the MIPS program retains the rigid, all-or-nothing scoring methodology of the PI category. CMS should consider aligning with the inpatient PI program by only requiring 50 performance category points to fully satisfy the PI category and receive 25 points toward the final MIPS composite score.

CMS should allow clinicians to select from a larger list of clinically focused measures that center on the areas of Health Information Technology (HIT)-related improvements that would be most beneficial to their practice and patients. This will be more effective in meeting the goals of increasing the use of HIT and improving patient care. Moreover, this will create more synergy between the PI Category and the Quality and Improvement Activities Categories, which include a menu of measures or activities to choose from. Allowing clinicians to choose the measures that are meaningful to their practice and lowering the point minimum for this category would significantly reduce burden, and more accurately reflect quality.

DIRECT GRADUATE MEDICAL EDUCATION

Provide Relief for Teaching Hospitals that Unintentionally Established Its Resident Cap

CMS should clarify through regulation that a nonteaching hospital's per resident amount (PRA) and the number of full-time equivalent (FTE) residents (resident cap) for direct graduate medical education (DGME) and the indirect medical education (IME) adjustment should not be established when a *de minimus* (less than 3 FTEs) number of residents from an existing teaching hospital rotate to a nonteaching hospital. In the past, nonteaching hospitals, a number of which are in rural areas, unknowingly established (“triggered”) their very low PRA and cap when they accepted a few rotating residents for training. When at a later date these hospitals wish to establish their own residency programs, they are discouraged from doing so because of the low PRA and cap. This burdens the entire health care system at a time when more residency programs are needed due to the physician shortage.

CMS should revise its regulations to allow nonteaching hospitals that want to establish residency programs but in the past had a *de minimus* (less than 3 FTEs) number of residents rotate to their institutions, build a PRA and residency cap as if they never had resident rotators. In other words, these hospitals would be considered “virgin teaching hospitals” and would be able to build a per resident amount and caps for DGME and IME.

Modify Rules Regarding Cap Relief When a Hospital/Program Closes

42 CFR §413.79(h) sets out the rules when a hospital or hospital residency program closes. Paragraph (3)(ii)(B) contains a further set of requirements that must be met for slots from the closed hospital or residency program to be transferred to another hospital to allow residents to complete their training. Among the requirements is that the closed hospital must identify “the

residents who were in training at the time of the program's closure." CMS interprets this phrase to mean that the residents must be at the closed hospital/program on the day prior to/or day of the hospital/program closure.

This requirement can be very burdensome on residents who may suddenly be in the position of having to find a new residency program which could be in a different geographic location from the program that is closing. It also may inadvertently penalize a hospital that thought it was entitled to temporary cap relief when it accepted a displaced resident, only to find that it will not get the cap because the resident was not at the hospital/program as required. For example, if a resident in an East Coast teaching hospital that was closing found a new residency slot at a Midwest teaching hospital, the resident—whose life is being upended by a significant and unexpected relocation, to say nothing of the financial costs associated with this change in training location—would have to return to the East Coast simply to fulfill this requirement.

The AAMC asks CMS to delete this requirement as it has no practical purpose, is burdensome and unnecessarily stressful on the very individuals who are meant to be helped by this provision. It also unfairly and penalizes those hospitals willing to take on displaced residents with the expectation that they will receive cap relief. Provided that the resident is not double counted by the closed hospital/program and the receiving hospital, and the other requirements of 42 CFR §413.79(h) are met, temporary cap relief should be given to the receiving hospital.

BILLING, DOCUMENTATION, AND MEDICARE COVERAGE REQUIREMENTS

Eliminate the Skilled Nursing Facility (SNF) Three-Day Hospital Stay Requirement

To better coordinate and improve care for patients, CMS should work with Congress to eliminate or modify the requirement that a patient must spend three days as a hospital inpatient before being eligible for SNF services. While we recognize that complete removal of the requirement would require legislative action, at a minimum we recommend CMS use its administrative flexibility to create additional waivers of the SNF three-day stay for APMs. Many patients who are not in APMs would benefit from an inpatient stay that is shorter than three days, followed by care in a SNF.

