Ascension

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

June 16, 2025

Submitted electronically via: www.regulations.gov

RE: *Request for Information; Health Technology Ecosystem (CMS-0042-NC)*

Dear Administrator Oz:

Ascension appreciates the opportunity to submit comments in response to the request for information recently issued by the Centers for Medicare & Medicaid Services (CMS) entitled *Request for Information; Health Technology Ecosystem (CMS-00420-NC)* (the "Health Technology Ecosystem RFI").[1]

Ascension is one of the nation's leading non-profit and Catholic health systems, with a Mission of delivering compassionate, personalized care to all, with special attention to those most vulnerable. In FY2024, Ascension provided $2.1 billion in care of persons living in poverty and other community benefit programs. Across 16 states and the District of Columbia, Ascension's network encompasses approximately 99,000 associates, 23,000 aligned providers, and 94 wholly owned or consolidated hospitals. Ascension also operates 30 senior living facilities and a variety of other care sites offering a range of healthcare services.

Ascension supports the agency's efforts to empower patients by promoting the effective and responsible adoption of technology across all facets of the healthcare system. We value the efforts of CMS and ASTP/ONC to create a patient-centered health technology ecosystem by promoting the broader use of health management and care navigation tools. These play a crucial role in breaking down barriers to accessing and exchanging health data, which ultimately leads to improved care and better health outcomes. We also believe that, while the Department of Health & Human Services (HHS) has laid a strong foundation for the secure and seamless flow of health information among patients, providers, and payers, additional progress is needed. Simplifying and enhancing these processes for patients, caregivers, and providers—particularly through the expanded use of digital health solutions—will help reduce reliance on paperwork and phone-based communication.

We feel strongly that a truly modern and efficient healthcare technology environment depends on aligning key elements: accessible, patient-controlled health data; innovative digital health solutions; and rigorous privacy and security safeguards. Empowering patients to view and manage their complete medical history—consolidated under a unified, longitudinal record—enhances care coordination and

[1] 90 Fed. Reg. 21,034 (May 16, 2025).

fosters greater patient involvement in their own health. Emerging digital tools and platforms further optimize care delivery and patient experience. To function effectively, these technologies must operate within a secure, dependable framework that ensures data protection and supports smooth, interoperable information sharing throughout the healthcare landscape. Together, these components create a trustworthy and high-performing digital health ecosystem that advances care quality and patient empowerment.

We outline our recommendations below to advance the adoption of health technology that will facilitate more efficient health data exchange, drive innovation in consumer-facing digital health tools, enhance engagement from patients, caregivers, and providers, and further support the transition to a value-based care (VBC) model.

I. Constraints in the Current Health Technology Landscape

Interoperability

As a healthcare organization delivering a wide spectrum of services across multiple care settings, Ascension sees firsthand that current data-sharing practices are outdated and fail to support emerging needs. This challenge is amplified by the untapped potential of technology to improve clinical decision-making and care delivery. Despite decades of federal investment, the health technology landscape still does not enable efficient, real-time exchange of patient information.

Interoperability is essential. Patients now generate more health data than ever—from hospitals, clinics, home devices, and mobile apps. While policy has evolved from Meaningful Use to Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interfaces (APIs) and data standards, access is limited, undermining the broader healthcare system. We should be advancing into a new era of digital health, where data is accessible, portable, and actionable. Yet legacy regulations, including those from the *Health Information Technology for Economic and Clinical Health* (HITECH) Act, impose rigid requirements that stifle innovation. We urge CMS to modernize the definition of meaningful use and interoperability to reflect today's clinical realities and remove arbitrary barriers that do not serve patients or care teams.

Interoperability must also extend to post-acute and community-based providers, many of whom were excluded from past federal incentives and cannot afford full-scale Electronic Health Record (EHR) systems. This leaves critical patient data disconnected, hindering care coordination.

Finally, integrating public health data with clinical systems is also crucial. The pandemic exposed major gaps in infrastructure and data flow. We need unified standards, updated technology, and investment at all levels to build a truly connected system that serves both individual and population health.

