January 12, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Center for Medicare and Medicaid Innovation White Paper: *Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade*

Dear Administrator Brooks-LaSure:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Center for Medicare and Medicaid Innovation (CMMI) White Paper, *Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade*. ACP is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP was very pleased to find many parallels between CMMI's strategy and ACP's own objectives and recommendations for improving health care. As ACP President Dr. George M. Abraham, MD, MPH, has pointed out, CMMI's strategy and priorities as laid out in the White Paper are consistent with ACP's recommendations issued in its 2020 *Vision for the U.S. Health Care System* and its 2021 *Comprehensive Framework to Address Disparities and Discrimination in Health Care*.

The College supports CMMI's plans to use broader measures of model success, such as equity, care delivery, transformation, patient outcomes, and market characteristics, in a shift from its traditional standard of improved quality while either maintaining or reducing cost, or reduced cost while maintaining or improving quality. ACP strongly supports and appreciates the Agency's overarching goals of reducing model complexity, reducing administrative burden, and streamlining participation requirements. Along with our support for these changes, ACP wishes to emphasize that any new models should increase quality and access without imposing undue burdens on physicians and other medical professionals. Additionally, mandatory models should not be introduced too soon.

The College's comments regarding each of the five strategic objectives described in the White Paper are below.

Objective 1: Drive Accountable Care
To meet its objective of driving accountable care, the Innovation Center intends to increase the number of people in a care relationship with accountability for quality and total cost of care.

CMMI's goals for clinicians include (1) "increas[ing] the capability of primary care providers, as well as specialists and other providers, to engage in accountable care relationships with beneficiaries through incentives and flexibilities to manage quality and total cost of care"; and (2) "[making] transformation supports, such as data-sharing, learning opportunities, and regulatory flexibilities, as well as varying levels of options to assume risk [...] available for primary care practices to transition to population-based payments and to sustain accountable care relationships."

CMMI specified that the goal is for beneficiaries in these valued-based care arrangements to have their needs "holistically assessed" and their care "coordinated within a broader total cost of care system." ACP believes that when considering high value care, care coordination is essential, and ACP is pleased that CMMI is emphasizing care coordination in their strategy. As more value-based payment (VBP) arrangements roll out, model overlap increases, causing confusion for physicians regarding which models they can participate in and how beneficiaries will be aligned. While participation in multiple VBP arrangements can be complementary with aligned goals of improving quality and outcomes, physicians often face conflicting financial incentives that make it difficult to participate in multiple arrangements. The Innovation Center plan to focus on launching fewer models may partly address model overlap concerns. However, these concerns should not be the primary driver for fewer models, as model overlap concerns must be balanced with ensuring VBP participation options for all physicians and other clinicians. CMS must intentionally design models and evaluation to account for model overlap. Additionally, CMS should establish clear model hierarchies and ensure physicians are not disadvantaged for participating in multiple models.

ACP agrees with CMMI that primary care plays a foundational role in transforming the health care system and appreciates that CMMI has spent time and resources to develop and test primary care models. ACP has been highly supportive of both the CPC and CPC+ models. In a joint letter to CMMI in May of last year, the College emphasized the benefits of both CPC+ and the original CPC model. The letter specifies that "(m)any of our practices have been transforming for years before CPC+, including through participation in the original CPC model. We have deployed vital care coordination and management services that enhance patient care and advance health equity while reducing health care costs. Year over year, our practices have improved quality, reduced emergency department utilization, and as 2019 data has shown, we reduced acute hospitalizations."

Additionally, in a joint letter with AAFP, ACP details how tools for transitioning away from CPC/CPC+ are needed. We continue to recommend that CMMI offer a bridge to CPC+ practices entering PCF which would allow them to continue to successfully provide enhanced primary care to their patients.

ACP is pleased that CMMI positively reviewed the National Academy of Medicine's report on rebuilding primary care. As outlined in our Medical Home Neighborhood Model (MNM) proposal, MNM provides a unique opportunity to build a strong foundation of primary care which aligns with CMMI's focus on rebuilding primary care and champions the importance of team-based care.

The College believes that in development of future models, CMMI should work closely with those involved in VBP models to optimize incentives and establish models which are equitable and create greater value

for patients and their health care systems. ACP supports CMMI's aim to make complex, overlapping models more transparent and streamlined.

ACP appreciates CMMI's focus on providing tools and incentives for delivering high-quality, coordinated, team-based care. ACP highly agrees with CMMI's emphasis on the importance of education, engagement with beneficiaries, and establishing meaningful outcome measures.

ACP thanks CMMI for committing to work with the Medicare Shared Savings Program (MSSP) and the Quality Payment Program (QPP) to incentivize the transition to value-based care and alternative payment model (APM) participation.

Objective 2: Advance Health Equity
To meet its objective of advancing health equity, the Innovation Center intends to embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.

CMMI's goals for clinicians include (1) "address[ing] barriers to participation for providers that serve a high proportion of underserved and rural beneficiaries, such as those in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs), and designated provider types such as Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), and other safety net providers and creat[ing] more opportunities for them to join models with supports needed to be successful"; (2) "offer[ing] targeted learning opportunities for model participants to advance health equity, including collaborating with community partners to address social needs"; and (3) "requir[ing] and consider[ing] incentives and supports for model participants to collect data on race, ethnicity, geography, disability, and other demographics and [reporting results] to the Innovation Center to help providers address health disparities (in a manner that protected health information (PHI) complies with HIPAA-and other applicable laws)."

The College is very pleased with CMMI's focus on improving health equity—an issue of top concern for ACP and its members. As ACP stated in our paper on delivery and payment system reforms, "poorly designed value-based models have the potential to exacerbate health inequities, particularly models that feature patient cost-sharing or those that are available only in certain, typically more urban, geographic regions. Practices and health systems that care for vulnerable patient populations must be supported rather than penalized." Improving support for primary care physicians could be key to helping those populations, as they have been demonstrated to provide patients with better outcomes at lower costs. That is why ACP remains particularly supportive of the Agency's mention of working to increase primary care engagement.