Eliminating the three-day stay would rely on physicians' judgment to ensure that their patients receive the most appropriate care in the most appropriate settings, without creating the possibility of an unforeseen financial burden on the patient.

Expand Medicare Coverage of Telehealth Services

The general Medicare rules related to payment for telehealth services are that the services must be provided to a patient in a rural area and at an originating site (hospitals, clinics, certain centers, and skilled nursing facilities) specified in statute. The home is not included as an originating site.

Many patients would benefit from telehealth services, but are unable to access a qualified originating site, disqualifying them from receiving telehealth services. Additionally, patients in urban and other non-rural areas who do not have convenient access to a provider also could benefit from telehealth.

Certain APMs, such as certain two-sided risk tracks of the Medicare Shared Savings Program, the Next Generation ACO Model and the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model, make telehealth waivers available, but such waivers should also be provided to other APMs. In addition, CMS and its Innovation Center should undertake demonstrations, through its delivery reform models, to expand coverage of telehealth and evaluate if expanded telehealth services for specific patient populations is cost effective and improves care quality. As Medicare payments move toward paying for value, there is reduced risk that these services will be used for other than the best quality, most cost-efficient care. CMS should encourage the use of telemedicine beyond rural areas and outside of APMs, as many patients would benefit from the availability of telemedicine services.

Remove Barriers to Coverage of Interprofessional Internet Consults

In 2019 CMS finalized a policy that would allow reimbursement of two new codes (CPT codes 99451 and 99452) for Interprofessional Internet Consults. The AAMC commends CMS for its decision to cover these services and its recognition of the value of these services. However, requirements associated with billing these services under Medicare create barriers to coverage. For example, CMS requires that the patient's verbal consent be obtained and noted in the medical record for each interprofessional consultation service. This poses some challenges.

There are clinically appropriate scenarios where a treating provider might request an interprofessional consult after the patient has left the office (e.g. in response to an abnormal laboratory test or value). In this case, it creates inefficiencies and could further delay care if the treating provider has to reach the patient and obtain consent before placing the consult. It could also cause undue stress for the patient, particularly if the specialist deems that the abnormal value is not of concern or does not need any additional follow-up at that time. We recommend more flexibility around the frequency and methods for obtaining patient consent to avoid patient confusion and be practical for providers.

CMS also requires the provider to collect a 20% coinsurance payment from the patient for each code (99451 and 99452). We are concerned that collecting two separate coinsurance payments for a single completed interprofessional consult may confuse the patient. In addition, the patient may not have an established relationship with the consulting specialty's practice and therefore may be confused when they receive the coinsurance fee from the provider that they have never seen face-to-face, and maybe never heard of. This could raise concerns about billing errors and place an undue burden on the practice's billing staff to address these questions, thereby discouraging consultations. We recommend that CMS explore pathways to allowing for waiver of coinsurance.

Clinician Documentation

Excessive documentation requirements have made it difficult for physicians and other health care professionals to locate important information in the medical record about the patient's current condition, recent changes, and the plan of care. As a result, the medical record has become "bloated" in order to meet billing rules, which has led to difficulties in following the care and proposed management of patients and has impeded quality care in some cases. Changes to documentation requirements would help to alleviate these problems, lead to improved patient care, and better align with current medical practice and the use of electronic medical records.

The AAMC appreciates CMS's recognition of the administrative burden physicians and other health care professionals experience and the proposal of a policy in the 2020 proposed physician fee schedule rule that would allow physicians (effective in 2021) to choose their method of documenting office visits among the following options: 1) medical decision-making; or 2) time; We commend CMS for eliminating the requirement that physicians document in accordance with the 1995 or 1997 E/M guidelines..

The 1995 and 1997 E/M guidelines were developed at a time when medical records were maintained on paper and clinicians worked largely independently. With the advent of the EHR, team-based care, and other changes over the past two decades, the E/M Guidelines are outdated and have led to much of the "note bloat" that is seen in EHRs. The current documentation requirements (such as noting negative review of systems) impose an onerous burden on physicians while providing little benefit to patients. In some cases, the requirements impede patient care by making it difficult to locate the physician's differential diagnosis or plan of care. The physician spends less time with the patient since so much time is spent on ensuring the information to support billing is included in the medical record.