Data Standardization

Despite decades of regulatory action and investment in health IT, true data standardization across the healthcare system remains out of reach. While both federal agencies and industry leaders continue to promote an FHIR-based infrastructure, the practical value of this approach remains narrow. Current FHIR APIs and the narrow scope of data elements in the U.S. Core Data for Interoperability (USCDI) restrict its usefulness beyond a few targeted applications.

Today, standardized data is confined to select elements. In key areas such as quality reporting, admission/discharge/transfer (ADT) systems, lab results, and clinical data, information is still exchanged among EHR vendors, payers, and providers using non-standard formats. This lack of consistency complicates quality improvement efforts, increases administrative burden, and contributes to higher patient costs. Broader standardization would not only support better outcomes but would also eliminate the common excuse that certain data exchange or reporting functions are technically infeasible.

Connecting Providers to Digital Health

As healthcare providers, we see growing potential in digital health technologies to improve patient outcomes and reduce costs. However, that potential can only be realized if the data these tools generate is captured in patients' medical records. Many digital health solutions are marketed directly to patients, with little visibility for care teams into how or when they are used. This disconnect poses a clear risk: when patients rely on third-party apps or devices to make health decisions without provider oversight, it can lead to fragmented care, missed opportunities for intervention, and even adverse outcomes. For care to be truly coordinated, we must have access to the data collected by these technologies as part of the clinical workflow.

Ascension urges the agencies to make healthcare providers the central hub for integrating digital health solutions. With the right policy support, provider organizations can manage and distribute these technologies in ways that add value to covered patient care. CMS should evaluate which tools—such as remote monitoring, digital scheduling, and at-home diagnostics—can be effectively embedded into provider workflows and then align reimbursement and incentives accordingly. By doing so, CMS can help build a connected, whole-person care model where digital health works in sync with clinical care to improve outcomes and control costs.

Misaligned Market Incentives

As providers, we rely on timely, accessible health data to deliver high-quality, coordinated care. While we recognize the important role technology vendors play in advancing digital health, current market dynamics and incentive structures have made it difficult to achieve seamless data exchange. In some cases, data access is limited by proprietary systems and complex integration processes, making it challenging to incorporate third-party tools or share patient information across platforms. Existing rules around data sharing and information blocking have not yet fully addressed these barriers, and limited enforcement has left gaps that impede progress toward true interoperability.

CMS and ASTP/ONC have an opportunity to strengthen enforcement of information blocking policies across all actors in the healthcare ecosystem—not just providers. The current framework, which includes multiple exemptions and limited accountability, can unintentionally create data silos and hinder innovation. Providers are often left navigating technical and procedural obstacles, which increases administrative costs and delays the adoption of digital tools that could enhance care. As artificial intelligence and data-driven technologies become more central to healthcare delivery, it’s critical that policies support open, secure, and equitable data exchange. Ensuring that interoperability is a shared responsibility will help advance patient access, promote innovation, and better support providers in delivering care.

II. Recommendations for Improvement

Patient Care

Patients need assurance that their health information is protected and used only in ways that align with their reasonable expectations. HHS can play a crucial role in building consumer trust in digital health products by establishing a certification program that evaluates these tools against rigorous privacy and security standards. Rather than directly conducting certifications, HHS could authorize qualified independent organizations to perform these assessments and grant certifications. This approach is particularly important given that many digital health products currently operate outside comprehensive national privacy and security regulations. Even with potential future legislation, a certification program would help patients identify trusted digital health tools, fostering greater adoption.

It is important to recognize that complex technologies, such as mobile applications, can create barriers to adoption, especially for individuals in vulnerable populations who may face challenges including limited data plans and unreliable internet connectivity. In this context, secure SMS texting has proven to be an effective and accessible method for patient engagement. Furthermore, health coaches offering personalized, timely support can help patients navigate complex healthcare systems, manage chronic conditions, and overcome barriers related to cost, medication adherence, and prior authorizations. Many patients also face additional challenges related to family dynamics and mental health, which can impact their ability to adhere to treatment plans.

