PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

June 16, 2025

Submitted via regulations.gov

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

Dr. Thomas Keane
Assistant Secretary for Technology Policy
National Coordinator for Health IT
U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS–0042–NC, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-0042-NC; Request for Information; Health Technology Ecosystem

Dear Administrator Oz and Assistant Secretary Keane:

Thank you for the opportunity to provide comment in response to the Request for Information (RFI) on the Health Technology Ecosystem.

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care among independent physicians and practices to reduce costs, improve quality, empower patients and physicians, and increase access to care. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association (CMA), and Medical Group Management Association (MGMA). We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

Health technology plays an essential role in supporting health care providers in value-based care arrangements. Small and independent practices are more resource constrained and struggle to develop the data infrastructure and associated supports necessary to fully leverage data and technology. PEPC appreciates the Administration's commitment to reducing burden and promoting seamless and secure flow of health information between patients, providers, and payers, which will be particularly beneficial to small and independent physician practices and further support CMS' goals of increasing health care competition and participation of independent physician practices in value-based care models.

We urge CMS to ensure that all policy is designed with small and independent physician practices in mind, considering their unique circumstances and instances where technical assistance and other resources may be necessary. Our responses to specific questions of the RFI are below.

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? What are the current obstacles? What information should providers share with patients when using digital products in the provision of their care? What responsibilities do providers have when recommending use of a digital product by a patient?

Independent practices are more resourced constrained than other practices in some circumstances, often starting from a point of fewer resources when entering a payment arrangement, and particularly benefit from models that provide upfront resources to invest in accountable care delivery. When provided appropriate support, small and independent practices are uniquely positioned to adapt, provide flexible care and quickly adopt virtual care platforms like Zoom.[1]

We recommend that HHS provides technical assistance to support small and mid-sized practices in leveraging digital health products. This should be coupled with a communications campaign to ensure that providers understand permitted products available to them and how they can be adopted.

2. Data Exchange

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?

We share CMS' commitment to realizing the promise of health care data through increased information sharing – the backbone of our collective efforts to improve quality, reduce total cost of care, and improve the patient experience. Conditions of Participation (CoP) related to Admission, Discharge, and Transfer (ADT) feeds would be transformative if implemented in a manner that encourages and incentives hospitals to share notifications broadly to enable better decision-making, reduce waste, and improve patient outcomes. The current CoP is too broad with loopholes that enable hospitals to limit information sharing. CMS should clearly and affirmatively state that hospitals should make every effort to accept patient rosters. This is common practice in states where event notifications have been shared at scale for years, and should be encouraged by CMS for the following specific reasons:

1. *Electronic Information Sharing is Key to Value-Based Care.* Real population health management – the bedrock of many delivery system transformation initiatives, including ACOs – cannot be achieved without timely access to patient health care information. Today's value-based care practices have to go hospital-by-hospital to find facilities willing to share information about their own patients. In the event that they are unable to find willing partners, they have to make do with the information they have or can get from their patients. This jeopardizes the success of our system-wide movement to value-based care and is counterproductive to our national goals of improved quality and reduced costs.

2. *Greater Information Sharing Promotes Health Care Competition.* Even after federal policymakers have invested billions of dollars to encourage the adoption and exchange of electronic health information, too many providers continue to see the data generated as proprietary rather than as

[1] PEPC, "White Paper – Independent Practice Success in CMS Innovation Center Models."

an enabler of higher value care. In the case of ADT feeds, the failure to communicate is not a technical problem, but rather a strategic decision not to share information to preserve its "competitive value."

3. *Roster-Based Approaches Can Be Accommodated by Hospitals Today With No New Technology*. Today, most hospitals have multiple technological options for sharing ADT feeds – participate in a local HIE, contract with a vendor to share alerts, and/or build their own data exchanges or interfaces. Conditions of Participation and Conditions for Coverage (CoP/CfC) requirements can and should be written to allow hospitals flexibility in the mechanism for implementing new requirements. No new standards are needed, and there are no technical barriers to sharing today as evidenced by the hospitals that are already frequently sharing this data with community providers.

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

CMS should reconsider policies that have increased complexity and burden for physicians, which disproportionately impact small and independent physicians. Last year, CMS finalized the Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set, which seeks to align to the Universal Foundation and will incrementally grow to eleven measures.

While we applaud CMS for its efforts to streamline quality measures and reporting requirements across payers and programs through the Universal Foundation, PEPC has serious concerns with this increased reporting burden. A key motivation for moving away from fee-for-service and adopting accountable care models is streamlined reporting requirements and reduced burden. These provisions will have the opposite impact and discourage providers from adopting accountable care models.

CMS should also ensure small and independent practices are supported in aggregating quality measures across electronic health records (EHRs). Different EHRs calculate quality measures different ways, which presents a unique aggregation challenge for groups of independent physician practices working together. It is significantly harder and more costly than it would be for a hospital-based system running off the same EHR system and that would have an easier time aggregating that information.

