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June 16, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

RE: [CMS-0042-NC] Request for Information; Health Technology Ecosystem

Dear Administrator Oz,

DaVita appreciates the opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with comments on the *Health Technology Ecosystem Request for Information* (RFI). DaVita has a foundational commitment to transforming kidney care delivery with the singular goal of improving the quality of life for individuals living with chronic kidney disease (CKD) and end-stage renal disease (ESRD).

As a comprehensive kidney care provider, DaVita has been a leader in clinical quality and innovation for 25 years. DaVita cares for individuals at every stage along their kidney health journey, applying strategies to slow disease progression and support them in obtaining a transplant. We serve patients from acute hospital care to dialysis at home. Our work across the spectrum of care settings – from acute hospitals to home – has allowed us to better understand the needs of patients and caregivers, and we apply this experience in our ongoing efforts to refine and adapt our care protocols. We know our work has made a difference. DaVita has contributed to reduced hospitalizations, decreased mortality, and engaged collaboratively to propel the kidney care community in maintaining a high-quality standard of care for all patients, everywhere.

Our innovations in dialysis and rapid adoption of novel technologies have allowed us to continue supporting and promoting our patients' health and well-being. We are particularly proud of our work in creating and applying a robust telehealth platform and additional remote monitoring technology to ensure strong, real-time connections between patients receiving home dialysis and their care teams. To support our transplant goals, we designed a nationwide tracking system that monitors transplant center referrals and waitlist updates. This work has a particular focus on our patients served by public programs who,

due to several factors, including transplant center eligibility rules, may have fewer opportunities for transplantation than patients with private coverage.

DaVita is excited by the Administration's focus on data interoperability and recognizes this RFI is the first step in a longer-term effort to transform information sharing processes. We appreciate that the breadth of questions reflects the ecosystem's intricacies, and although we limited our responses to certain sections, CMS should not construe this approach to indicate that we view the other RFI topics as less critical. Rather, we focused on areas in which we believe we could offer the most thoughtful and informed recommendations. As discussed in detail below, the most pressing – and in our view, most transformational – immediate action CMS should take is expanding the "Data at the Point of Care" (DPC) program and the Beneficiary Claims Data API (BCDA) to include dialysis facilities. The current framework applies only to Type 1 (individual) National Provider identifier (NPI) numbers, which effectively excludes facilities such as dialysis facilities, which have Type 2 NPIs.

Again, we welcome the opportunity to offer feedback through this RFI. We look forward to continuing to engage with CMS as this important effort advances. If you have questions or need any additional information regarding any portion of these comments, please contact Kayla L. Amodeo, PhD, Director of Government Affairs at kayla.amodeo@davita.com or via phone at 202-210-1797.

Sincerely,

Kathleen A. Waters
Chief Legal and Public Affairs Officer

Summary of Policy Recommendations

- CMS's version of the physician access API, the "Data at the Point of Care" (DPC) program, and the Beneficiary Claims Data API (BCDA) is set up for Type 1 (individual) NPI numbers, which effectively excludes facilities such as dialysis facilities.
    - We urge that CMS clarify its definition of "provider" eligible to use the provider access API to include Type 2 (facility) NPI numbers, or at a minimum, dialysis providers have access.
    - We suggest "blanket" attribution after the first dialysis treatment, or if that is not possible, CMS could take a paper-based approach in which it collects and uses a consent form to authorize access (as is done with ACO REACH / BCDA).
    - This change is essential for dialysis providers to have the ability to leverage digital health technologies that support the delivery of the highest quality of care to individuals with kidney disease while reducing administrative burden. These outcomes squarely align with the Administration's goals.
- Collect and distribute outcome and other quality data sets and elements on Medicare Advantage (MA) enrollees with CKD and ESRD. The data definitions, formats, fields, and content should align exactly with those applied under Fee-For-Service (FFS).
- Ensure that the Trusted Exchange Framework and Common Agreement (TEFCA) — and any enhancements to it — promote transparency, accountability, and equitable access across the full spectrum of healthcare organizations and technology partners.
- The United States Core Data for Interoperability (USCDI) defines the minimum data elements required for interoperability. To realize its full potential, CMS should complement these content standards with policies that ensure the exchange of data with appropriate context, accuracy, and traceability. By leveraging tools such as API certification, program participation requirements, and quality-linked incentives, CMS can support more reliable, accountable data exchange across the ecosystem, benefiting patients and providers.
- Grant dialysis organizations clinical data repository (CDR) access. When CMS first proposed the ESRD Quality Reporting System (EQRS), it highlighted the CDR and dialysis organizations' ability to access the EQRS and other ESRD data. CMS intended the CDR to address the major limitation of the prior system, namely, access to the data. Since that time, the CDR has come online, and the EQRS data feeds into it; **however, dialysis organizations continue to be denied access**.

