American College of Physicians
Leading Internal Medicine, Improving Lives

August 15, 2018

The Honorable Mike Kelly
U.S. House of Representatives
Washington, DC 20515

The Honorable Ron Kind
U.S. House of Representatives
Washington, DC 20515

The Honorable Markwayne Mullin
U.S. House of Representatives
Washington, DC 20515

The Honorable Ami Bera
U.S. House of Representatives
Washington, DC 20515

Dear Congressmen Kelly, Kind, Mullin, and Bera:

On behalf of the American College of Physicians (ACP), I am writing to provide our recommendations and respond to your questions regarding the development of innovative policy ideas to improve the quality of health care for our patients and lower health care costs. We appreciate your efforts to initiate a Health Innovation Caucus to explore and advance successful innovative payment models as well as new technologies to enhance the health care delivery system. We hope that our policy recommendations and the experience of our internal medicine physicians will be constructive to your efforts regarding value-based provider payment reform, value-based arrangements, and health information technology. We look forward to working with you to continue the transformation of Medicare from a volume-based payment and delivery system to one of value, accountability, and patient-centered care.

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 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.

As noted in detail below, ACP is pleased to provide our views and recommendations on specific questions that you posed to stakeholders:

VALUE-BASED PROVIDER PAYMENT REFORM

1. *Please describe any value-based payment models that you participate in by payer, Medicare, Medicaid, employer coverage?*

- *Which have been most successful at reducing costs and improving quality and access?*

ACP believes that all public and private payers should transition their payment systems to support innovative payment and delivery models linked to the value of care provided. We believe that the Comprehensive Primary Care Initiative (CPCi) and the Comprehensive Primary Care Plus (CPC+) Programs, the only patient-centered medical home (PCMH) model specifically identified as an Advanced Alternative Payment Model (APM) in MACRA offers great potential in reducing costs and improving quality and access. The success of this program will depend on Medicare and other payers providing physicians and their practices with the sustained financial and logistical support needed for them to meet the goal of providing comprehensive, high-value, accessible, and patient-centered care, with realistic and achievable ways to assess each practices' impact on patient care. The College is committed to working with CMS on the ongoing implementation of this program to ensure that it is truly able to meet such requirements of success.

- *What changes were made in practice management or care delivery as a result of these value-based arrangements?*

In the way of a response, ACP would like to point to several examples, as derived from one of our ACP Fellows, Dr. Louis Friedman, a board-certified internal medicine physician, who has practiced in Woodbridge, New Jersey, in an NCQA level three Patient Centered Medical Home, since 2008, and as a participant in both the original CPCi program and now in CPC+. He testified at a hearing in the House Energy and Commerce Health Subcommittee on MACRA and Alternative Payment Models: Developing Options for Value-based Care, on November 8, of 2017. His practice experiences, as conveyed through his testimony, address this question well.

"The addition of care coordination staff has enabled us [our practice] to better track our patients who have been discharged from the hospital, reach out to them within 48 hours of discharge, and review medications and determine whether further ancillary services are needed. Follow up visits are also arranged at that time, which has helped to limit confusion on the patient's part and we anticipate this will lead to a decrease in readmissions."

"Feedback data from CMS is another tool that we did not have access to previously, but now do as a result of our participation in CPC+. Often patients simply are not aware that many medical issues such as upper respiratory infections, rashes and minor cuts and bruises can be easily treated in a less expensive urgent care or office setting (often with a shorter wait for the patient). Now we can review the number of our patients per quarter who were admitted to the hospital, seen in the emergency room or seen in urgent care centers. Once identified, we hope to better educate these patients as to when and when not to seek emergency room care. Prior to CPC+, we did not have this ability and thus had no idea how many unnecessary emergency room visits there were."

"Pre-visit planning by ancillary staff and effective monitoring within the EHR have helped us to improve our rates of vaccination, screening procedures for mammograms, and diabetic eye exams. Screening tools for early detection of dementia have helped at-risk

families better prepare to care for their loved ones. The CPC+ reimbursement for managing patients with this diagnosis has been helpful with targeting this effort."

"On a practice management level, regulations issued by CMS and the Office of the National Coordinator (ONC) requiring EHR vendors to obtain health information technology certification, as part of the EHR Incentive Programs, have made it possible to track patient parameters more effectively. Bear in mind that there are many EHR vendors out there, large and small, and many of them simply had not been powerful or sophisticated enough for a practice to track and report the measures required by the program. Prior to enactment of these regulations, EHR vendors had no incentive to create effective dashboards with which we can track patient measures (blood pressure, blood sugar measurements, screenings such as mammograms and eye exams). Without this ability, there would be no way that a practice could hope to report the necessary measures for the program."

