January 29, 2016

The Honorable Orrin Hatch
Chair, Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
Member, Senate Committee on Finance
Co-chair, Chronic Care Working Group
United States Senate
Washington, DC 20510

The Honorable Mark Warner
Member, Senate Committee on Finance
Co-chair, Chronic Care Working Group
United States Senate
Washington, DC 20510

Submitted electronically to: chronic_care@finance.senate.gov

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

AMIA appreciates the opportunity to comment on the Policy Options Document developed by Finance Committee Chronic Care Working Group. We support the goals outlined by the working group to increase care coordination; streamline Medicare's payment system to incentivize appropriate care; and better manage growth in Medicare spending by improving care transitions and patient outcomes.

AMIA is the professional home for more than 5,000 informatics professionals, representing researchers, front-line clinicians and public health experts who bring meaning to data, manage information and generate new knowledge across the health and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA members play a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluating interventions, innovations and public policy across settings and patient populations.

Our comments touch briefly on the four following areas: (1) Advancing team-based care; (2) Expanding innovation and technology; (3) Identifying the chronically ill population and ways to improve quality; and (4) Other policies to improve care. Given our multidisciplinary focus on health informatics, we will limit our comments to those policies and research opportunities needed to improve care delivery, accountability and patient engagement for the chronically ill.

Specifically, AMIA urges members of the Senate Finance Committee Chronic Care Working Group to:

- Advance team-based care by directing the Center for Medicare and Medicaid Innovation (CMMI) to fund pilot programs to define the technical specifications needed for a

longitudinal care plan, as well as implementation guidance on how to integrate these care plans into various settings of care most relevant for chronic care populations;

- Leverage policymaking related to implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to encourage development and sharing of longitudinal care plans using health informatics tools, such as electronic health records (EHRs) or health information exchanges (HIEs);
- Improve efforts to integrate social and behavioral measures of health within chronic care by supporting data standardization, efficient measure collection, and integration with decision support;
- Expand the use of telehealth and telemedicine tools to improve care quality and reduce costs, while improving the rural infrastructure for such tools;
- Incentivize discovery and actionable insights related to chronic care populations by encouraging clinical practice improvement activities and Alternative Payment Models (APMs) to leverage informatics tools and data analytics capabilities;
- Urge development of electronically-specified measures for chronic care, while more critically scrutinizing the current state of electronically-specified quality measures needed for MACRA-related policies; and
- Consider how the Patient-Centered Outcomes Research Institute (PCORI) might be leveraged to identify pragmatic comparative effectiveness research focused on chronically ill individuals.

We hope our comments, attached in more detail below, are helpful as you undertake this important work. Should you have questions about these comments or require additional information, please contact Jeffery Smith, Vice President of Public Policy at jsmith@amia.org or (301) 657-1291. We look forward to continued dialogue.

Sincerely,

Douglas B. Fridsma, MD, PhD, FACP, FACMI
AMIA President and CEO

Attachment: AMIA recommendations to Senate Finance Committee Chronic Care Working Group

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Advancing Team-Based Care

The Finance Committee appropriately identifies team-based care as a best-practice care model for those with multiple chronic conditions. All too often, diagnoses, medications, and care plans are not shared nor understood by all members of a patient's care team. The policy considerations deliberated in this section correctly focus on Medicare beneficiary access to team-based care and access to enhanced benefits structure; reimbursement changes to better incentivize care through chronic care management (CCM) codes; and ways to integrate care for individuals with a chronic disease combined with a behavioral health disorder.

As our nation's clinicians continue their adoption of electronic health records (EHRs), development of longitudinal care plans (LCPs) provide new opportunities to improve communication and coordination as patients transition across settings. However, more progress is needed. **AMIA urges policymakers to leverage existing and newly developed policy to ensure continued progress on EHR adoption, and encourage the ongoing evolution of EHR functionality to support team-based care.**