Finding the right provider for specific healthcare needs remains a fundamental patient-centered goal, emphasizing timely access to appropriate care. Virtual care modalities can play a vital role by improving access and enabling patients to connect with the right providers for suitable conditions more efficiently. Effective care coordination—including scheduling, rescheduling, understanding diagnoses, and managing treatment plans—is essential to patient outcomes. Drawing on models from other industries, such as banking, Ascension recommends exploring mechanisms to allow patients to designate authorized proxies who can assist with care management while preserving patient autonomy through the ability to revoke such access at any time. Patient information should be presented in clear, concise formats that accommodate varying levels of health literacy, ensuring accessibility for all individuals.

Seamless integration of data from wearables and home health devices into healthcare applications and patient portals is another priority. To avoid overwhelming providers with raw data, systems must offer summarized, actionable insights that fit within clinical workflows. This need extends to both formal remote patient monitoring programs and consumer-grade wearables that track health metrics such as activity and sleep patterns. To support the reliability of this data, collaboration between HHS and regulatory bodies such as the Food and Drug Administration (FDA) is recommended to establish clear standards for accuracy and validity.

Comprehensive access requires policies that cover the costs of devices for patients and provide appropriate reimbursement for providers' time spent managing and interpreting this data. Initiatives such as those led by the Center for Medicare and Medicaid Innovation (CMMI) should be evaluated holistically, ensuring alignment across patient coverage, provider reimbursement, and assessments of total cost and quality outcomes. Many pilot programs have struggled due to existing fee-for-service payment structures and cost burdens placed on patients, highlighting the need for comprehensive, coordinated policy solutions.

Greater transparency regarding patients' out-of-pocket costs is also essential to support informed decision-making and engagement. Additionally, improved collection and use of data around well-being and patient centered care can enhance care planning, but providers must be supported with appropriate incentives and reimbursement to collect and act upon this information without undue burden.

By combining trust-building through these various mechanisms, we can facilitate broader adoption of digital health tools and advance the transformation of the healthcare ecosystem for patients as envisioned by CMS and ASTP/ONC.

Interoperability

CMS should consider updating meaningful use criteria to better align with technologies that genuinely enhance patient outcomes. While the Promoting Interoperability Program was initially designed to accelerate EHR adoption, it now falls short in addressing the evolving demands of today's data-centric healthcare environment. Meaningful use should advance beyond the foundational capabilities established a decade ago and prioritize maximizing data exchange and effective utilization.

Although EHRs efficiently manage individual patient records, they remain limited in supporting broader objectives such as population health management, advanced analytics, and quality improvement initiatives. Providers and health systems need access to comprehensive, validated datasets that extend beyond transactional records to facilitate care coordination, benchmarking, and workflow enhancements. Presently, accessing and sharing such enriched data is complex and often requires considerable resources or reliance on third-party vendors. Moreover, barriers persist due to information blocking and market dynamics, where EHR vendors impose technical and legal restrictions on bulk data access. Transactional EHRs house thousands of distinct data elements, resulting in critical operational data being inaccessible to advanced analytics and AI applications.

To fully realize healthcare's potential, CMS should revise certification standards and incentive structures to promote broader, more seamless access to extensive datasets. Empowering health systems and trusted third parties with this data can stimulate innovation, reduce expenses, and enhance quality and patient outcomes—without imposing undue burdens on EHR vendors.

Hospitals' data requirements have surpassed the scope of existing meaningful use and interoperability frameworks, which are increasingly misaligned with the complexities of modern, data-driven care. Although EHR adoption and FHIR APIs have driven progress, the intricate regulatory landscape introduces unnecessary burdens and conflicting incentives. Streamlining these regulations will better reflect current healthcare realities. Further, bulk FHIR APIs can strain system performance and are not designed to manage large historical datasets critical for research, clinical trials, or population health analysis. While current standards emphasize structured data, vital insights often reside in unstructured formats such as clinical notes and imaging. Without enhancements, hospitals must resort to costly workarounds and face restricted access to essential data needed for AI, analytics, and quality improvement efforts.