According to a report issued in May of this year on the CPCi, one of the most substantial impacts of the Patient Centered Medical Home has been found in the area of physician practice transformation and improved care delivery. As the report notes, as a result of the CPC program, practices "engaged in substantial, challenging, transformation, and we see improvement in how they delivered care over the course of CPC," including large strides of improvement in risk-stratified care management, expanded access to care, and continuous data-driven improvement." These practice management reforms were implemented without affecting burnout, control over work, or job satisfaction among clinicians and staff as the report notes that "79 percent of responding physicians at CPC practices reported that they support their practice participation in CPC.

- *What effect did you observe on your patient outcomes?*

ACP's response is again addressed by Dr. Friedman from his testimony to the Energy and Commerce Committee on November 8, 2017.

"We have expanded our ability to analyze and deliver care and our patients have benefitted in many ways. With the added financial support that the CPC+ program provides, we have been able to offer self-management programs such as nutrition classes and dietitian visits. These are available free of charge to patients, and have been well received by many who need them. Gaining a patient's commitment to attend these classes on a regular basis, however, can be inconsistent. That being said, I had one patient who was six foot three inches tall and weighed 442 pounds. He had high blood pressure and terrible venous insufficiency of the legs which causes massive chronic swelling. He enrolled in our eight-week class and by the end of it had lost 31 pounds. He dropped another 10.6 pounds in the next two months and his swelling improved. This is an extreme example, but shows that we can induce positive lifestyle changes, which in turn can help prevent disease."

2. *What barriers in each of the following areas limit the full potential of innovation in Medicare and Medicaid?*
   - *Payment and reimbursement*
   - *Policy and regulation*
   - *Data and reporting*

As Congress performs its oversight role in the implementation of MACRA and the Quality Payment Program (QPP), the College wishes to highlight several recommendations, comments, and concerns regarding barriers in payment and reimbursement, policy and regulation, and data and reporting that limit the full potential of innovation in Medicare and Medicaid. ACP has been a strong supporter of MACRA and embraces its shift from a volume-based payment and delivery system, as was the case under the preceding fee-for-service system with yearly adjustments based on Medicare's Sustainable Growth Rate (SGR) formula, to one of value, accountability, and patient-centered care. Similarly, ACP appreciates the ongoing Congressional oversight of MACRA as being conducted by the relevant committees of jurisdiction so as to ensure its successful implementation.

Payment and Reimbursement

ACP strongly believes that CMS should make significant efforts to simplify the QPP, especially in the MIPS pathway, by reducing the administrative burdens associated with reporting and standardizing the approach to scoring. The College appreciates that Congress included several changes to MACRA in the Bipartisan Budget Act of 2018 (H.R. 1892) that allowed CMS additional flexibility in weighing the Cost Performance category and setting the performance threshold to allow for a more appropriate ramp up in reporting requirements. Additionally, we appreciate that CMS allowed for "pick your pace" options during the 2017 performance period to allow a simple test option to avoid a negative payment adjustment, but similar clear-cut options do not exist in 2018, leaving clinicians to try to navigate the complicated MIPS scoring system and changing policies to avoid a payment cut. More specifically, ACP asks Congress to urge CMS to make a number of policy changes including:

- Further simplify and standardize the scoring approach within MIPS in order to allow the point value for each measure or activity to be fully reflective of its value within the overall composite performance score (CPS). The points available with each measure are not reflective of the value a measure or activity has in the overall composite performance score. We appreciate recent proposals to simplify scoring in the Promoting Interoperability category, but this does not go far enough. We urge Congress to press CMS to simplify the requirements and points system across MIPS as a whole drastically to bring it more in line with Congress' vision of a streamlined quality reporting program.
- For the basic scoring system, continue modifying the point values within the overall MIPS performance scoring to reflect a more unified approach by making the points available for performance on each category and measure reflective of the value it has in the overall CPS. This means that all of the available points

within the Quality component would add up to a total of 50 points – counting for 50 percent; the points within Improvement Activities would add up to 15 – counting for 15 percent; the points within Promoting Interoperability (PI) would add up to 25 – counting for 25 percent; and under the current rule, cost would add up to 10 points if 10 percent; 30 points if 30 percent.

