August 12, 2014

The Honorable Ron Wyden
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Chuck Grassley
United States Senator
135 Hart Senate Office Building
Washington, DC 20510

Submitted electronically to data@finance.senate.gov

Dear Chairman Wyden and Senator Grassley:

On behalf of the American Medical Group Association (AMGA), thank you for the opportunity to comment on your June 12, 2014 letter to stakeholders regarding healthcare data transparency. AMGA represents some of the country's largest integrated healthcare delivery systems and multi-specialty medical groups. The nearly 150,000 physicians practicing within AMGA member medical groups deliver healthcare services to more than 120 million patients in 49 states.

Healthcare data, and its transparent use, has the potential to better educate the consumer/patient and drive significant change and improvement in the delivery system. Already, the publishing of healthcare data around quality and cost measures is causing healthcare providers to rethink how they deliver care, focus on patient outcomes, and manage populations of patients.

However, transparency is not as transparent as it seems. Currently, data is fragmented among provider, payor, and government silos, and often jealously protected. This non-system of measurement was barely adequate in a fee-for-service system where providers were not at risk and consumers generally enjoyed low-cost sharing obligations. It is completely inadequate in a value-based system where providers accept risk for improving care and reducing costs and patients are increasingly responsible for paying a greater share of their care.

Many barriers exist in using healthcare data to drive quality improvement, lower costs and facilitate informed choices. However, reasonable reforms are possible that would transform the current non-system of quality measurement into one that truly supports value.

Healthcare Data Drives System Improvement

While much of the focus around data and transparency center on educating the consumer, the collection, reporting, and analysis of clinical and claims data may be the key to redesigning processes to improve care and reduce costs. AMGA members are some of the earliest adopters of electronic medical record (EMR) systems and as such have access to volumes of rich clinical data. However, simply collecting EMR derived clinical data does little to improve care without the people and technology to analyze the information. Utilizing sophisticated analytics and quality improvement staff, medical groups comb the clinical data to determine gaps in care, make improvements to close those gaps, and identify patients with chronic illnesses most in need of intense management. Analytics are key in identifying patients at risk of hospital admissions, emergency department visits, and most in need of primary care follow-up after an inpatient discharge. Internally, data is used to create transparent physician quality reports which identify outlier physicians who need management attention. Data assists medical group service lines to identify areas that need improvement or have significant treatment patterns that diverge from evidence-based guidelines. This information allows medical groups to develop new care protocols and design improved order sets within the EMR. Collection and analysis of healthcare information results in better quality scores and, often, lower costs.

Nearly 40 AMGA member organizations participate in Anceta, AMGA's data warehouse collaborative. Their goal is to improve population health through comparative clinical analytics—integrated longitudinal claims data plus comprehensive clinical data extracted from the groups' electronic health records (EHRs), mapped and normalized for apples-to-apples comparisons. Anceta members use a database of nearly 30 million lives to create predictive models. AMGA facilitates shared learning about how to redesign care processes to best take advantage of these predictions. This is a major shift toward proactive care, requiring new roles such as health coaches, care coordinators, and case managers. Among patients with congestive heart failure, one medical group achieved a 65 percent reduction in the rate of hospital admissions for heart failure, using a care process designed around a predictive model. Among those patients who were admitted, they achieved a 30 percent reduction in the rate of all-cause readmissions. The savings more than offset the cost of the intervention, and, not surprisingly, patient satisfaction was significantly higher.

What Data Sources Should Be Made More Broadly Available?

While medical groups with EMRs are able to review their own clinical data, claims data - which covers office visits, tests, procedures, lab results, medications, etc., - is critical to painting a fuller picture of the patient. Claims data is needed for providers to understand the care that happens outside of the medical group office. Claims data is also needed to better predict risk and identify chronically ill and high-cost patients. In other words, medical groups, indeed all providers, need both clinical and claims data to manage patients' care and their costs. However, access to claims data is uneven. Some commercial payors will share claims data with providers while many will not. The Centers for Medicare and Medicaid Services (CMS) shares its Medicare claims data with Accountable Care Organizations but there are limits to the effectiveness of this data-share effort. The data is delivered in ever-changing formats, which needlessly takes up hours of administrative time to reformat it, and is not delivered in a timely manner.

AMGA recommends the development of a central data warehouse, coordinated by a trusted party that would house administrative claims data from a variety of sources (e.g., Federal healthcare programs, commercial payors, labs, pharmacy benefit managers, etc.). Examples of data warehouses already exist. The Organ Procurement and Transplantation Network collects data on every organ transplant in the country and has helped improve transplant care. Specialty physician societies have created sophisticated disease registries and dozens of states have implemented or are implementing all-claims data bases. However, we believe a central database is needed to avoid fragmentation. Providers would be able to request data from this warehouse as needed, instead of the current practice of receiving data at a certain designated time (i.e., monthly, quarterly, etc.). At a minimum, Congress should require CMS to provide its claims data, including Part D drug data, to a central warehouse. Congress should also consider requiring commercial payors to submit their claims data to the warehouse.

Barriers to Using Healthcare Data

Another major barrier to effectively using healthcare data is a total lack of standardization for collecting, submitting, and reporting data. Different payors require providers to submit different quality measures in different formats, at different times, with different inclusion/exclusion criteria. This fragmented quality measurement system takes up resources on the provider end and diverts attention from building the infrastructure necessary to effectively manage population health. From a consumer perspective, this lack of standardization means the same physician can be ranked "good" by one payor, and "poor" by another. Without an apples-to-apples comparison system, consumer interpretation of the "data" is literally left up to the imagination of the reader, making a truly informed choice challenging at best.

Of course, different measures do apply to different populations. For instance, measures for the Medicare and Medicaid programs must address different priorities, given the different populations served by these programs. However, standardizing the collection, submission, and reporting formats for these programs is essential to allow providers to focus on redesigning care processes and providing consumers with real actionable information that lets them make informed choices.

While not a barrier per se, Congress along with the healthcare industry, should examine the larger issue of whether the current measurement system is truly measuring and improving quality. Currently, there are large measure gaps in the National Quality Strategy that should include measures in the care coordination and patient safety domains. Overuse and underuse of services for costly disease states are not covered by current measurement regimes. Acute care measures such as admissions, length of stay, days in the intensive care unit may be good measures of quality.

AMGA recommends that Congress require CMS to convene a stakeholder group to discuss and agree upon developing a consistent format and process for the collection, submission, and reporting of data and the feedback reporting of data. The recommendations of the stakeholder group should be reported within 18 months to ensure action is taken on this issue. The recommendations should be subject to Notice and Comment requirements under the Administrative Procedure Act.

Conclusion

The transparent reporting of healthcare data has the potential to improve the healthcare delivery system and create an educated patient/consumer. Transparency is in its infancy, and there is understandably much confusion surrounding the data. However, this is the right direction to pursue and by allowing providers to access all forms of data and by standardizing the data submission process, Congress has the opportunity to dramatically improve the quality measurement system for patients and providers.

We look forward to working with you on this very important matter.

Sincerely,

Donald W. Fisher, Ph.D.
President and CEO
American Medical Group Association