An LCP is a holistic, dynamic, and integrated plan that documents important disease prevention and treatment goals and plans. Using electronic systems to link together various elements, an LCP can be customized for the relevant clinician, patient and/or family member, and provide actionable information to identify and achieve the individual's health and wellness goals. A 2014 study published in the *Journal of the American Medical Informatics Association* sought to describe the current state of LCPs versus what is needed to improve care, manage populations and lower costs.[1] Professionals from emergency departments, acute care hospitals, skilled nursing facilities, and home health agency settings across six regions of the US were surveyed to understand the degree to which current practice meets the definition of an LCP. However, results indicated that there are serious deficiencies in how LCPs are conceptualized and used in current practice. Researchers found that care plans are not routinely shared or reconciled across settings, and there are wide variation in the types and formats of care plan information communicated as patients transition across settings. Researchers conclude that until "standardized, structured, electronic LCP data elements and value sets are routinely captured within individual settings and exchanged across all settings, it is not possible to realize potential benefits [of the LCP]."[2]

Another study identified how EHRs facilitate and pose challenges to care teams, as well as how practices are overcoming related challenges.[3] Survey participants indicated that EHR functionalities posed challenges to teamwork due to the lack of integrated care manager software and care plans in EHRs, poor practice registry functionality and interoperability, and inadequate ease of tracking patient data in the EHR over time. Researchers concluded a "shift in the policy and regulatory

[1] Dykes, P., Samal, L., Donahue, M., et al "A Patient-centered Longitudinal Care Plan: Vision versus Reality." J Am Med Inform Assoc 21.6 (2014): 1082-090. http://bit.ly/1OJRe24

[2] Ibid.

[3] O'Malley, A., Draper, K., et al "Electronic health records and support for primary care teamwork." J Am Med Inform Assoc 22.2 (2015): 426-434.

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environment toward encouraging providers and EHR vendors to work supporting team-oriented care for individuals and populations could bolster that evolution."[4]

Both of these studies represent an opportunity to make progress in advancing team-based care by improving adoption and functionality of informatics tools, such as care plans and care manager software, within EHRs. Specifically, **AMIA recommends the working group consider ways to fund pilot programs to define a common set of LCP tools, practices and processes to enable care plan reconciliation across settings.** In addition, studies are needed to obtain the patient and family perspectives on the LCP and their role in achieving this vision. Concurrent with ongoing policy development related to MACRA, CMS could urged to work with individual primary and specialty societies to identify and prioritize elements of LCPs, or be encouraged to develop LCPs within the purview of clinical practice improvement requirements related to the Merit-based Incentive Payment System (MIPS) and as-yet-defined APMs.

Lastly, advancing team-based care must, as working group deliberations have indicated, include care for individuals with a chronic disease combined with a behavioral health disorder. The first step towards better integration of care for this population is to gather more and better data. The Institute of Medicine (IOM) issued a report in 2014 calling for more social and behavioral determinants of health to be captured by EHRs, arguing that such data can improve clinical care, prevention and general health, patient satisfaction, research and public health.[5] Capturing and using the measures identified in the IOM report will be difficult, and if not done cautiously, these additional data will further complicate point of care delivery for chronically ill populations. Therefore, **AMIA calls on the working group to consider funding studies or pilots that address challenges around standardization, efficient collection and review of measures, integration with decision support, and further identification of areas for research.**

<u>Identifying the Chronically Ill Population and Ways to Improve Quality</u>

Scholarship published by AMIA members has demonstrated how electronic health records (EHRs) can be powerful tools to identify and treat patients with chronic pain and illness. We urge working group members to encourage clinicians to leverage their EHRs in ways similar to what is described below. Further, we support efforts to develop quality measures related to chronic care; however, we strongly recommend increased congressional oversight over electronically generated quality measurement, as deficiencies in this arena will have important consequences far beyond chronic care.

As part of a large-scale quality improvement initiative focused on improving chronic pain management in a state-wide, multisite community health center, researchers sought to develop an accurate and reliable method for identifying patients with chronic pain – a condition that affects an

[4] Ibid.

[5] IOM (Institute of Medicine). Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, DC: The National Academies Press; 2014.