- Consider additional options in rulemaking to promote awarding credit for high-value activities across multiple performance categories to strengthen MIPS and make the program more streamlined as Congress originally envisioned, rather than siloed like the legacy programs it was designed to replace. For example, award credit in the PI category for reporting quality measures via EHRs.

Policy and Regulation

ACP provides the following recommendations to Congress to implement reforms to MACRA policy and regulation to accommodate the needs of small practices. ACP appreciates that CMS made several additional changes for the 2018 performance period to accommodate the needs of small practices better. These include increasing the low-volume threshold to $90,000 in Part B allowed charges or 200 Part B patients, creating a virtual groups policy, adding a small practice bonus, and implementing a hardship exception policy for the Promoting Interoperability category for small practices. These policies will help create a playing field that allows small practices and those in rural and underserved areas more opportunities to succeed. As Congress performs its oversight role, the College encourages consideration of the following additional recommendations for small practices:

- There are many small practices that believe that they cannot afford the upfront investments in EHR technology and those who have not adopted EHRs due to the administrative and financial burden to maintain these systems. Therefore, a hardship exemption for small practices will provide significant relief. At the same time, we are concerned that some small practices are being left behind in the overall computerization of health care. Accordingly, in addition to a hardship exemption for those who choose to accept it, we urge CMS to provide more assistance to small practices that are willing to try to integrate information technology, but cannot accomplish the task without additional help.
- Extend the small practice bonus to clinicians in rural and underserved areas.
- Allow practices (TINs) to subdivide into smaller groupings (i.e., specialties, practice sites, etc.) for performance assessment purposes to allow for selection of performance measures and activities that are most relevant to a clinician's scope of practice and patient population.
- Offer lower nominal risk standards (i.e., the medical home model standard) for small practices and those in rural and underserved areas that choose to participate in Advanced APMs.

Data and Reporting

ACP believes that a number of administrative burdens and tasks associated with data and reporting quality measures pose barriers that prevent physicians from spending additional time with patients. The College has been a strong advocate for reducing the burdens of regulatory and administrative tasks, as evidenced in the launch of our Patients before Paperwork initiative in 2015. ACP has strongly advocated for CMS and other payers to ensure that measures used in reporting are evidence-based and go through a multi-stakeholder evaluation process. This not only includes filling critical measure gaps, but also removing measures that are of poor quality.

We are pleased that CMS is implementing two initiatives "Meaningful Measures" and "Patients Over Paperwork" designed to ease the process of reporting quality measures data and reducing unnecessary administrative burdens. We look forward to working with Congress and CMS to ensure that patients and physicians are the focal point of any policy changes that result from these initiatives. CMS and other payers must monitor the measurement/reporting system to identify and mitigate any unintended consequences including clinician burden and work to have measurement data collection and submission to be part of the clinician workflow – and not an added burden. We have also called on developers and payers to work to ensure that measurement does not exacerbate, and ideally reduces, inequities in care including through incorporating adjustments for socioeconomic status.

ACP provides the following recommendations to Congress to exercise its oversight authority to ensure that:

- CMS collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of quality measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and on decreasing clinician burden.
- Quality performance category reduce the reporting period requirement for the from 12 months to a minimum of a 90-day performance period in order to align it with the other reporting categories of Promoting Interoperability and Improvement Activities. This will allow clinicians to prepare for full participation gradually and for CMS to continue to facilitate the idea of a learning health care system focused on value over volume.
- Clinicians and practices receive timely feedback on their data submission. This will serve to facilitate meaningful improvement and improve the ability for clinicians to experience incentives in a timely and understandable manner.

3. *How can we develop better outcomes measures that accurately reflect quality, safety, and value without burdening innovation*?

The College strongly recommends that Congress call on CMS to use ACP's Performance Measurement Committee (PMC) recommendations when considering what measures to use

for reporting by internal medicine specialists. ACP's PMC has reviewed and provided detailed recommendations on performance measures that are particularly applicable to internal medicine— and we believe that our recommendations will allow for better outcomes measures that accurately reflect quality, safety, and value without burdening innovation.

ACP is currently reviewing the 2019 quality payment program proposed rule that was recently released. Overall, we are encouraged to see CMS making an effort in the proposed rule to eliminate measures that it deems to be of low-value, along with ensuring specialists and subspecialists have enough measures to report. We believe that reducing the set of available quality measures should be coupled with reducing the number of measures required to be reported to truly reduce burden and align with the "meaningful measures" initiative.