We believe that CMS can simplify the documentation by allowing physicians to elect to document based on medical decision-making only or time without setting one payment rate for code levels 2-4. The AAMC is pleased that CMS proposed separate payment rates in the 2020 proposed physician fee schedule rule. The AAMC is committed to working with CMS on future refinement of the coding structure and payment for E/M Services.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Section 218(b) of the Protecting Access to Medicare Act of 2014 (PAMA) directs CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. Under the law, as a condition of payment to a provider who furnishes imaging services, the health care provider ordering advanced diagnostic imaging services must consult AUC. This involves entering patient clinical data into an electronic decision tool, referred to as a clinical decision support mechanism (CDSM), to obtain information on the appropriateness of the services. The AUC must be developed or endorsed by national medical professional societies or other provider-led entities. The results of the AUC consultation must be documented on the claim submitted by providers furnishing imaging services in order to be paid by Medicare.

In the 2018 Medicare Physician Fee Schedule (PFS) final rule, CMS stated that ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting and ordered on or after January 1, 2020. CMS also proposed that furnishing professionals report the following information on Medicare claims for applicable imaging service, furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2020:

- Which qualified CDSM was consulted by the ordering professional;
- Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered; and,
- The NPI of the ordering professional (if different from the furnishing professional).

In the 2019 PFS final rule, CMS stated it will establish a set of G-codes and HCPCS modifiers to capture this AUC consultation information on Medicare claims. CMS clarified that AUC consultation information must be reported on all claims submitted by the furnishing provider, including the practitioner's claim for the professional component and the provider's or supplier's claim for the facility portion or technical component (TC) of the imaging service.

While the AAMC supports the use of clinician-developed, evidence-based AUCs to improve the quality of care, and understands the statutory requirement, we are concerned about the unreasonable burden placed on providers. The AAMC urges CMS to provide sufficient time for providers to learn and comply with this program. There is a need to engage providers and their staff about the guidelines, introduce them to the CDSM software, modify work flow patterns, update EHRs, and pilot test the systems to gradually build up the program.

As CMS further develops this policy, we request that the following also be addressed:

- The impact this policy will have on providers who furnish imaging services. The imaging providers will have limited control over whether the ordering professional consulted a CDSM as required. Yet, if the ordering professional does not consult the AUC, the imaging professional would not get paid for the services. We urge CMS to consider allowing the imaging provider to occasionally use the AUC themselves, if appropriate, to demonstrate that the test was warranted.
- The need to phase in the implementation over time starting with a list of priority conditions that would be consulted rather than requiring consultation for all tests.
- Ensuring that CDSMs are designed to be easy to use. Providers would prefer CDSMs that can be used quickly and efficiently and that are integrated with their electronic health record system. It is frustrating to providers if they are required to exit their electronic health record system and enter an entirely new platform to order imaging services.
- A simplified tracking and reporting system. This policy involves a complex system of tracking consultation of AUCs. CMS requires G-codes and modifiers that must be included on the claim form in order for the furnishing provider to be paid. It can be difficult for the furnishing professional to supply the ordering physician's AUC-use information to CMS. In most cases, the ordering physician and furnishing professional

will not share the same office space or EHR system. Sharing this information requires additional health IT interoperability between the ordering physician's EHR and the systems used by the furnishing physicians in their practices.

Prior Authorization

The prior authorization process under the Medicare Advantage program needs to be improved to promote safe, timely and affordable access to care for patients while reducing administrative burden. Physicians strive to deliver quality health care in an efficient manner. However, the frequent phone calls, faxes, and different forms that physicians and their staff must complete to obtain prior authorizations hinder efficient care. Rules and criteria for prior authorization must be transparent and available to the physician at the point of care. In addition, if a service or medication is denied, the physician should be provided a reason for the denial and other alternatives that may be covered (e.g., different medications). Finally, prior authorizations need to be studied in general to determine if they meet the goal of the authorization or decrease use because of the complicated steps required to complete. Care should not be denied because a physician and/or patient cannot jump through complicated opaque hoops.