In January 2021, ACP and six other primary care physician groups released a proposed *New Paradigm for Primary Care Financing*, rejecting the current cost-based financing paradigm and advocating for primary care financing as a public good and investment in health. In our proposed new paradigm:
- The purpose of health care is to foster optimal health for all members of society. Therefore, payment is connected to both upstream aspects of health (social drivers and preventive care) and downstream aspects of illness (acute and chronic conditions).
- Payment models create predictability through baseline streams of revenue that allow local adaptations to meet person-centered needs that align with individual life circumstances, as well as population-level health needs, such as community and public health partnerships with primary care (e.g., community walking programs).

- Payments increase access to and use of high value, community-based care solutions that build on local assets, promote person-focused coordinated care, and reduce long-term costs by creating better health.
- Social services agencies and public health have robust resources to address systemic inequities and social drivers of health [SDOH] at the local and federal levels.
- Primary care is able to address the majority of needs – from health problems to health promotion – in the broader context of the human condition in which biological and biographical circumstances are interrelated.

Incremental increases in physician payments themselves do not do enough to strengthen primary care's foundation or to help physicians and practices address the needs of populations facing inequities or other SDOH. Solutions such as prospective per patient per month payments, hybrid payment programs, and additional remote care flexibilities can help, so long as they are designed with intention and focus on health equity.

Payment models must value primary and comprehensive care appropriately and be sufficient to cover the costs of treating patients, especially those most vulnerable, recognizing and supporting the additional resources involved in providing care to underserved patients and advancing health equity. Such payments should not impose additional administrative and reporting burdens on physicians that do not advance quality, value, or equity, nor should they require physicians and their teams to accept an unreasonable and unsustainable degree of financial risk for population-based outcomes.

ACP agrees that health equity should be considered through all stages of model design. A joint letter to the Secretary of Health and Human Services points out that current models do not consider approaches physicians employ to address health equity, nor are there appropriate flexibilities for APM participants to strengthen their focus on addressing health inequities. Incentives across the health care delivery and payment system need to be aligned to promote equity and eliminate disparities. CMS should consider a wide array of approaches for addressing health equity in APMs, such as incorporating SDOH into risk adjustment. It is essential that APM participants are not disadvantaged for serving medically and socially complex beneficiaries and that they have the resources to continue providing vital services to their communities. CMS should consider paying for services that address SDOH and increasing access to standardized sociodemographic and social driver information.

The College recently developed a series of policies and recommendations for understanding and addressing disparities and discrimination in health and health care. In an April 2021 policy paper about ameliorating health and health care disparities, ACP proposed a comprehensive policy framework for mitigating SDOH that contribute to poorer health outcomes. In addition to this framework, which includes high-level principles and discusses how disparities are interconnected, ACP offers specific policy recommendations on disparities and discrimination in education and the workforce, those affecting specific populations, and those in criminal justice practices and policies in its three companion policy papers. ACP believes that a cross-cutting approach that identifies and offers solutions to the various aspects of society contributing to poor health is essential to achieving its goal of good health care for all, poor health care for none. Specific policy positions and recommendations from the high-level paper include:
(1) ACP believes that more research and data collection related to racial and ethnic health disparities are needed to empower policymakers and stakeholders to better understand and address the problem of disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns.

(2) ACP recommends that U.S. policymakers commit to understanding and addressing disparities in health and health care related to a person's race, ethnicity, religion, and cultural identity [their personal characteristics], as aligned with ACP's mission "to enhance the quality and effectiveness of health care for all."

(3) ACP recommends that policymakers comprehensively address the interconnected contributors to health and health care disparities, including the role of racism, discrimination, lack of coverage and access to care, poverty, and other SDOH.

(4) ACP believes that a diverse, equitable, and inclusive physician workforce is crucial to promote equity and understanding among clinicians and patients and to facilitate quality care, and it supports actions to achieve such diversity, equity, and inclusion.

(5) ACP believes that public policy must strive to make improvements to coverage, quality, and access to care for everyone, while addressing the disproportionate effect on those at greatest risk because of their personal characteristics.

(6) ACP believes that health care delivery and payment systems should support physician-led, team-based, and patient- and family-centered care that is easily accessible to those affected by discrimination and SDOH.

(7) ACP recommends that policymakers understand, address, and implement evidence-based solutions to systemic racism, discrimination, and violence in criminal justice and law enforcement policies and practices because they affect the physical health, mental health, and well-being of those disproportionately affected because of their personal identities.

In a January 2020 position paper, ACP called for ending discrimination based on personal characteristics, correcting workforce shortages, including the undersupply of primary care physicians, and understanding and ameliorating SDOH. Specific policy positions and recommendations in this paper include:

(1) ACP believes that all persons, without regard to where they live or work; their race and ethnicity; their sex or sexual orientation; their gender or gender identity; their age; their religion, culture, and beliefs; their national origin, immigration status, and language proficiency; their health literacy level and ability to access health information; their socioeconomic status; whether they are incarcerated; and whether they have intellectual or physical disability must have equitable access to high-quality health care and must not be discriminated against based on such characteristics.

(2) ACP believes that public policies and efforts should be directed to ensuring an adequate supply and distribution of physicians and other clinicians to meet the nation's health care needs, especially for underserved rural and urban populations. Integrated actions are needed to address the barriers to physicians, including internal medicine specialists, from entering and remaining in the primary care workforce and practicing in underserved communities. Research and policies to address the impact of hospital closures on access and outcomes of care are urgently needed.

(3) ACP supports greater investment in the nation's public health infrastructure, research, and public policy interventions to address the SDOH and other factors that have a negative impact on health.

In a companion position paper, ACP advocates for a fundamental restructuring of U.S. payment, delivery, and information technology (IT) systems to achieve a health care system that puts patients' interests first and supports physicians and their care teams in delivering high value, patient- and family-centered care. ACP's recommendations include increased investment in primary care; alignment of financial incentives to achieve better patient outcomes, lower costs, reduce inequities in health care, and facilitate team-based care; freeing patients and physicians of inefficient administrative and billing tasks and documentation requirements; and development of health information technologies that enhance the patient-physician relationship. Specific policy positions and recommendations from this letter include:

(1) ACP recommends that value must always be defined with patients and families at the center, fully empowered to be active partners in all aspects of their care.

(2) ACP recommends that all patients, families, and caregivers and their clinical care teams be provided with transparent, understandable, actionable, and evidence-based quality, cost, and price information to meaningfully compare medical services, facilities, and products.

(3) ACP recommends that health care delivery and payment be redesigned to support physician-led, team-based care delivery models in providing effective, patient- and family-centered care.