ACP strongly recommends that CMS collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of quality measures with a focus on integrating the measurement of and the reporting on performance with quality improvement, care delivery, and decreasing clinician burden.

4. What employer sector innovations have had success bending the health care cost curve?

ACP continues to be a major supporter of the Patient Centered Medical Home (PCMH) model, including the Comprehensive Primary Care Plus (CPC+) model. The plethora of currently available research have defined a strong connection between PCMH programs and higher quality and lower costs. [1] ACP would like to highlight several recent examples of significant cost savings achieved by PCMH programs in the private sector:

- CareFirst Blue Cross Blue Shield – recently released results of the first seven years of its PCMH program, which found that it lowered the expected cost of care by $1.2 billion.[2] It also found that patients seeing a physician in the PCMH program had lower rates of hospitalization, readmission, and emergency department use, among other significant finding.
- Blue Cross Blue Shield of Michigan has also shown cost savings through its large PCMH program. Over the first six years, the program found $427 million in prevented costs in addition to similar rates of reduction in hospitalizations, readmissions, and emergency department use.[3]
- Arkansas' Medicaid PCMH model has also seen success in improvements in quality and decreases in costs, with $34 million in savings to the state Medicaid program in the first year of the model.[4] This model was subsequently expanded to encompass commercial payers including those operating Qualified Health Plans on the exchange and dual-specialized needs managed care plans.

[1] https://www.pcpcc.org/resource/impact-primary-care-practice-transformation-cost-quality-and-utilization
[2] https://member.carefirst.com/carefirst-resources/pdf/2017-pcmh-program-performance-report.pdf
[3] http://www.valuepartnerships.com/wp-content/uploads/2017/10/2017-PCMH-Media-Fact-Sheet.pdf
[4] http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=335

In addition to the medical home, payers have tested other types of value-based payment models including ACOs, bundled payments, and capitation with varying levels of savings.

5. *How can Congress help the Centers for Medicare and Medicaid Innovation achieve its purpose of developing and testing innovative payment and delivery models?*

ACP strongly supports expanding the options that are available for internal medicine physicians and subspecialists to participate in value-based models through the Advanced APM pathway. Currently, there are few APMs available for internal medicine physicians, especially subspecialists, to participate in through the Innovation Center, and those that include the most participants, such as the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) in Track 1, do not even qualify as Advanced APMs due to strict financial risk requirements. Those Advanced APMs that are available are often very limited in scope and only allow participants in certain regions or who meet very limited criteria, including size limits like the arbitrary 50-clinician limit for CPC+. Many specialists and subspecialists lack any Advanced APMs that are relevant to their specialization. For primary care physicians, a PCMH model that is an Advanced APM is simply not available yet.

ACP recommends that the Center for Medicare and Medicaid Innovation (CMMI) take into account a number of options and considerations to make Advanced APMs more readily available including:

- Expand opportunities for primary care physicians to participate in medical home models as Advanced APMs. Additional medical home models should include both models that meet the medical home model nominal amount standard, as well as by using 1115A(c) authority to expand PCMH models that do not have a nominal risk requirement. The details of ACP's recommendations regarding medical home options can be found in our comments on the 2018 QPP rule. The College re-iterates our strong support for the Comprehensive Primary Care Plus (CPC+) program.
- Apply medical home model standards to specialty practice models. On the MIPS side, certified/recognized PCMHs and comparable specialty practice models are treated the same when it comes to receiving full credit for improvement activities. For APMs, CMS should allow comparable specialty practice models that are Advanced APMs to qualify for the medical home model nominal amount standard as well as utilize the non-risk-bearing standard for PCMHs that meet the criteria for expansion under 1115A(c).
- Eliminate arbitrary limits on the number of clinicians in an organization to be considered an Advanced APM. We urge CMS to remove any limitations on medical home models based on the number of clinicians in the organization who owns and operates the practice site. A TIN may have many practice sites under it but only one or two that are primary care and therefore able to be recognized PCMHs—or, more specifically—CPC+ practices. These practice sites are then not able to receive the bonus payments for being an advanced APM when they are otherwise performing the same functions as other CPC+ practices.