The proposed two-year timeline for transitioning to FHIR-based eCQM reporting is overly ambitious. Most hospitals require at least four years to effectively implement, troubleshoot, and optimize these processes, given challenges like bulk FHIR limitations, variable technical capacity, and insufficient training. CMS could facilitate adoption by providing tools such as open-source QRDA-to-FHIR converters and dedicated testing environments.

Addressing resource disparities—particularly in rural and underserved hospitals—is crucial. CMS should invest in consistent data capture and validation efforts while encouraging reusable vendor solutions to minimize duplication and reduce costs. Restrictions by some EHR vendors on data access compel hospitals to engage expensive third-party services, further straining budgets.

Interoperability initiatives must encompass all care delivery models, including Accountable Care Organizations (ACOs) and Medicare Shared Savings Program (MSSP) participants managing multiple disparate EHR systems. CMS should advocate for a unified, scalable data-sharing infrastructure rather than fragmented, use-case-specific approaches. Such a strategy will promote genuine healthcare transformation, improving quality, cost-efficiency, and patient outcomes.

Information Blocking

Ascension appreciates ASTP/ONC's ongoing efforts to refine the information blocking regulations to advance interoperability and promote the exchange of electronic health information (EHI) to improve care and outcomes. However, as the regulations have evolved, they have become increasingly intricate. Complexity complicates compliance and makes it difficult for stakeholders and others to rely on the rules for accessing and exchanging EHI, undermining the policy objectives of the *21st Century Cures Act*. To address this, the agency should simplify and streamline the regulation through clearer, more precise definitions and narrower, well-defined exceptions. Aligning information blocking rules with other relevant HHS regulations, such as HIPAA Privacy and Security Rules, would reduce confusion and administrative burden.

As the nature and volume of EHI systems expand, adjudicating information requests requires greater resources. Clarifying the definition of EHI will improve data exchange across healthcare entities. Simplification does not imply broader exceptions; instead, efforts should reduce overlap and interdependence among exceptions, and clarify the actionable definition of "interference" without codifying specific examples that risk narrow focus and unintended consequences. Additionally, when new practices emerge that circumvent or weaken the effectiveness of information blocking rules, ASTP/ONC should address these through guidance and enforcement rather than frequent regulatory revisions, preserving flexibility and avoiding overcomplication.

We urge reconsideration of specific exceptions, particularly the Protecting Care Access exception and the Individual Request Not to Share EHI sub-exception under the Privacy exception. The current low threshold for Protecting Care Access based on a "good faith belief" of potential legal risk may permit actors to withhold EHI requested for treatment without consequence. This could lead to a slippery slope, allowing withholding of data for various concerns, potentially conflicting with other laws. A more balanced approach would require an objective basis to believe that EHI will be used in legal action, or limit the exception to situations where disclosure is prohibited under HIPAA. Similarly, reinstating the limitation on the Individual Request Not to Share EHI exception, allowing withholding only when disclosure is prohibited by law, would align with HIPAA, reduce complexity, and protect patient care.

Critically, enforcement must be prioritized. Despite information blocking complaints submitted, no enforcement actions have been taken. This lack of enforcement forces affected parties to seek relief through litigation, contrary to the intent of the *Cures Act*, which envisioned regulatory enforcement. We urge HHS to secure sufficient resources to enforce these regulations effectively.

Clearer, more aligned, and enforceable information blocking regulations are essential to advance interoperability, foster innovation, reduce barriers to data sharing, and ultimately improve patient outcomes and healthcare system efficiency.

Medicare Advantage (MA)

As healthcare providers committed to delivering patient-focused care, Ascension urges CMS to adopt policies that foster more consistent and accessible data exchange across the MA landscape. Despite progress, key gaps remain: how data is shared by health plans, how authorization decisions are implemented, and how compliance is monitored. Addressing these issues will help ensure that providers can fully support care delivery and improve patient outcomes.