Patients and Caregivers

2. Data Access and Integration

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

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)?*

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

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?*

Beneficiary Claims Data API (BCDA)

Beneficiary Claims Data API (BCDA) includes unprocessed CMS claims for patients attributed to an organization. This data offers information on comorbidities, testing and procedures, providers, medications, care transitions, and utilization of durable medical equipment (DME)/home care, peritoneal dialysis (PD) supplies, and advance care planning (ACP)/hospice. BCDA helps guide real-time care discussions with patients. Having this data readily available to a treating provider is essential.

The existing DPC program provides physicians valuable access to Medicare claims data. However, its current implementation restricts usage to Type 1 (individual healthcare practitioner) NPIs, thereby limiting its potential impact on care coordination and quality improvement initiatives. As CMS knows, the nature of in-center and home dialysis care entails multiple hours of patient-provider interactions each week prior to, during, and after treatment sessions. Individuals with kidney disease also often experience multiple comorbidities and receive care from several clinicians and facility types. The treatment paradigm, coupled with patients' need for comprehensive, coordinated, and integrated care, strongly supports an expansion of this access model to include Type 2 (organizational provider) NPIs, or at a minimum, to dialysis providers specifically, which would enable them to leverage this critical data resource. As previously communicated to CMS, dialysis clinics would particularly benefit from organizational-level access to DPC data to enhance care coordination and facilitate timely access for surgery coordination for their patients.

We believe CMS could efficiently achieve this expansion to all Medicare patients by modifying the existing DPC Type 1 NPI framework and incorporating the currently used Center for Medicare and Medicaid Innovation (CMMI) attribution rules for dialysis providers. These rules would ensure appropriate patient attribution while maintaining necessary privacy and security protections. This approach would build upon proven

infrastructure and methodologies, making implementation both feasible and cost-effective while significantly expanding the DPC program's reach and impact. We suggest "blanket" attribution after the first dialysis treatment – or if that is not possible, CMS could take a paper-based approach in which it collects and uses a consent form to authorize access (as is done with ACO REACH / BCDA). Again, we are asking CMS to make available BCDA data for all Medicare patients, not just for those receiving care under a CMMI model.

Medicare Advantage Encounter Data

In addition to timely access to BCDA data, DaVita believes that access to more complete MA encounter data and greater transparency are necessary to ensure that CMS and Congress can fulfill their Medicare program oversight obligations. Given that nearly 50% of beneficiaries with ESRD have elected MA, we recommend that CMS provide access to MA encounter data through the same mechanism as BCDA data, with the same timeline and the ability to see final or post-adjudication claims. These post-adjudication claims represent the most accurate data for many use cases.

One of the most consequential ways to reduce overall spending on renal care is to prolong the effectiveness of an individual's kidney function, which depends on early identification and diagnosis of CKD. We have seen firsthand how data lags and differences in reporting protocols can impact existing mechanisms, such as the United States Renal Data System (USRDS), to fulfill its vital mission of collecting, analyzing, and distributing information about CKD and ESRD in the United States. As MA enrollment among beneficiaries with ESRD has grown, the USRDS has been requesting and receiving data from MA plans over the past several years. However, the USRDS has identified challenges that limit the utility of its analyses for its annual data report (ADR).

Notably, MA encounter data lags FFS claims data by one year, resulting in presentation of FFS claims data through 2021 and MA encounter data through 2020. DaVita (in particular) and the nephrology community (in general) rely heavily on the ADR to identify gaps in kidney care and plan for future needs in the patient population. A two-year lag in the case of FFS claims already is challenging; a three-year lag is formidable.

Furthermore, although the USRDS has itself obtained MA encounter data for use in the ADR, there is no apparent mechanism to redistribute those data to researchers through the often-utilized Standard Analysis Files (SAFs). As such, many researchers, including health services researchers who study kidney care, are inclined to characterize practice patterns and disparities through the increasingly narrow prism of the experience of beneficiaries enrolled in FFS Medicare. This engenders the risk of incorrect research conclusions, particularly considering the larger shift into MA enrollment among certain demographic groups and beneficiaries with lower incomes since 2021.

We urge CMS to collect and distribute the following data sets and elements on beneficiaries with CKD and ESRD. The data definitions, formats, fields, and content should align exactly with those applied under FFS.