- Create a lower nominal amount standard for models focused on small practices and those in rural areas and health professional shortage areas (HPSAs). In recognition of the challenges that small and rural practices face in accepting the general nominal amount standard of risk including limited liquid financial assets and less sophisticated infrastructure, CMS should allow these practices to join Advanced APMs under a lower nominal risk standard (e.g., the medical home model standard). This would include small and rural practices that are part of a medical home model and those that join larger APM entities.
- Ensure that reporting and other administrative tasks within current and new advanced APMs are developed, implemented, and monitored in a manner that ensures they do not add unnecessary burden to the clinician practice and/or to their patients and families. This approach is aligned with the Administration's recently announced "Patients over Paperwork" initiative and with the College's "Patients Before Paperwork" initiative that has been in place since 2015, as well as our policy paper "Putting Patients First by Reducing Administrative Tasks in Health Care." Note that stakeholder engagement is critical through the development of APMs and that ACP is happy to work with both the administration and Congress.

VALUE-BASED ARRANGEMENTS

1. *What are some of the barriers to value-based arrangements for drugs, devices, and therapies in Medicare and Medicaid?*

Prescription drug pricing and costs are of considerable interest to ACP members. ACP believes a truly competitive marketplace can help to keep prescription drug costs reasonable for consumers; however, the current marketplace is broken and is not efficiently self-regulating. ACP's position paper "Stemming the Escalating Costs of Prescription Drugs" puts forth several recommendations with regards to lowering the cost of prescription medications through transparency, competition, and multi-stakeholder engagement, including the following:

- There should be transparency in the pricing, cost, and comparative value of all pharmaceutical products:
  a. Pharmaceutical companies should disclose:
     i. Actual material and production costs to regulators;
     ii. Research and development costs contributing to a drug's pricing, including those drugs which were previously licensed by another company.
  b. Rigorous price transparency standards should be instituted for drugs developed from taxpayer-funded basic research.
- Medicare and other publicly funded health programs should have the flexibility to negotiate volume discounts on prescription drug prices and pursue prescription drug bulk purchasing agreements.
- Legislative or regulatory measures to develop a process to reimport certain drugs manufactured in the United States should be pursued, provided that the safety of the source of the reimported drug can be reasonably assured by regulators.

- Policies or programs that may increase competition for brand-name and generic sole-source drugs should be established.
- Research into novel approaches to encourage value-based decision making should be conducted, including consideration of the following options:
  a. Value frameworks;
  b. Bundled payments;
  c. Indication-specific pricing;
  d. Evidence-based benefit designs that include explicit consideration of the pricing, cost, value, and comparative effectiveness of prescription medications included in a health plan's benefit package.

Potential Prescription Drug Models should take into consideration the variation among drug classes with regard to the availability of alternative treatment options and the existing reimbursement rates for certain drugs. In certain drug classes, there are very few options for treatment or difference in price among drugs. Additionally, any Prescription Drug Model should not place the primary responsibility of keeping costs down on the prescriber.

ACP outlined ways physician engagement would be beneficial to potential drug pricing models in a May 2016 letter regarding CMMI's proposed Part B Drug Pricing Model. These benefits include a heightened understanding of how physicians measure effectiveness of drugs in patients long-term and ways to capture this information.

The College is also an active participant and partner in the Campaign for Sustainable Rx Pricing (CSRxP). The Campaign works to foster a national dialogue focused on innovation and affordability in drug pricing, through support of market-based reforms that address the underlying causes of high drug prices in the U.S. through increased transparency, competition, and value. We encourage CMS to consider CSRxP's recommendations as the Agency considers developing prescription drug models.

2. *What role should Medicare play in creating value-based arrangements and encouraging manufacturers, payers and providers to take on such risk?*

As was mentioned earlier, we strongly support expanding the pathways for internal medicine and subspecialists to participate in value-based models through Advanced APMs but there are too few APMs available for internal medicine physicians, especially subspecialists to join within Medicare. Another barrier to the development of additional APMs is that physicians are unwilling to bear the substantial financial risk to developing a new model of care that may or may not be approved by CMS as an advanced APM.

ACP recommends that Congress urge CMS to implement the following reforms within Medicare to encourage manufacturers, payers, and providers to take on the risk in developing new value-based models of care:

- Maintain or reduce nominal amount standards for risk to create on-ramps to participation as new models are being developed. Groups that are designing APMs expend significant time and resources during the development process, potential

review by the PTAC, and possible work with CMS to further refine and implement. By the time this process, which can take years, is completed and a model is being tested, nominal amount standards will likely have changed or increased over what they were during the development process. In order to expand the available Advanced APMs, CMS should at a minimum maintain the current nominal amount standards indefinitely so that groups developing models know what risk target they need to meet. To bring models and participants into the fold more rapidly, a reduction in the arbitrary nominal amount standards should be considered for new models.