(4) ACP believes there is not a one-size-fits-all approach to reforming delivery and payment systems to increase value, and a variety of approaches should be considered, evaluated, and expanded.

    a. Physicians and their clinical care teams should have a variety of voluntary VBP models to choose from to help them deliver high-value care that meets the needs of a diverse patient population. Value-based initiatives differ in design, with varying strengths and weaknesses. Model developers and policymakers should harness the strengths of each model to construct a robust network of value-based innovations that can be layered to meet a wide range of unique patient types and needs while being cognizant of the potential for adverse consequences on patient access or quality of care, particularly for underserved populations. Having more choices of value-based programs and models allows physicians and their practices to select value-based solutions that meet their individualized needs on the basis of their specialty, patients, and other considerations.

    b. Of note, models should have varying levels of risk and reward to appeal to a wide range of practices with differing abilities to take on financial risk. Smaller, independent practices can struggle to make the upfront investment necessary to successfully participate in APMs, absorb financial risk, and manage the changing APM landscape. Model developers and policymakers should keep these important considerations in mind to attract small, independent, and rural practices to APMs.

    c. Models should reward improvement, as well as consistent high value. A key criticism of the MSSP has been that accountable care organizations that already provide high-quality, low-cost care have a difficult time continuously improving their performance, which could make it difficult to beat their benchmarks and earn shared savings. Value-based models and programs should undergo regular, independent evaluation to ensure accurate measurement of their impact on cost, quality outcomes, and patient satisfaction. Assessment should also consider how well they support the quadruple aim of improving outcomes, enhancing patient satisfaction, lowering costs, and improving physician satisfaction. Evaluations should be used to improve the accuracy of individual performance metrics and make design improvements to increase a model's ability to effectively drive and capture quality or efficiency enhancements, as well as to recognize when it is time to sunset a particular program or model. Payers should be encouraged to test and implement new models. Quality improvement or delivery efficiency may take years to develop, and lessons learned can inform future value-based models and programs. Capitation, patient-centered medical homes (PCMHs), and direct primary care (DPC) models are gaining momentum from policymakers and physicians.

(5) ACP recommends that payers prioritize inclusion of underserved patient populations in all VBP models.

(6) ACP recommends that all payment systems substantially increase relative and absolute payments for primary care commensurate with its value in achieving better outcomes and lower costs. Inappropriate disparities in payment levels between complex cognitive care and preventive services, relative to procedurally oriented services, should be eliminated.

(7) ACP recommends the immediate elimination of unnecessary, inefficient, and ineffective billing and reporting requirements for all health care services, as well as reducing administrative barriers to appropriately paying for and valuing non-face-to-face-based care, such as care management.

(8) ACP believes that VBP reform initiatives should increase flexibility and freedom from billing, reporting, and other administrative burdens in exchange for holding physicians and clinical care teams accountable for quality and cost outcomes.

(9) ACP recommends that performance measures and measurement methodologies, when tied to public reporting and payment, be aligned across payers, models, and programs whenever possible.

(10) ACP recommends that VBP programs move away from "check the box" performance requirements toward a limited set of patient-centered, actionable, appropriately attributed, and evidence-based measures for public reporting and payment purposes, while also supporting the use of additional clinically meaningful measures for internal quality improvement.

(11) ACP recommends that all performance targets be provided to physicians and their clinical care teams in a prospective and transparent manner and that all performance feedback be accurate, actionable, and timely.

(12) ACP calls for a collaborative, multistakeholder measure development and maintenance process that features upfront, ongoing, and transparent input from patients and frontline physicians and their clinical care teams.

(13) ACP recommends that the performance measurement infrastructure evolve into one that supports, with policy that prioritizes, what is important to measure and evaluates and continually improves upon the science of and methodologies for performance measurement.

(14) ACP recommends that improvements to health IT usability should prioritize the needs of patients and frontline physicians and their clinical care teams, strive to remove non-value-added interactions, and support VBP reform initiatives.

(15) ACP calls for interoperability efforts to be focused on the adoption and consistent implementation of health IT standards irrespective of the health IT system or digital technology.

(16) ACP believes that the testing and subsequent implementation of health IT standards and interoperability rules should be conducted in stages to avoid and/or mitigate adverse effects on patient care, privacy, security, clinical workflow, and data visualization and interpretation.

(17) ACP recommends that stakeholders support the development, adoption and use of innovative technologies that seamlessly enable enhanced and coordinated patient-centered care.

Over the past decade, the Innovation Center has launched 54 payments models. However, only three models have been certified for nationwide expansion to-date. Provider organizations invest significant resources to participate in model tests. Setting a clear vision and path forward for building on the success of these models will encourage continued model participation. We appreciate CMS' commitment to incorporating what works into other Innovation Center models. However, CMS should revisit its evaluation criteria and how it considers models for expansion as part of its vision. The current approach has faced several critical challenges, including issues with model overlap, beneficiary leakage across models, ignoring positive spillover effects outside of models, and the impact of physician participation in earlier models. Moreover, model evaluations tend to focus on short-term aggregate results, overlooking participant-level trends and potential for longer-term impact. CMS should work with stakeholders to improve how it evaluates models for success and to revisit its criteria for model expansion.

Objective 3: Support Care Innovation
To meet its objective of supporting care innovation, the Innovation Center intends to leverage a range of supports that enable integrated, person-centered care such as actionable, practice-specific data,

technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities.

ACP strongly supports CMMI's goals for clinicians, which include (1) providing "support to leverage actionable, practice-specific data, detailed case studies, and other data to implement practice changes that deliver integrated, person-centered, and community-based care"; and (2) "[giving physicians] participating in models, particularly total cost of care models [...] and access to more payment flexibilities that support accountable care, such as telehealth, remote patient monitoring, and home-based care."

Regarding integrating whole-person care, ACP is very pleased that CMMI is examining how to enhance addressing SDOH in models. The College supports the Agency's efforts to improve the collection and precision of SDOH data, address evidence gaps on what works, understand beneficiary needs and the costs of services, improve coordination between community-based organization and health care entities, better coordinate federal funding, and identify incentives to address SDOH in health care settings. The College also strongly supports CMMI's goals to develop and test models or care delivery innovations across models that address gaps in care, including behavioral health, SDOH, and palliative care.

