(PC-1) I would like to be able to schedule appointments, complete initial appointment documentation, ask questions of the nurse or doctor along with requesting care/support for my loved one.   I would like to upload my healthcare and durable power of attorney once to apply across all health care providers and all payers versus executing multiple HIPAA representative forms or providing a copy of documents each time a new doctor is engaged.

(PC-2) I do not have a single source of my records or those of my loved ones. Even providers with the same EHR do not offer a single portal resulting in multiple My Chart accounts with different credentials – a single sign on would be fantastic. It would be helpful to have one single portal that contains medical records, lab or diagnostic tests, appointment scheduling and billing. In addition, providing cost transparency tools to the single portal would allow for management of financial restraints that can negatively impact SDoH.

(PC-4) An app that stores each patient's demographic information to include global consent information that satisfies all provider and payer requirements along with address, phone, email and health care power of attorney would make managing a loved one's healthcare while securing this very private information.

(PC-5) CMS should select the applications available to Medicare beneficiaries through an RFP process coupled with education programs leveraging healthcare providers' office, senior centers, and community social services as HUBs. The training should be provided to resources at the HUBs by the companies that developed the chosen applications. The application would need to be highly accessible, highly secure, and part of the beneficiaries' health care coverage. PC-5(b) – Timely access to CMS and Provider data could be benefit from a review of the current HIPAA Privacy rules against our current technology advancements along with needs to access health data for the good of public health.

(PC-6 & PC-7) CMS needs to drive the plan for education on tools available to empower the Medicare beneficiaries and their loved ones to actively participate in health care decisions across the family. Some ideas for education is taking the program to the local level leveraging those that interact most with the beneficiaries – SHIPP, DOI, Social Services, Home Health agencies, Primary Care Physicians, Churches, etc. Also, incentives to engage are never a bad idea – perhaps the application is free of charge funded by better health care cost management.

(PC-14) The challenges of digital identity and patient access extend far beyond convenience; they directly affect care continuity and the ability of loved ones to advocate for those who can't speak for themselves. To make matters worse, the senior community has been targeted by bad actors attempting to access personal information such as banking details, Social Security numbers, and member IDs, leading to a deterioration of trust. As a result, efforts to promote secure storage of personal information in a centralized way are often met with skepticism, limiting the effectiveness of educational and awareness campaigns.   The critical gap is the need for a national, standardized digital identity solution that allows trusted caregivers to be pre-authorized for health information access across providers. Credentialed ID platforms like ID.me, Login.gov, or CLEAR could play a transformative role by creating a global consent layer that lives outside fragmented provider portals and enables designated proxies to engage with digital health tools on behalf of the beneficiary. Certification of these credentialing platforms could add credibility to these solutions and further adoption.

Medicare beneficiaries, who are ideal candidates for digital engagement, need a trusted family member to navigate apps and portals for them. CMS should champion policies that simplify proxy access by integrating digital ID with caregiver delegation and HIPAA-compliant permissions at the point of enrollment or benefit renewal. Doing so would reduce legal burden, support caregiving families, and improve both access and outcomes for vulnerable populations.

(PA –1) CMS needs to champion expansion of exchange purposes in TEFCA – Healthcare Operations to allow access to records through QHINs to perform claim reviews. Claim reviews ensure the proper amount is paid to the provider which is the basis for Medicare beneficiary cost share leaving cost savings for the plan to keep member premium costs down and to allow members to put savings, both premium and cost share towards SDoH.

(PA-2) Incentivize the MA plan via expanded payments for MA members to offset the development cost of the API or CMS could partner with EHR suppliers to build standard APIs to allow for easier integration with the providers. Another avenue would be for CMS to address the trust issue between payers and providers by mandating the exchange purposes that lead to cost saving for the payer freeing up dollars to pay for the API development.

(PA-3) Centralized digital credentials need to have something in it for the payer. For example, POA documents, HIPAA representative forms (global consent), other coverage information (Section 111), eligibility information such as ESRD and Hospice, all in one place available via API.

(PA-4) Trust would need to be established that the data is current and matching to their current data is available through a unique provider ID. The database should include

Medicaid ID, Medicare ID, NPI, TIN, and information to contact the provider via secure email, fax and phone based on specific needs -for example – Medical Record, Other Insurance, etc. Database would need to be easier to use and more complete than NPPES.

(VB-1) CMS should consider innovative ways to incentivize providers part of value-based models to suggest patients designate a HIPAA representative to accompany them on their healthcare journey. This designation would allow the provider to collaborate with the HIPAA representative to increase awareness of available digital tools and highlight how caregiver involvement can positively impact health outcomes.

In addition, CMS should explore a "Caregiver Loyalty Program" modeled after commercial QR-based systems, where family members can track participation in care tasks (e.g., attending wellness visits, supporting transitions of care) and receive rewards such as tax credits, HSA/HRA-eligible reimbursements, or even gift cards. This approach leverages familiar technology to encourage real-world behavior change.

Lastly, employers could serve as critical education touchpoints, raising awareness of tools available to manage their family's care. As an example, my employer is evaluating whether such applications could be offered to our own workforce during open enrollment. If not HSA-eligible today, this could be a valuable area for CMS to consider expanding in future rulemaking.