Providers rely on timely, accurate, and complete clinical and claims information to support care coordination, quality improvement, and population health initiatives. Yet health plans, particularly in the MA program, are not uniformly required or incentivized to share data in a standardized format. Ascension recommends CMS use its existing oversight of MA plans to require that quality measures be reported using consistent data standards, such as FHIR-based APIs. We also encourage CMS to expand the Blue Button 2.0 initiative to include MA beneficiaries, enabling both patients and providers to access comprehensive claims data in a usable and interoperable format.

Ascension also supports strengthening the electronic prior authorization process. As it stands, even when services are approved electronically, delays or denials can still occur at the claims stage, undermining clinical decision-making and disrupting care delivery. Electronic prior authorization should serve as a binding commitment between the payer and provider, ensuring timely service delivery and payment. We urge CMS to move swiftly to require health plans to adopt standardized, real-time authorization and adjudication systems that prevent unnecessary administrative obstacles.

With regard to audit reform, Ascension agrees that improving documentation and coding accuracy is critical. However, the current Risk Adjustment Data Validation (RADV) process is resource-intensive and difficult to scale. Many provider organizations already utilize advanced tools for internal audits and coding validation. CMS should consider allowing providers and payers who use certified self-audit technologies to submit this information in lieu of traditional RADV reviews. This would reduce administrative burden, improve compliance transparency, and allow CMS to reallocate audit resources more effectively. A parallel option could include a user fee for health plans opting for CMS-led audits, ensuring equity in oversight responsibilities.

Ultimately, achieving a modern, data-driven MA program requires aligning incentives for all stakeholders—especially those delivering care. By promoting data standardization, streamlining prior authorization, and modernizing audit strategies, CMS can enable providers to focus more on patient care and less on paperwork, while strengthening accountability across the system.

Quality Reporting Programs

Through its quality programs, CMS plays a vital role in setting national standards for safe, effective, and equitable care. As integrated health systems like Ascension work to improve care quality across populations, the growing complexity and redundancy of measurement and reporting programs has created significant administrative and operational burdens. Today's overlapping quality programs, delayed feedback cycles, and fragmented requirements make it difficult for even the most committed

systems to use data as a real-time tool for improvement—creating a punitive rather than instructive environment.

To better align with the needs of modern healthcare delivery, CMS should prioritize streamlining and aligning quality measure sets across programs, settings, and payers. Many existing measures are duplicative or poorly aligned with clinical workflows. By eliminating these and standardizing reporting processes, health systems can reduce compliance costs, enhance data accuracy, and redirect resources toward patient-centered care. Streamlined, clinically relevant measures also support clearer benchmarking, more actionable insights, and greater transparency, ultimately benefiting both patients and providers.

Reducing reporting lag is equally essential. Providers currently wait 12 months or more to receive performance data on core metrics, even for simple indicators like infection rates or patient safety events. Delayed data hinders continuous quality improvement. CMS should explore how modern data exchange and EHR capabilities, combined with early predictive analytics such as large language models, can enable faster, more actionable feedback. Access to timely quality data would allow providers to address performance gaps within the same reporting year, leading to better outcomes.

We encourage CMS to continue advancing the critical work of simplifying and modernizing its quality and value-based programs. By working closely with stakeholders to align metrics, improve data infrastructure, and reduce lag, CMS can foster a learning health system that rewards improvement and supports providers in delivering high-quality, cost-effective care.

III. Value-Based Care (VBC)

The overarching goals of VBC are to enhance the patient experience, improve population health, reduce healthcare costs, and support clinician well-being. Emerging technologies such as artificial intelligence (AI), patient-centered digital applications, and interoperable APIs are uniquely positioned to accelerate progress toward these objectives. When thoughtfully integrated with team-based care models, these tools improve care coordination, reduce avoidable utilization, and alleviate administrative burdens on providers.