CMMI's goals for improving health equity are aligned with the views of ACP and six of our fellow primary care physician and clinician societies. In our 2017 *Shared Principles of Primary Care*, we advocate for primary care that is comprehensive and equitable. Our *Shared Principles* include that:

- Primary care addresses the whole person with appropriate clinical and supportive services that include acute, chronic and preventive care; behavioral and mental health; oral health; health promotion; and more.
- Primary care clinicians seek out the impact of SDOH and societal inequities. Care delivery is tailored accordingly.
- Primary care practices partner with health and community-based organizations to promote population health and health equity, including making inequities visible and identifying avenues for solutions.

ACP envisions a health system that ameliorates SDOH that contribute to poor and inequitable health, overcomes other barriers to care for vulnerable and underserved populations, and ensures that no person is discriminated against based on characteristics of personal identity, including but not limited to race, ethnicity, religion, gender or gender identity, sex or sexual orientation, or national origin.

To move closer towards such a health system, the College supports increased interprofessional communication and collaborative models that encourage a team-based approach to treating patients at risk to be negatively affected by SDOH and recommends: (1) development of best practices for utilizing electronic health record (EHR) systems as a tool to improve individual and population health without adding to the administrative burden on physicians; (2) adjusting VBP models and performance measurement assessments to reflect the increased risk associated with caring for disadvantaged patient populations; and (3) increased screening and collection of SDOH data to aid in health impact assessments and support evidence-driven decision-making.

ACP believes that more research and data collection related to racial and ethnic health disparities are needed to empower policymakers and stakeholders to better understand and address the problem of disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns.

While ACP acknowledges the importance of data elements like social, behavioral, and environmental factors in treating certain patients, and while we appreciate CMMI's goals of collecting demographic data such as race, ethnicity, geography, and disability as described in the Innovation Center's goals for Strategic Objective 2, we are concerned about others' assumption that physicians would be responsible for collecting, managing, and updating this data and distributing it freely. The College is uncertain as to the availability of standards for SDOH data elements, the ability to clinically translate these terms, and the implications on physician workload and burden from taking the time to enter coded data into structured formats for mandated questions.

The College also wishes to emphasize that other HHS agencies implicated by CMS' goals, such as the ONC, must prioritize balancing the need to capture, manage, and update this extremely important data within the EHR in a way that is not a new and overly burdensome administrative or data entry task for physicians or their care teams, and pursue further study before requiring the capture of these data elements. Also, the data are not actionable unless available interventions or social services are known to the physician and care team. Having data that are not directly actionable results in additional stress and burden on physicians and their care teams—who should be the receivers of SDOH data and not the creators and managers. ACP urges CMS to consider these points in carrying out its strategic goals and next steps for integrating whole-person care.

Regarding providing payment and regulatory flexibilities, ACP appreciates that the Innovation Center has tested several payment and regulatory waivers and flexibilities in models to support the delivery of more person-centered care. The waivers included in these models, such as telehealth waivers of originating site requirements in order to furnish care in new settings, are and continue to be integral to the nation's emergence from the COVID-19 public health emergency (PHE), while dually affording the most accessible care to patients.

Since the start of the PHE, ACP has advocated for these waivers and subsequent extensions, recognizing that both physicians and patients seek to benefit from the increased accessibility and flexibility. While COVID-19 has presented deeply challenging issues and impacted the lives of so many in our nation and across the globe, we should not lose sight of the "good", and the positive impact that the necessity to innovate has had on our collective moving forward. For these reasons, the College is grateful that the Innovation Center has recognized this and will strive to make these flexibilities in models permanent. Relatedly, the College is very pleased that under the 2022 Physician Fee Schedule Final Rule, the increased flexibilities for telehealth and coverage for audio-only technology to provide telehealth for mental and behavioral health services will move forward.

For additional information regarding ACP's stance on payment and regulatory flexibilities that should be included in these models, please see the below:
- ACP Response to Senate Finance Committee Inquiry Concerning Policies to Improve Behavioral Health Care, November 1, 2021.
- ACP Comments on 2022 Physician Fee Schedule and Quality Payment Program Proposed Rule, September 13, 2021.
- ACP Statement for the Record, U.S. Senate Finance Committee Hearing on COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned, May 19, 2021.
- ACP Recommendations for Maintaining Certain Telehealth Policies and Waivers after the Public Health Emergency, June 4, 2020.

Regarding sharing actionable, practice-specific data, the College agrees with CMMI that access to more actionable, close to real-time data is needed to support clinicians in value-based care arrangements and appreciates the Innovation Center's commitment to making practice-specific data on performance available through a value-based care management system designed to help clinicians better understand and forecast their performance through interactive data visualizations and dashboards.

The College remains concerned, however, about performance measures. As the College's Performance Measurement Committee cautioned in August 2021:

> Data are needed demonstrating that [patient reported outcome-based performance measures (PRO-PMs)] improve quality of care and are an effective tool to accurately compare physician performance and, as a result, can be used for accountability purposes. PRO-PMs should be based on the same rigor of evidence as any other performance measure. The use of empirical data, at a minimum, is needed to demonstrate a relationship between a patient-reported outcome (PRO) and at least one health care structure, process, intervention, or service that is actionable by the accountable entity (for example, physician, group practice, health plan). The number of physician-, system-, and patient-related factors tied to the successful management of multiple coincident chronic conditions—as is done in both ambulatory and hospital-based internal medicine—makes developing and applying PRO-PMs particularly challenging. The results of systematic reviews have been mixed [...] with some studies showing potential benefits in using PRO-PM data to assess quality of care, primarily at organizational or system levels (for example, hospital level) or when the PRO-PM is assessing an outcome that is linked to clinical procedures. Some PRO-PMs that are specified at the individual physician level are associated with procedures or processes that are clearly under the control of an individual physician. However, individual physician attribution is not appropriate for PROs that are highly dependent on patient factors (for example, access to care, family and community support). Studies have demonstrated limited correlation between PRO-PM scores and individual physician performance, citing factors that are not under the influence of the individual physician [...]. Consequently, PRO-PMs should not be used to measure individual physician performance unless there is evidence to show an association between the patient-reported outcome measure (PROM) and the care provided by the physician.