- Consider the upfront costs of participating in APMs as well as the ongoing maintenance costs when determining whether models meet nominal financial risk criteria. Significant "at risk" capital requirements are necessary to start and maintain APMs such as ACOs. The College reaffirms its belief that Track One MSSP ACOs should qualify as meeting the nominal risk requirement for determining an Advanced APM. This position was more fully articulated in a joint comment letter signed-onto by the College on March 25, 2016.
- Consider adding flexibility to the nominal risk standards for Other-Payer Advanced APMs.

We also believe that APM participants in risk-bearing models are already held accountable for cost and quality outcomes and should therefore be exempted from a number of Medicare requirements or restrictions, including:

- Stark, anti-kickback and other F&A restrictions that inhibit APM entities' abilities to reward participating clinicians for delivering high value care
- Billing requirements that are redundant in a risk-bearing model, including hospital discharge, the skilled nursing facility three-day rule, home health, home visits, and telehealth requirements, as well as grant model participants the ability to waive patient cost sharing or provide other direct patient benefits.
- Burdensome administrative requirements such as, prior authorizations, appropriate use criteria, evaluation and management documentation guidelines. We appreciate and support that this issue is addressed in the 2019 physician fee schedule proposed rule.

TECHNOLOGY AND HEALTH IT

1. *What impact does health IT and data interoperability have on successfully running valu-e based payment models and contracting? What are some ways to improve interoperability and the sharing of data?*

Health information technology (health IT) and data interoperability play an integral role in running successful value-based payment models and contracting. In a patient-centered, value-based delivery system, health IT, including EHRs, should make patient care better and safer, enhance the patient-physician relationship, and support value-based payment. Specifically, the measures used to determine value are based on data available within health IT and EHRs. Until interoperability improves, data for value-based measurement will be limited and clinical workflows within EHRs will be burdensome and designed to generate

data just for the sake of measurement – and not related to providing high-value patient care. Improved interoperability will lead to the availability of relevant clinical data upon which measure developers could build new measures and leverage data generated in the course of providing care and reduce or eliminate the need for special workflows. Additionally, when discussing health IT in support of value-based payment models, it is crucial to discuss what is needed for *practical interoperability* – or what is needed to improve care and value without losing both the patient's and clinician's narrative, while avoiding clinical information overload. There is growing concern among physicians that the result of improving interoperability will be a flood of data that they will be responsible to read, manage, and to act upon without clinical evidence for efficacy. More clinical data does not equal better care and data without sufficient context may lead to diagnostic or treatment errors. Therefore, improvements in practical interoperability could reduce the burden of quality measurement; improve the quality of measures because of the availability of more robust clinical and operational data; and enhance patient care through providing actionable, relevant clinical data at the point of care – all the while supporting value-based payment.

Transparency and alignment among all stakeholders are the keys to improving interoperability and supporting value-based payment. For example, a first step to improve interoperability would be for all healthcare stakeholders to agree to standardized formatting for clinical documentation exchange (e.g., methods used for medication reconciliation). Between the numerous EHRs and Health Information Exchanges (HIEs), there are hundreds of different ways that medications are listed within the record – making it extremely difficult to share those data between clinicians, health systems, and pharmacies. As interoperability is considered, operability of the system – its efficacy and ease of use should also be addressed.

2. *What technology is needed to integrate physician networks to be able to effectively manage a population's health?*

The functionality that allows clinicians within a single healthcare organization to look up and review each other's documentation regarding a shared patient needs to be easily available to clinicians who are not in the same organization. Copying and moving care summaries is hardly a reasonable approach to facilitate the asking and answering of specific questions – and contributes to significant note bloat and an abundance of unnecessary information at the point of care. Additionally, all EHRs must have registries that are user friendly and flow into an HIE and patient portals must have the ability to integrate information- and documentation to the chart.

CONCLUSION

We appreciate the opportunity to provide our guidance and suggestions as you examine innovative policy ideas to launch new models of care that improve quality for patients and lower costs for consumers. We are pleased that the Innovation Caucus intends to host regular staff and member meetings with health care stakeholders and hope that we can continue to be helpful in providing our insights from our policies and the direct experiences of our members as

you develop new policies to transform the health care delivery system. If you have any questions regarding our responses to your questions, please do not hesitate to contact Brian Buckley on our staff by phone at 202-261-4543 or by email at bbuckley@acponline.org. We look forward to our continued collaboration.

Sincerely,

Ana Maria Lopez, MD, MPH, FACP
President