B. Patients and Caregivers

1. Patient Needs

PC-1. What health management or care navigation apps would help you understand and manage your (or your loved ones) health needs, as well as the actions you should take?

a. What are the top things you would like to be able to do for your or your loved ones' health that can be enabled by digital health products? It is our strong belief that patients and their family caregivers should be able to access their health records. Particularly in the context of managing chronic conditions, there is not enough support for people living with dementia – we applaud CMS for investing in the GUIDE program and believe we need more digital health solutions targeted at family caregivers of people living with dementia.

b. If you had a personal assistant to support your health needs, what are the top things you would ask them to help with? In your response, please consider tasks that could be supported or facilitated by software solutions in the future.

Insurance and benefits navigation – help me move through the confusing world of benefit availability and coverage.

Access the providers I need – help me get an appointment with the type of provider I need to see, quickly and easily

Personalized, ongoing support – help me get the help I need, based on my unique medical and social needs, when I need it

PC-2. Do you have easy access to your own and all your loved ones' health information in one location (for example, in a single patient portal or another software system)?

a. If so, what are some examples of benefits it has provided? Yes – we have gone to great lengths to build provider-facing software that brings health information for the patients we serve and their family caregivers in one place. For our clinicians, the benefit this provides is two-fold – it promotes joy of practice and allows our team to deliver an excellent experience to the families

we serve. We do the heavy lifting to bring their health information into one place.

b. If not, in what contexts or for what workflows would it be most valuable to use one portal or system to access all such health information?

c. Were there particular data types, such as x-rays or specific test results, that were unavailable? What are the obstacles to accessing your own or your loved ones' complete health information electronically and using it for managing health conditions or finding the best care (for example, limitations in functionality, user friendliness, or access to basic technology infrastructure)? Yes – we have been unable to procure DICOM images from the Health Information Exchanges we work with. Cost is a tremendous barrier to accessing that data.

2. Data Access and Integration

PC-8. In your experience, what health data is readily available and valuable to patients or their caregivers or both?

Most beneficiaries are able to access their clinical data through provider portals. However, most beneficiaries have multiple provider portals they must access; they are not able to view comprehensive longitudinal records anywhere. Beneficiaries in rural areas are much less likely to have access to patient portals, as small providers typically have less advanced EMRs.

a. What data is valuable, but hard for patients and caregivers, or app developers and other technical vendors, to access for appropriate and valuable use (for example, claims data, clinical data, encounter notes, operative reports, appointment schedules, prices)?

Patients typically have access to brief encounter notes, lab results, appointment schedules, and invoices. Again, access is more limited for beneficiaries living in rural areas.

We participate in the GUIDE program which promotes data sharing between providers. We share records through Particle. When coordinating care with smaller provider groups that don't participate in HIEs, we have fax- and phone-based protocols to share patient data and coordinate care. GUIDE and similar APMs encourage providers to take on the work of data sharing

and support the time it takes to do that in a fax- or phone-based way when necessary.

b. What are specific sources, other than claims and clinical data, that would be of highest value, and why?

In our experience, most beneficiaries do not have access to cost data before a procedure / visit. It can be difficult for beneficiaries to understand total cost, i.e., what they will owe to the facility, provider, anesthesia, etc.

We would also encourage CMS to support more small and rural provider groups to modernize their EMRs, facilitating broader HIE access.

c. What specific opportunities and challenges exist to improve accessibility, interoperability and integration of clinical data from different sources to enable more meaningful clinical research and generation of actionable evidence? Patients and caregivers should be able to use an identifier of their choice w/ providers they interact with – this will support ease of patient matching.

PC-9. Given that the Blue Button 2.0 API only includes basic patient demographic, Medicare coverage, and claims data (Part A, B, D), what additional CMS data sources do developers view as most valuable for inclusion in the API to enable more useful digital products for patients and caretakers?

a. What difficulties are there in accessing or utilizing these data sources today? Not enough organizations know about the BB 2.0 API or have resources to make this work for them. It's cumbersome to get set up on the API.

b. What suggestions do you have to improve the Blue Button 2.0 API experience? Accessibility and awareness

c. Is there non-CMS data that should be included in the API? Clinical data, SDOH data and DICOM images would be very helpful

PC-11. How are health information exchanges (HIEs) currently helping to advance patient access to health information in the real world? **Enhancing Care Coordination and Continuity Through Health Information Exchange:**