4. Information Blocking

PR-12. Should ASTP/ONC consider removing or revising any of the information blocking exceptions or conditions within the exceptions (45 CFR part 171, subparts B through D) to further the access, exchange, and use of electronic health information (EHI) and to promote market competition?

PEPC strongly supports efforts to discourage anti-competitive information blocking. We do not believe that patient information should ever be used for the purpose of gaining or maintaining "control" over patient lives, and encourage ONC to explicitly state that providers who choose not to share information with other providers for competitive reasons are information blocking. We also urge ONC to consider an information blocking exception for small practices that are acting in good faith.

We continue to recommend that ONC provide additional technical assistance to support small and midsized practices in understanding and navigating these new requirements. This should be coupled with a communications campaign to ensure that providers understand what is permitted for other providers,

IT vendors and other stakeholders. Without additional support from HHS, small practices and independent providers are unlikely to be able to fully benefit from the new requirements.

Information blocking exceptions that push providers to one exchange mechanism over another remove choice and optionality that may be important to reflect the differences between various providers and provider practices. We have heard anecdotally that several QHINs have adopted an "opt out" approach to TEFCA participation, and note that such an approach – coupled with the proposed exception – could potentially eliminate or discourage use of other exchange options, such as FHIR APIs, that might be preferred by some providers.

Value-Based Care

1. Digital Health Adoption

VB-3. What are essential health IT capabilities for value-based care arrangements? 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. What other health IT capabilities have proven valuable to succeeding in value-based care arrangements?

Value-based care aligns incentives between payers and providers by basing reimbursement levels on care quality and cost savings and exchanging additional data to determine care quality and cost savings compared to relevant population benchmarks. Key components to this work include access and quality, point of care services, care compass and care transitions (e.g., between primary and specialty care). These components are all supported by five core data needs for value-based care[2]:

1. *Attribution*. Identifying the patient population served by each health care provider is crucial for developing accurate benchmarks and attributing patient outcomes to relevant health care providers. Attribution lists must be updated regularly (e.g., monthly or quarterly) and should include patient details (e.g., demographic data, risk score/categorization) to identify risk-adjusted benchmarks.
2. *Quality.* Quality reporting is crucial for identifying potential gaps in primary care. Relevant quality metrics include Healthcare Effectiveness Data and Information Set (HEDIS) Care Gaps reports and medication adherence lists.
3. *Risk Adjustment*. Adjusting for patient risk requires proper patient attribution and is necessary to identify benchmarks for different patient populations and ensure providers are fairly reimbursed.
4. *Revenue/Funding*. Data for attributed patients, such as relevant premiums and funding, is important for successful value-based care model participation.
5. *Medical Claims*. Value-based care participants must have all claims and non-claims expenses for paid professional and institutional medical claims for all attributed members, regardless of status (e.g., reversed, denied, adjusted). Fulfilling these data needs requires further alignment of health care data standards, particularly harmonization of administrative and clinical data. Data exchange also requires the flexibility to test, update, and advance the use of FHIR-based transactions (e.g., prior authorizations and claims attachments) to identify new efficiencies in data exchange.

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

[2] HHS, National Committee on Vital and Health Statistics April 2024 Virtual Meeting

We believe that the ONC Health IT Certification Program should be a platform for ensuring that certified products have functionality needed to support physicians practicing in a variety of different employment arrangements and practices sizes. We recommend that ASTP/ONC prioritize data elements necessary for value-based care in future versions of USCDI.

2. Compliance and Certification

VB-5. In your experience, how do current certification criteria and standards incorporated into the ONC Health IT Certification Program support value-based care delivery?

As stated above, we believe the ONC Health IT Certification Program should ensure certified products include the functionality necessary to support physicians across diverse practice sizes and employment arrangements. We support adoption of v3 of the U.S. Core Data for Interoperability (USCDI) data set. As noted by ONC, v3 includes Social Determinations of Health (SDOH) data elements, including SDOH assessment, SDOH goals, SDOH interventions, and SDOH problems/health concerns. Access, exchange, and use of these data elements can support more information for and care of patients. We recommend that ONC prioritize data elements necessary for value-based care for future versions, potentially considering whether there is an opportunity to partner with the CMS or another federal partner on a USCDI+ initiative.

VB-9. What technology requirements should be different for APM organizations when comparing to non-APM organizations (for example, quality reporting, and interoperability)?

Burden reduction is an important non-financial incentive for providers who adopt value-based care models, particularly small and independent practices who are more resource constrained and impacted by reporting requirements. Despite this, CMS has finalized a recently requirement that MSSP ACOs report the MIPS Promoting Interoperability performance category measures instead of the attestation requirement. This requirement adds, rather than reduces, burden for APM participants. CMS should rescind this requirement and work to differentiate APM requirements from MIPS to the greatest extent possible.

***

Conclusion

PEPC appreciates the opportunity to provide comments on this request for information. If you have any questions about our comments or need more information, please do not hesitate to contact Kristen McGovern at kristen@physiciansforvalue.org.

Sincerely,

Kristen McGovern
Executive Director