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estimated 100 million Americans with an annual cost of up to $635 billion in medical treatment and lost productivity.[6] The 2013 study performed by Middletown, Connecticut-based Community Health Center, Inc. used structured data representing patient-reported pain scores, diagnostic codes and opioid prescription medications ordered electronically with the EHR to identify chronic care pain with high accuracy.[7] This method has implications for clinicians interested in identifying chronic pain patients in large datasets for research, evaluation or quality improvement purposes, and it is an important first step in addressing this critical public health challenge.

Likewise, a 2015 study sought to predict patients who are at risk for chronic kidney disease (CKD) progression from stage III to stage IV using data found in EHRs.[8] CKD affects as many as 20 million adults in the US, with chances of acquiring the disease increasing with age.[9] Researchers at Columbia University and Princeton found that when longitudinal data on clinical documentation is combined with longitudinal laboratory test results, a risk prediction model can predict CKD progression more accurately than three prevailing methods, which could improve outcomes by facilitating timelier initiation of appropriate therapies, monitoring, and specialty referral.

Similar findings, related to other priority areas in chronic care, are increasingly possible with continued adoption of EHRs. **We recommend working group members seek to generate new discovery and actionable insights by including such work as part of clinical practice improvement activities, under MIPS, or give preference to APMs that include such activities as part of their design.** These opportunities should supplement wherever possible the EHR Incentive Program, known as Meaningful Use. For example clinical decision support can and should remain a central component of how clinicians use health informatics tools to identify and improve care for chronically ill patients moving forward.

Working group members are also considering development of quality measures for chronic conditions. AMIA supports development of measures in this domain, and we believe the topic areas identified by the working group for a GAO report will serve as a good foundation for continued exploration. However, we wish to call attention to the current state of electronically specified clinical quality measures (eCQMs), which we fear is insufficiently mature for reimbursement purposes.

Recently, CMS issued a pair of Requests for Information seeking input on MACRA-related policymaking. AMIA has twice issued strong statements urging CMS to reconsider quality

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[6] Institute of Medicine. *Relieving pain in America: a blueprint for transforming prevention, care, education, and research*. Washington, DC: National Academy Press, 2011.
[7] Tian, T., Zlateva, I., and Anderson, D. "Using Electronic Health Records Data to Identify Patients with Chronic Pain in a Primary Care Setting." J Am Med Inform Assoc 20.E2 (2013). http://bit.ly/1OJGzEL
[8] Perotte, A., Ranganath, R., et al. "Risk Prediction for Chronic Kidney Disease Progression Using Heterogeneous Electronic Health Record Data and Time Series Analysis." J Am Med Inform Assoc 22.4 (2015): 872-80. http://bit.ly/1OJGFfr
[9] National Center for Chronic Disease Prevention and Health Promotion. National Chronic Kidney Disease Fact Sheet, 2014. http://1.usa.gov/1OJLV2O

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measurement development in an electronic environment.[10,11] Providers have very little, if any, confidence in eCQM accuracy and completeness; health IT developers spend an inordinate amount of resources devoted to eCQMs, which represents an opportunity cost for other customer priorities; and there is little time for the stakeholders to incorporate updates into their products and workflows. In short, the task of gathering and reporting eCQMs overshadows the benefits of tracking measures in many instances. AMIA has called on CMS to overhaul how quality measures are developed and conceptualized using EHRs. This overhaul must begin with a better endorsement process, which should include pilot testing and an assessment of how implementable the new measure is for the target population of providers. It is not enough that a measure be deemed clinically appropriate for endorsement; the measure should also be demonstrably implementable. We urge Senate policymakers to consider the broader landscape of quality measurement, while looking to develop measures specific to chronic care.

Other Policies to Improve Care for the Chronically Ill

Working group deliberations have included a number of potential studies for specific conditions, as well as more the need for more general research on chronic conditions. AMIA supports the need for new discovery and knowledge. We encourage working group members consider how the Patient Centered Outcomes Research Institute (PCORI) might be leveraged to identify pragmatic comparative effectiveness research focused on chronically ill individuals.

[10] AMIA Response to CMS Request for Information Regarding the Implementation of MIPS and APMs, Nov. 2015. Available at http://bit.ly/1PO2zfi

[11] AMIA Response to CMS Stage 3 Open Comment Period, Dec. 2015. Available at http://bit.ly/1PO2DvA

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