- **Interoperable Information Exchange:** HIEs facilitate secure, standardized data sharing across the healthcare ecosystem, including providers, specialists, hospitals, laboratories, pharmacies, and payers—supporting CMS's interoperability goals. This infrastructure enables:
    - **Cost-Effective Care Delivery:** Healthcare organizations can access existing clinical data and imaging studies, reducing duplicate testing and unnecessary procedures, thereby lowering costs for both Medicare/Medicaid programs and beneficiaries
    - **Evidence-Based Clinical Decision Support:** Providers gain real-time access to comprehensive patient histories at the point of care, facilitating data-driven decisions and promoting value-based care models
    - **Care Transition Management:** During critical care transitions (e.g., hospital-to-home, primary-to-specialty care), HIEs ensure seamless transfer of essential clinical documentation, supporting CMS's goals for reduced readmissions and improved care coordination
    - **Enhanced Emergency Response:** In urgent situations, emergency departments can instantly access vital clinical information, supporting rapid triage and appropriate interventions while reducing adverse events

While significant progress has been made in health data interoperability standards development, implementation challenges persist. Primary barriers include varying levels of standards adoption (particularly FHIR vs. C-CDA), inconsistent data quality, and the need for enhanced compliance mechanisms to ensure uniform implementation across healthcare stakeholders.

a. How valuable, available, and accurate do you find the data they share to be?

b. What changes would you suggest? The most important change needed is to reinforce that patient data belongs to patients themselves — not provider organizations. Empowering patients to make their health data accessible, transferable, and usable would be one of the most impactful improvements HIEs could implement.

c. Are there particular examples of high-performing HIE models that you believe should be propagated across markets?

d. What is the ongoing role of HIEs amidst other entities facilitating data exchange and broader frameworks for data exchange (for example, vendor health information networks, TEFCA, private exchange networks, etc.)? **The "Network of Networks"** approach of TEFCA or vendor health information networks like Particle strives to provide organizations like ours with a universal adapter for different health information networks (HINs) across the country. This offers superior solutions to overcome the historical fragmentation of health information systems in the U.S. Instead of each HIN needing individual agreements with every other HIN, TEFCA provides a common set of rules and technical standards that allow them to connect and share data seamlessly.

- The combination of common principles, high-level requirements for trusted data sharing, and a unified legal agreement establishes clear governance and rules for TEFCA network participation. With voluntary participation for HINs and healthcare organizations, this makes TEFCA particularly appealing for companies with strong software development and product teams.

PC-12. What are the most valuable operational health data use cases for patients and caregivers that, if addressed, would create more efficient care navigation or eliminate barriers to competition among providers or both?

a. Examples may include the following: Finding the right provider for specific healthcare needs

(1) Binding cost estimates for pre-defined periods.

(2) Viewing provider schedule availability.

(3) Using third-party apps for appointment management.

(4) Accessing patient-facing quality metrics.

(5) Finding the right provider for specific healthcare needs.

b. What use cases are possible today? Using third-party apps for appointment management

c. What should be possible in the near future? Accessing patient-facing quality metrics.

d. What would be very valuable but may be very hard to achieve? Giving patients and caregivers transparent information about cost of healthcare services based on their specific insurance

3. Information Blocking and Digital Identity

No comment

C. Providers

1. Digital Health Apps

PR-1. What can CMS and its partners do to encourage providers, including those in rural areas, to leverage approved (see description in PC-5) digital health products for their patients?

a. What are the current obstacles?

b. What information should providers share with patients when using digital products in the provision of their care?

c. What responsibilities do providers have when recommending use of a digital product by a patient?

PR-2. What are obstacles that prevent development, deployment, or effective utilization of the most useful and innovative applications for physician workflows, such as quality measurement reporting, clinical documentation, and billing tasks? How could these obstacles be mitigated?

Frequently when beneficiaries come to the doctor they have a very good idea of what they want to discuss. Current mechanisms for quality measurement reporting can be at odds with efforts to be patient-centered in care delivery. For example, a patient may come into the office with serious concerns about their cognition, but the EMR is alerting the physician to focus on colon cancer screening. Cancer screening is critically important, no doubt, but ignoring signs of cognitive decline are higher priority for that particular encounter.

This is a great example of why we participate in GUIDE and deliver the type of care GUIDE champions. We support the model's focus on condition-specific outcomes as well as its complementary approach with other value-based care models, e.g.,

Medicare Shared Savings Programs. Clinically we see great success delivering specialty care in close partnership with Primary Care. From an APM perspective, we support specialty- and condition-specific models that align with, and are complementary to, existing models.