In 2017, the College's Performance Measurement Committee conducted a study on the validity of 87 measures relevant to ambulatory general internal medicine, finding that less than half of the measures (37%) were valid, over a third (35%) were not valid, and over a quarter (28%) were of uncertain validity. ACP believes performance measures need to be improved while CMMI works on improving models.

The College supports CMMI's exploration of efforts to accelerate data sharing, including the use of Fast Healthcare Interoperability Resources-based (FHIR®) application programming interfaces (APIs) and greatly appreciates the Innovation Center's efforts to give clinicians access to more timely, user-friendly information that reduces administrative burden.

ACP appreciates that the Innovation Center will continue to work across CMS and HHS to support adoption and implementation of interoperability standards that allow for the exchange of health data to enhance care delivery, support patient engagement, and improve research on and evaluation of models. We hope that the Innovation Center will consider the points and recommendations we present in this section regarding data interoperability and usability, especially in the early stages of model design and development.

Collaboration and agreement across the health care industry on interoperability standards and their implementation are essential elements for improving interoperability and allowing disparate health IT systems to communicate effectively. While ACP appreciates the federal government's ongoing efforts to establish an interoperable health IT infrastructure, including improving patients' rightful access to their data and promoting the use of standards, we continue to reiterate our ongoing concerns around the industry's focus on exchanging as much data as possible, regardless of the value of the data. This type of data liquidity does benefit certain sectors of the health IT industry, but when assessing interoperability from the patient-centered care perspective, receiving large amounts of data points, often disorganized, duplicative, and without context, hinders a clinician's ability to find useful and actionable information and can even negatively affect patient care.

Clinicians and patients need better tools for consolidating, filtering, and selectively viewing the information they need, as well as more uniform presentations of information with the underlying data available at a moment's notice to validate. While ACP commends ONC's continued efforts to advance interoperability through promoting the adoption of modern interoperability standards, including FHIR, and promoting the use of standards-based APIs, we reiterate our ongoing comments regarding the need for meaningful and actionable data exchange, concerns around data overload and data without context, and recommendations to encourage development of Substitutable Medical Applications, Reusable Technologies (SMART) on FHIR apps that aim to decrease burden and help consolidate and show clinicians and patients intelligent summaries of data. As the interoperable infrastructure continues to expand, ACP recommends implementing these interoperability efforts in stages so the impacts on patient care, privacy, security, clinical workflow, and data visualization and interpretation can be assessed and mitigated.

In July 2021, the College issued a position paper on health information privacy, protection, and use that included policy principles and recommendations for health data collection and sharing of health information. The following recommendations from the paper are particularly relevant to CMMI's goal of sharing actionable data.
- ACP supports increased transparency and public understanding, and improved models of consent about the collection, exchange, and use of personal health information within existing Health Insurance Portability and Accountability Act (HIPAA) rules, as well as for entities collecting, exchanging, and using personal health information outside the health care system.
  - o All entities that collect or use personal health information should provide standard and easily understandable notices of privacy practices, end-user licensing agreements, or terms of service to persons that contain the type of information collected, all allowable uses of information, and consent requirements.
  - o There should be a single, comprehensive taxonomy for consent provisions as well as standard structure for consent documents. Such consent models must account for literacy levels and preferred language, be revocable, and be unambiguous about which activities are permitted and which require consent.
  - o Within the guardrails of HIPAA and the health care system, permitted information-sharing activities requiring notice but not requiring consent must be narrowly defined, societally valuable activities of public health reporting, population health management, quality improvement, performance measurement, and clinical education.
- ACP believes that the confidentiality of personal health information is a fundamental aspect of medical care, and physicians and other clinicians have an obligation to adhere to appropriate privacy and security protocols to protect individual privacy.

- ACP believes that health IT and other digital technologies, including personalized digital health products, should incorporate privacy and security principles within their design as well as consistent data standards that support privacy and security policies and promote safety.
  - Health IT standards should be developed and consistently implemented to collect and exchange relevant consent information along with the personal health information to which they apply.
  - Health IT and other digital technologies should facilitate the provision of useful and appropriate disclosure notifications to persons when personal health information is disclosed and for what purpose, with the ability to customize the types of disclosure notifications received.
- ACP supports oversight and enforcement to ensure that all entities not currently subject to HIPAA rules and regulations and that interact with personal health information are held accountable for maintaining confidentiality, privacy, and security of that information.
- ACP believes that new approaches to privacy and security measures should be tested before implementation and regularly re-evaluated to assess the effect of these measures in real-world health care settings.

We hope that the Innovation Center will consider these privacy- and security-related policies and recommendations in its efforts to share actionable data in new and existing models.

In January 2020, ACP issued a series of [policy positions and recommendations](#) calling for comprehensive reform of U.S. payment, delivery, and information technology systems to achieve ACP's vision for a better U.S. health care system. The following four recommendations related to health IT are relevant to CMMI's strategic objectives of supporting care innovation and sharing actionable data, and they should be considered and incorporated throughout the development and implementation of models.

(1) ACP recommends that improvements to health IT usability should prioritize the needs of patients, frontline physicians, and clinical care teams; strive to remove non–value-added interactions; and support VBP reform initiatives.
- The primary goal of health IT should be to improve high-value, patient-centered care and facilitate successful implementation of VBP and delivery reforms. To reach this goal, health IT should enhance patient care and the patient-physician relationship to improve health outcomes while also contributing to seamless data collection, exchange, and access to support value-based care delivery and payment.
- Health IT should engage patients and caregivers and should facilitate shared decision-making instead of serving as a barrier to care or communication. Improving the efficiency of health IT and EHR-enabled care will provide the health care team with the time and focus necessary to leverage the technology to make care delivery better, safer, and more valuable, as well as decrease the amount of face-to-face time spent on low-acuity care.
- Health IT should include features that help physicians and patients make better care decisions and to effectively and securely share information with the entire care team, patients, families, and other caregivers.
- Patient engagement in technology and efforts to promote patient-centered, team-based, coordinated care has evolved the role of EHRs and the kinds of tools and functionalities necessary to improve care delivery. Physicians need tools within their health IT systems that provide clinical and administrative workflow support, data analytics, advanced data visualization, and anticipatory decision support. These new tools need to leverage existing data within the EHR – as well as data that exist in other EHR systems or external data sources, such as digital health apps or wearable devices – and remove the need to click

through numerous pages and templates to find useful and actionable data. Specifically, EHR screen views and data management can be enhanced by implementing user-centered design practices and knowledge available on human computer visualization and memory methodology. These types of analytical tools can help care teams close gaps in care and identify populations of patients who need closer attention, while helping patients avoid unnecessary hospitalizations and manage chronic diseases. Not only are the usability and usefulness of the technology important for all health care stakeholders, but research also shows that basic usability enhancements to EHRs are associated with better clinician cognitive workload and performance. To meet and exceed these important usability needs, patients, physicians, and clinical care teams must be involved throughout the entire health IT development and testing process. Moreover, the usability of these systems should be effectively assessed before physicians and other clinicians are held accountable for their use regarding performance metrics and financial incentives or consequences.