Adopting a standardized form and process for prior authorization among all payers would reduce burden. Specifically, we support initiatives that standardize data and processes around ordering services and related prior authorization, and that automate ordering and prior authorization processes through adoption of standardized templates and data elements. Also, prior authorization should be waived in certain alternative payment models that have financial incentives in place to provide cost-effective, quality of care and accountability.

Prevent Inconsistent and Duplicative Audits

Medicare subjects providers to claims review by multiple entities including Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), and Comprehensive Error Rate Testing Contractors (CERT). These redundant and overlapping audits place an enormous burden on providers and have resulted in inappropriate denials. There is a need to streamline and eliminate these duplicative audits.

FRAUD AND ABUSE LAWS AND REGULATIONS

Loosen Stark and Anti-Kickback Laws and Regulations that are Barriers

To achieve the goals of delivery system reform, there is a need for changes to federal laws and regulations affecting hospital-physician arrangements, including the Physician Self-Referral Laws (also known as "Stark"), the Anti-Kickback law, and the Civil Monetary Penalties (CMP) law. These laws were predicated on a fee-for-service reimbursement system. Since enactment of these laws, there have been major changes in health care delivery and payment, including many initiatives to align payment with quality and to improve coordination of care. Provisions in these

laws present significant barriers to clinical and financial integration aimed at improving the quality of care, population health, and reducing costs.

The AAMC encourages an approach that allows for maximum flexibility and supports innovation and changes that are needed to help move to a health care system that rewards providers for making the changes that are necessary to provide cost-efficient, patient-centered quality care. Physicians are barred from participating in innovative and cost-saving care models due to outdated regulations, including Anti-Kickback and complicated Stark prohibitions. While some safe harbors and exceptions exist in this area, they are limited in scope. CMS should create new exceptions or safe harbors for Stark and Anti-Kickback laws that facilitate coordinated care and promote cost reductions. Additionally, CMS should establish an “alternative payment model” exception and safe harbor and revise the definition of “fair market value” to account for new payment models.

INNOVATIVE MODELS

Waiving Documentation Requirements in APMs

APMs incentivize providers to deliver high quality care while also reducing cost. Unfortunately, there are additional documentation requirements both on clinical characteristics and quality measures that are essential to APMs but significantly increase the overall burden on clinicians as these requirements do not replace but rather escalate the chronicling needs. For example, in the Oncology Care Model (OCM), clinicians are required to tally specific Hierarchical Condition Categories (HCCs) that are otherwise noted in the record but need to be re-recorded. Similarly, clinical and staging data which is in the record must laboriously be extracted and reported in OCM specific data collection tools. The additional funds in OCM that were designed to enhance care are in reality are being used for data entry. When CMS requires additional documentation, there should be a specific fee to pay for the additional work. Where feasible, CMS should explore opportunities to waive certain documentation requirements in APMs when appropriate.

Address Overlap in Value-Based Care Programs

As more APMs are rolled out, APM overlap within markets and provider organizations has occurred more frequently, causing confusion in the marketplace regarding which APMs providers may participate in, and when. While some APMs can complement one another when it comes to improved quality and other outcome-based goals, participation in more than one APM can result in conflicting financial incentives that undermine the objectives of those already in existence.

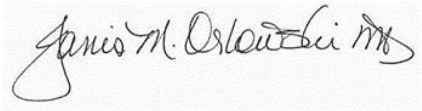
CMS should review current overlap policies to address overlap in a transparent manner when models are designed and released to the public. CMS should also enable savings to be distributed in certain circumstances to each program when there is overlap.

Administrator Verma
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Conclusion

The AAMC welcomes engagement on these issues and appreciates the opportunity to comment. We look forward to continuing work with the CMS on these issues. If you have any questions, please contact Gayle Lee at (202) 741-6429 or galee@aamc.org or Mary Mullaney at (202) 909-2084 or mmullaney@aamc.org.

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski M.D.". The signature is written in a cursive style and is placed on a light gray rectangular background.

Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer

Cc: Ivy Baer, JD, MPH, AAMC
Gayle Lee, JD, AAMC