From a billing perspective, we applaud the approach taken in GUIDE. Our care team is able to focus on providing our beneficiaries the responsive care they need

PR-3. How important is it for healthcare delivery and interoperability in urban and rural areas that all data in an EHR system be accessible for exchange, regardless of storage format (for example, scanned documents, faxed records, lab results, free text notes, structured data fields)?

Please address all of the following:

a. Current challenges in accessing different data formats.

b. Impact on patient care quality.

c. Technical barriers to full data accessibility.

d. Cost or privacy implications of making all data formats interoperable.
e. Priority level compared to other interoperability needs.

PR-4. What changes or improvements to standards or policies might be needed for patients' third-party digital products to have access to administrative workflows, such as auto-populating intake forms, viewing provider information and schedules, and making and modifying an appointment?

2. Data Exchange

PR-5. Which of the following FHIR APIs and capabilities do you already support or utilize in your provider organization's systems, directly or through an intermediary? For each, describe the transaction model, use case, whether you use individual queries or bulk transactions, and any constraints:

a. Patient Access API Yes

b. Standardized API for Patient and Population Services Yes

c. Provider Directory API N/A

d. Provider Access API N/A

e. Payer-to-Payer API N/A

f. Prior Authorization API N/A

g. Bulk FHIR – Do you support Group ID-based access filtering for population-specific queries? N/A

h. SMART on FHIR – Do you support both EHR-launched and standalone app access?

What does the process for application deployment entail?

i. CDS Hooks (for clinical decision support integrations) Yes

PR-6. Is TEFCA currently helping to advance provider access to health information?

a. Please provide specific examples.

b. What changes would you suggest?

c. What other options are available outside of TEFCA?
d. Are there redundant standards, protocols or channels or both that could be consolidated?

PR-7. What strategies can CMS implement to support providers in making high-quality, timely, and comprehensive healthcare data available for interoperability in the digital product ecosystem? How can the burden of increasing data availability and sharing be mitigated for providers? Are there ways that workflows or metrics that providers are already motivated to optimize for that could be reused for, or combined with, efforts needed to support interoperability?

PR-8. What are ways CMS or partners can help with simplifying clinical quality data responsibilities of providers?

a. What would be the benefits and downsides of using Bulk FHIR data exports from EHRs to CMS to simplify clinical quality data submissions? Can CMS reduce the burden on providers by performing quality metrics calculations leveraging Bulk FHIR data exports?

b. In what ways can the interoperability and quality reporting responsibilities of providers be consolidated so investments can be dually purposed?

c. Are there requirements CMS should consider for data registries to support digital quality measurement in a more efficient manner? Are there requirements CMS should consider for data registries that would support access to real-time quality data for healthcare providers to inform clinical care in addition to simplifying reporting processes?

3. Digital Identity

No comment

D. Payers

No comment

E. Technology Vendors, Data Providers, and Networks

1. Ecosystem

2. Digital Identity

No comment

4. Data Exchange

No comment

5. Compliance

No comment

F. Value-Based Care Organizations

1. Digital Health Adoption

VB-1. What incentives could encourage APMs such as accountable care

organizations (ACOs) or participants in Medicare Shared Savings Program (MSSP) to leverage digital health management and care navigation products more often and more effectively with their patients? What are the current obstacles preventing broader digital product adoption for patients in ACOs? Voluntary alignment models (like the GUIDE model) put agency in the hands of patient / caregivers and may make it easier for providers to adopt APMs.

VB-2. How can key themes and technologies such as artificial intelligence, population health analytics, risk stratification, care coordination, usability, quality measurement, and patient engagement be better integrated into APM requirements? Population health analytics, risk stratification, patient engagement mechanisms and closed loop communications with the provider on record

VB-3. What are essential health IT capabilities for value-based care arrangements?

a. Examples (not comprehensive) may include: care planning, patient event notification, data extraction/normalization, quality performance measurement, access to claims data, attribution and patient ID matching, remote device interoperability, or other patient empowerment tools.

b. What other health IT capabilities have proven valuable to succeeding in value-based care arrangements?

VB-4. What are the essential data types needed for successful participation in value- based care arrangements?

- Claims
- Clinical
- SDOH
- Family History
- Cost information (what is the expected cost of the services that will be provided?)

2. Compliance and Certification

No comment

3. Technical Standards

No comment