- Health IT should not only facilitate improvements in patient care, but also reduce the administrative burdens on practices and help both physicians and patients communicate and navigate the complexities of the health care system. However, a large body of empirical evidence suggests that health IT is not reaching these goals, but rather adding burden to clinical practice and increasing physician burnout. Functionality of health IT is an important element in reducing burden and improving patient care; health IT usability and the ability to exchange electronic health data are essential when supporting and enhancing VBP and delivery system reforms. This initial focus, coupled with other regulatory requirements and market-driven incentives, pushed health IT vendors to develop systems designed to collect information for coding and billing purposes and to satisfy regulatory requirements, which has resulted in the current state of poor EHR usability and dissatisfaction. The widespread adoption of disparate EHR technologies, developed on the basis of billing and regulatory requirements (in an already overly complex health care system and without a foundation for exchanging information), has resulted in backward incentives across the health IT industry.

(2) ACP calls for interoperability efforts to be focused on the adoption and consistent implementation of health IT standards irrespective of the health IT system or digital technology.

- The widespread adoption of disparate health IT systems without the infrastructure for these systems to communicate has resulted in silos of health information. Health IT standards enable software designed by different companies to understand how to exchange clinical data and interpret complicated medical concepts. Several nationally recognized standards development organizations develop and test these health IT standards through a consensus-based, deliberative process. However, there is still a lack of industry consensus, within and outside health care organizations, on which standards to use, and the implementation of these standards is not always consistent across systems—creating issues when trying to exchange and interpret data. Improvements in interoperability should focus on promoting the consistent adoption and implementation of industry-approved, standards-based technologies, and all health care stakeholders must collaborate to develop and implement shared technical requirements to achieve the desired outcomes of improved quality, safety, and efficiency of patient-centered care delivery.

(3) ACP believes that the testing and subsequent implementation of health IT standards and interoperability rules should be conducted in stages to avoid and/or mitigate adverse effects on patient care, privacy, security, clinical workflow, and data visualization and interpretation.

- Much of the current focus of improving interoperability is enhancing the flow of all health data ever collected and moving large portions of data elements back and forth between health systems and physicians. This results in an overflow of patient information that can sometimes hinder the ability to find useful and actionable information at the point of care. In addition to industry-approved, standards-based solutions to interoperability, efforts to enhance interoperability should consider the concept of "practical interoperability." Practical interoperability focuses on the exchange of context-rich, meaningful, and actionable data at the point of care, as well as the ability to incorporate clinical perspectives and query health IT systems for up-to-date information related to specific and relevant clinical questions. While industry efforts continue to look at both large population-level datasets and individual data elements for exchange, the importance of context and meaning behind the data is critical. The functionality to retrieve and review both large and targeted datasets is important, but the ability for a physician and clinical care team to better understand another clinician's assessment and the patient's encounter in a different health care organization is extremely important. Efforts to improve the exchange of health information should target the high-yield clinical data that have been shown to be the most useful in the clinical management of patients as they transition through the health care system. It is not reasonable or practical to expect a physician or clinician to copy/paste pages and pages of care summaries as an appropriate solution to improving interoperability. Such an approach inhibits addressing specific questions and contributes to substantial note bloat and information overload. Physicians need data presented in a way that allows them to interpret the important elements and apply medical judgment to the patient at hand, communicate and educate patients on their health, and engage in shared medical decision-making.
- Patients should have seamless access to their health information and will benefit from improvements in interoperability. However, privacy, security, and patient safety concerns remain regarding the increased exchange of health information, particularly given the industry's focus to open the data floodgates and share as much health information as possible. Personal health information is some of the most sensitive information. There is evidence showing how health-related app developers sell data to third parties and how most of those developers do not share privacy policies with the patient—or, when they do, do not adhere to those policies. Although it is absolutely a patient's right to have access to that information, allowing and promoting access to such sensitive information without requiring necessary privacy and security controls presents risks for public embarrassment or possible discrimination. Lack of trust in the system could affect patients' willingness to disclose information to their physicians. As the digital health ecosystem continues to expand and evolve, and third-party technology vendors are gaining access to personal health information, privacy and security guardrails must be put in place before opening any new avenues for exchange. With continued access and exchange of personal health information, the health IT industry must build and maintain a foundation of trust among patients and consumers. Failing to do so will limit the ability of technology to improve patients' experiences with the health care system and improve the ability of physicians and clinical care teams to provide individualized, thoughtful care to patients. Exchanging inaccurate and outdated information poses a patient safety issue as well. From a technical perspective, once a full set of clinical data is sent from the source, it is considered historical data. Something may have changed since the latest copy was received that would cause a change in decision-making about the patient. Therefore, it is extremely important that efforts to improve the exchange of sensitive and critical health

information should move forward in stages to effectively assess the risks to patient safety, privacy, and care delivery.

(4) ACP recommends that stakeholders support the development, adoption, and use of innovative technologies that seamlessly enable enhanced and coordinated patient-centered care.