However, encouraging accountable care organizations (ACOs) and Medicare Shared Savings Program (MSSP) participants to adopt digital health management and care navigation tools more broadly and effectively certainly remains a challenge. Sustainable adoption hinges on access to upfront capital: through prepaid shared savings, one-time investments, or interim capitated payments available to all ACOs regardless of size or revenue status. Many hospital-led ACOs face financial pressures despite being labeled "high-revenue," lacking the venture-backed infrastructure that supports some provider-led ACOs. Accordingly, CMS should pilot tiered financial incentives that reward meaningful digital adoption, alongside mandates for standardized integration of these tools into EHRs to overcome barriers and promote patient engagement.

Central to effective VBC is the aggregation and normalization of data across disparate EHR systems, which often differ in data formats and definitions. Care teams rely on consolidated, interoperable data to create, monitor, and adjust care plans, making seamless data sharing across providers essential. Feedback loops that provide real-time notifications to providers—such as alerts for emergency room admissions—and enable communication of treatment effectiveness and recommended behavioral changes to patients are critical to closing care gaps. Additional capabilities that support care team

workflows, including population health software with integrated patient self-reported data and multi-CEHRT system integration for streamlined quality reporting, further enhance care delivery.

Key technologies like AI-driven analytics, population health management tools, risk stratification, care coordination platforms, usability-focused applications, quality measurement dashboards, and patient engagement solutions must be fully embedded within APM frameworks. Tools disconnected from the provider-patient relationship or EHR workflow see poor patient uptake and incomplete care coordination. To reduce complexity while maintaining necessary flexibility, certification programs like CEHRT should focus on essential VBC capabilities, primarily interoperability, and offer flexible timelines for smaller or less-resourced providers. The ONC's development of a modular certification track tailored to value-based care would support phased adoption aligned with practice capabilities.

As discussed elsewhere in this RFI response, interoperability challenges continue to hinder progress. The ONC should enforce FHIR API standards, and CMS should facilitate real-time claims data access to improve data sharing and timeliness. Implementing digital identity credentials can enhance patient matching and secure portal access, and CMS should pilot these in collaboration with ONC standards. Moreover, establishing a nationwide provider directory of FHIR endpoints—including provider IDs, endpoint URLs, and FHIR versions—and integrating it with TEFCA would significantly improve data accessibility and clarity across care settings.

Importantly, incentives for technology adoption must focus on encouragement rather than penalty. CMS should offer positive financial levers such as enhanced shared savings or reporting exemptions instead of reducing payments for non-adoption, as punitive approaches have historically increased administrative burden without improving outcomes. A one-size-fits-all mandate risks alienating providers who vary widely in size, infrastructure, and community needs. Clear articulation of desired patient outcomes, paired with flexibility for providers to innovate and leverage technology as best suits their context, is critical.

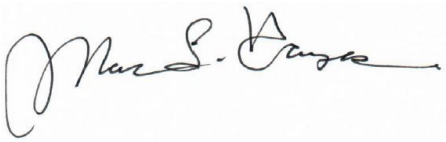
Finally, CMS must address the erosion of incentives established under the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), including the expiration of the Advanced APM bonus and the proposed elimination of the APM conversion factor. These changes, combined with new reporting mandates, reduce the appeal of downside-risk participation, despite ACOs' demonstrated ability to generate meaningful Medicare savings. A balanced, predictable framework combining financial and non-financial incentives—including streamlined reporting and practical support for technology adoption—is essential to sustain and expand value-based care.

By embedding these principles and capabilities into future VBC models, CMS can foster a more equitable, flexible, and innovation-friendly environment. This will empower health systems to deliver higher-value, patient-centered care while enhancing provider sustainability and advancing the goals of modern healthcare delivery.

IV. Conclusion

We appreciate your consideration of these comments. If you have any questions, or if there is any additional information we can provide, please contact me at mark.hayes@ascension.org.

Sincerely,



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