- As the health care system continues to transform, all key health care stakeholders, including physicians, other clinicians, patients, vendors, payers, and the federal government, should support the development, adoption, and optimal use of innovative information technologies based on the needs of patients, physicians, and care teams. VBP and delivery initiatives that support the adoption and use of these innovative technologies are necessary to effectively spur use and innovation. The health care industry must utilize and leverage existing and emerging health IT to shift the current paradigm to one where EHRs are seen as the solution and not the problem. Examples of innovative, team-based care delivery that can be facilitated by health IT, with appropriate practice infrastructure and support, include integration of non-visit-based care and patient-generated data, facilitated self-care, and proactive chronic care management. Specifically, health IT and EHRs can be used to identify patients who have not had preventive services and put into place processes to notify those patients. Recent reports have shown success in new technologies used to connect patients to community resources that help address the ongoing effects of SDOH and close gaps in care. The National Academy of Medicine outlined necessary components of a patient-centered health information system that include supporting clinical workflow and real-time decision-making, allowing visualization of meaningful and actionable cost and coverage data, as well as connecting to all relevant health applications and devices that can span the vast definition of digital health. ACP supports the expanded role of telemedicine as a method of health care delivery that may enhance patient-physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care.
- The integration of artificial intelligence (AI) into health IT remains an important area of focus when discussing innovative technologies to promote seamless delivery of individualized patient care, population health management, and removing burdens associated with EHR use.
- Certain AI technologies have the capability to enhance the clinical documentation process in order to reduce documentation burden on physicians and other clinicians; increase the accuracy of coded data; and support other uses of the clinical documentation, such as for research, performance measurement, and public health. Specifically, computer-assisted coding and diagnostic support allow physicians to document care without having to perform all the coding that payers, regulators, and other stakeholders require. At present, AI-related technologies are making their way into daily use in back-office health care processes. Health care organizations are seeing some success in such areas as automated customer service, managing computer system security, and automated coding for billing, all of which could help detangle the use of health IT systems from administrative processes and instead associate the use of health IT with enhanced clinical care. There is great potential for new technologies, including AI and other digital health technologies, to advance value-based care reform, but more evidence is needed on their ability to improve health outcomes. In the near future, experts expect to see strong growth in support for diagnosis, therapy selection, and population health management through the use of AI capabilities. The movement of automated, AI-based systems into these areas is a

cause for concern by many physicians and others—specifically when considering care decisions regarding diagnosis and therapy selection. There is justifiable concern that what may be initially presented as an assistant could easily become a risk to physician autonomy, as well as to patient safety. The work in this area could endanger patient safety if not done carefully and in close consultation with physician and other expert clinicians to make those concerns very clear at every opportunity. These concerns must be addressed satisfactorily before these technologies are permitted to enter the clinical workflows, and more research on the potential effects of the use of AI or any other emerging technology in clinical workflows is needed. Once these new technologies are proven safe for patient care, VBP initiatives must support incorporating and testing these new technologies in practice. As discussed previously, user-centered design methodologies should be used, and physicians and patients should be included in the development and implementation of these technologies to adequately represent what is needed for high-value care. Moreover, any new technology, platform, or functionality that is incorporated into health IT systems or existing workflows must be proven safe, effective, and useful before physicians and their care teams are held accountable for using them for reporting or achievement of metrics with financial consequences.

- Health IT plays an integral role in VBP and delivery system reforms, and the industry should continue to develop innovative technologies, policies, and technical standards that support the needs of both patients and physicians throughout the health care continuum without adding to administrative or documentation burden. ACP believes that health IT innovation comes from private health care stakeholders, including payers, physician organizations, technology vendors, physicians, and other clinicians, and the role of the federal government is to serve as a convener and source of information, providing recommendations that help to further the use of health IT to improve care. The health care industry must utilize and leverage existing and emerging health IT to improve care delivery, reduce administrative burden, and shift the current paradigm to one where EHRs are seen as the solution and not the problem.

- Care must be taken so that the unintended consequences of technology use, especially AI and machine learning (ML) algorithms, do not exacerbate health care disparities. AI, ML, and other algorithmic technology, if not implemented with caution and appropriate regulations, can embed implicit biases into health care decision-making systems, which can in turn threaten patient health and quality of care. ACP urges CMMI to study and consider the potential negative downstream effects of AI implementation on patient care and safety in administering and developing new and existing models.

The College strongly recommends CMMI consider these health IT recommendations in pursuing its objective to support care innovation and improve the sharing of actionable data in the development and administration of its models.

The College supports the ongoing efforts of ONC and CMS to engage in public-private initiatives aimed at automating certain aspects of workflows and data exchange to improve efficiency. However, we want to emphasize that these efforts to decrease regulatory and administrative burdens should not rely exclusively on technology. There is risk of technology duplicating existing inefficient processes—similar to the introduction of EHRs that duplicated paper-based chart processes and office workflows. There are a number of other non-technical elements at play, including health plans' and insurers' willingness to be transparent with certain requirements and cost information, among many other factors. Addressing those underlying factors will help reduce complexity and burden, as well as improve the technology.

Health IT developers, particularly those who develop EHRs, [must comply](#) with requirements for user-centered design and the science of usability. In addition to improved physician-EHR user interfaces and more uniform presentations of information, another critically important element of health IT usability is whether the system is clinically useful. Clinicians need new tools within their EHR, including workflow support, data visualization tools, and shared decision-making tools that leverage existing data within the EHR, and do not need to click through numerous pages and templates to try to find the truly useful and actionable data. Vendors should be strongly encouraged to partner with cognitive and memory scientists in improving this functionality, as other industries have done. Screen views and data management are all enhanced by implementing knowledge available on both human computer visualization and memory methodology.

Objective 4: Improve Access by Addressing Affordability
To improve access by addressing affordability, the Innovation Center intends to pursue strategies to address health care prices, affordability, and reduce unnecessary or duplicative care.

CMMI's goals for clinicians include (1) "better align[ing] provider and beneficiary incentives to increase use of high-value services that efficiently deliver and coordinate care, achieve the best outcomes for patients, and reduce utilization of duplicative or wasteful services – especially in total cost of care models"; and (2) "creat[ing] payment and performance incentives in models, especially in total cost of care models, for specialty and primary care providers to coordinate delivery of high-value care and to reduce duplicative or wasteful care."

The College appreciates that CMMI's strategy recommends offering greater opportunities for specialists to engage in models. These ideas align nicely with an alternative payment model (APM) that ACP and the National Committee for Quality Assurance (NCQA) developed jointly, the [MNM](#), which was [recommended](#) by the Physician-Focused Payment Model Technical Advisory Committee. To provide CMMI with additional details regarding this model, the College submitted a [joint letter](#) with nearly 50 physician organizations as signees in May 2021. This letter details the severity of fragmentations in care and the communication gaps between specialists and primary care physicians that lead to care delays, inappropriate care, and errors. The College strongly believes the MNM's coordinated approach would prevent these issues and provide patients with what they want most: an entire treatment team to collaborate with and implement their treatment plan seamlessly. It is ACP's hope that CMMI will look to the MNM and similar models as it moves forward with its strategic outline.

In 2019, the College submitted a [letter](#) to CMMI regarding CMS' Primary Cares Initiative. In this letter, we discuss our appreciation for the Innovation Center's efforts to deliver more Advanced APM options, particularly in the primary care space. We additionally emphasize that models like this give physicians opportunities to deliver transformative, innovative, and patient-centered care for Medicare beneficiaries while breaking down administrative barriers, restoring the physician-patient relationship, and reducing costs. In discussing the Primary Care First (PCF) Model, we note our concern about the overall structure of models that incorporate performance-based adjustment practices and caution that these regulations pit practices against one another to compete for a higher adjustment. Rather than incentivizing competition, the College believes that practices that are successfully delivering high-quality, advanced primary care and other services, while maintaining or reducing costs, should all be rewarded accordingly. In reviewing existing and developing new models, ACP also urges CMMI to free participating practices from duplicative administrative hoops originally designed for a fee-for-service (FFS) environment, such as prior authorization and appropriate use criteria (AUC). The College also calls for all APMs to provide broad

waivers from the Physician Self-Referral "Stark" Law and Anti-Kickback Statute. These restrictions serve as a barrier to the exact value-focused relationships and compensation structures that APMs aim to foster and serve as an unnecessary and counterintuitive barrier to the growth and development of new APMs. As a point of reference, we hope CMMI will consult the College's 2017 position paper outlining a cohesive framework for identifying and evaluating administrative tasks, as well as detailed policy recommendations to reduce excessive administrative tasks across the health care system.

While ACP supports CMMI's strategy as outlined, we encourage the Innovation Center – and CMS at large – to consider that many criteria can be used to gauge value and that cost alone is not, and cannot be, the only factor. The College urges the Innovation Center to look at criteria aside from literal monetary expenditures and savings. The fact remains that the most expensive thing health care can do is provide high-value, quality care, because this necessitates individuals have a longer life span and thereby cost more as they move along the spectrum of age. As stated in our paper on delivery and payment reforms, ACP believes that value must be defined around the patient, including the processes of care they receive, their clinical outcomes, their own health and health care goals, their safety, and their experience and engagement with their care. While investing in more patient-centered comprehensive care can mean more costs in the short term, this ends up generating savings down the road in the form of reduced hospitalizations and services in acute care settings. As the Innovation Center and CMS continue to tease out the details regarding implementation of these new and revised models, ACP encourages the Agency to develop, review, and deploy programs and models that consider more than just cost and begin to assess cost-*effectiveness*. For additional information on how ACP envisions these measures can be improved for use in current and future models, please reference our comments on Objective 3: Support Care Innovation.

The College is also pleased with CMMI's proposal of Value-based Insurance Design (VBID) as it seeks to encourage high-value care. ACP has long been committed to improvements to the health care system that put patients first and prioritize value-based care. In our delivery and payment system reform paper released in January 2020, we discuss our support for VBP reform initiatives but emphasize that value should always be defined with patients and families at the center. The College is encouraged by aspects of the outline that consider equity and put patients at the center. These aspects include reduced cost-sharing, improving access to new and existing technologies, vouchers for transportation to health care visits, and potential food and housing support. As CMMI continues to work on VBP, ACP encourages CMMI to consider value with the equity of patients at the center.

Moving forward, ACP will be carefully watching how the Agency proceeds with mandatory models. The College recommends that CMMI remain cognizant of the fact that mandatory models can increase quality and access, but they also place undue burden on the physicians and other clinicians who are forced to move forward with models that might not make sense for their practices or patient populations. The College also emphasizes the strong need for practices to receive the necessary upfront resources and ongoing support to be able to succeed in models. In this regard, ACP welcomes the opportunity to collaborate with CMMI across the lifecycle of these models – from design to evaluation and potentially expansion – and greatly appreciates CMMI's work to implement its strategic refresh and foster a deeper partnership with physicians and beneficiaries.

Objective 5: Partner to Achieve System Transformation
To meet its objective to partner to achieve system transformation, the Innovation Center intends to align priorities and policies across CMS and aggressively engage payers, purchasers, physicians and

other clinicians, states, and beneficiaries to improve quality, to achieve equitable outcomes, and to reduce health care costs.

CMMI's goals for clinicians include (1) "[enabling] providers […] to deliver more integrated care across settings and engage in more comprehensive and longitudinal care as a result of accountable care relationships and participation in total cost of care models"; (2) "burden reduction as a result of alignment across payers on value-based care initiatives"; and (3) "aligning and partnering with other payers on key design features such as clinical tools and outcome measures [that] will enable improved evaluation and scaling of transformation."

ACP strongly agrees with the Innovation Center's assessment that real innovation and transformation within health care will require the collaboration of public and private sector partners, including physicians, patients, private payers, nonprofit partners, and all levels of government. The College believes partnerships with physician, patient, and caregiver groups, as well as collaborations with the Health Care Payment Learning and Action Network (LAN) and state and Medicaid partners, are key to the Innovation Center's ability to implement this new strategy effectively and equitably. Achieving health equity in the U.S. must remain a priority of all stakeholders within health care, and ACP is encouraged to see the Innovation Center maintaining its focus on health equity throughout this new strategy, including through health equity partnerships. The College looks forward to continued collaboration with the Innovation Center and other stakeholders to achieve transformation in the health care system that results in lower physician burden and better, more equitable care for patients.

Conclusion

ACP appreciates the opportunity to provide feedback on the Innovation Center's White Paper, *Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade*. We hope that CMS and the Innovation Center carefully consider our comments and recommendations, and we look forward to continuing to work with CMS to support the transition to innovative value-based care models and the development of performance measures that are truly meaningful to physicians and their patients. These new measures can better contribute to improved patient quality and outcomes and reduced costs, ultimately allowing enhanced price transparency for patients, physicians, and payers. Please contact Brian Outland, PhD, Director of Regulatory Affairs, by phone at 202-261-4544 or email at boutland@acponline.org if you have questions or need additional information.

Sincerely,

William Fox, MD, FACP
Chair, Medical Practice and Quality Committee
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