- Outcome and other quality data aligned with data collected through the Chronic Care Policy Group (CCPG), the ESRD Quality Incentive Program (QIP), and the ESRD Networks
- All data necessary for the USRDS to complete its annual report

Transplant

We encourage CMS and the Health Resources and Services Administration (HRSA) to collaborate and set a minimum, uniform data set to be transacted between dialysis facilities and transplant centers for initial listings and maintenance of listings. A defined data set would mitigate inefficiencies that result from variability in required elements across transplant centers across the country. Differences in data elements also contribute to unnecessary confusion for patients who receive similar, but not identical, information from various transplant centers. It would also be helpful for CMS to support the development and adoption of technological advances that promote better data flow and communication between all providers involved in caring for patients pursuing a transplant. For example, although we support our patients being included on a transplant waitlist, we are not always informed if and when there is a missing piece of data or information that results in the patient being removed from the waitlist. Improved communication would enhance the efficiency and efficacy of the waitlisting process and provide much-needed, real-time transparency to patients, transplant centers, and dialysis facility staff.
We recognize that existing tools have these capabilities but require additional support from CMS. Dialysis providers need easy access to data through APIs for our patients, which will help accelerate the effectiveness of the tools already built.

Q: PC-9. Given that the Blue Button 2.0 API only includes basic patient demographics,

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?*
b. *What suggestions do you have to improve the Blue Button 2.0 API experience?*
c. *Is there non-CMS data that should be included in the API?*

Real Time Data

We applaud CMS's efforts to serve as the digital front door to allow non-claims-based data access. To build on this work, CMS should utilize the existing *Blue Button 2.0 API OAuth* process to make both MA data and electronic medical record (EMR) data available through a patient single sign-on (SSO) for federated data access, allowing that data's real-time availability. *OAuth 2.0* is a widely used standard for secure delegated access to user

resources for beneficiary authorization. That same patient identification process may be used to allow other applications permission to access their data through a secure process, rather than the current process of human-readable portals, each with their own login credentials.

Further, we encourage CMS to develop more open and transparent criteria regarding its plans to define "trusted data exchange." We believe this could be an iteration on the current TEFCA model or driven through stakeholder input via a technical expert panel (TEP) of "early adopters."

Provider Access to Application Programming Interface (APIs)
DaVita believes having standard APIs will allow plan and provider systems to integrate more easily and facilitate the needed transparency to help streamline authorizations. Overall, more timely sharing of clinical information will better ensure that all providers have a complete understanding of a patient's health status, which is essential to the effective management of kidney disease. Many of our patients have multiple comorbid conditions and take several medications in addition to their dialysis treatment. Prior efforts have demonstrated the importance of care coordination to improve patient outcomes. Data interoperability holds great promise in improving information flow as well as the efficacy, efficiency, and quality of care, especially for patients with complex needs, such as those with ESRD.

Physician application access to payer data will improve patient care and reduce workload burden, not just for individual healthcare providers, but also for facilities. We understand that CMS's version of the physician access API, the DPC program, is set up for Type 1 (individual) NPI numbers, which effectively excludes facilities such as dialysis facilities.

As we mentioned in a previous comment, we urge CMS to clarify its definition of "provider" eligible to use the provider access API and ensure it includes Type 2 (facility) NPI numbers. We view this as the most critical step for dialysis providers to leverage digital health technologies to continue to deliver the highest-quality care to individuals with kidney disease and reduce administrative burdens, which align with the Administration's goals.

Provider Directory
DaVita supports CMS's effort to establish a dynamic, interoperable national provider directory as a foundational step toward scalable, trusted data exchange. Today, the lack of a centralized and accurate directory forces networks and health IT vendors to create and maintain duplicative, inconsistent versions of provider and endpoint data. To succeed, the directory must not only build on existing NPI infrastructure but also incorporate real-time updates, delegated attestation models, and standardized digital endpoints. CMS should ensure the directory is designed for API-first access, supports Fast Healthcare Interoperability Resources (FHIR)-based integration, and is aligned with broader interoperability frameworks like TEFCA and national endpoint registries.

2. Information Blocking and Digital Identity

Q: PC-14. Regarding digital identity credentials (for example, CLEAR, Login.gov, ID.me, other NIST 800-63-3 IAL2/AAL2 credentialing service providers (CSP)):

a. *What are the challenges today in getting patients/caregivers to sign up and use digital identity credentials?*

b. *What could be the benefits to patients/caregivers if digital identity credentials were more widely used?*

c. *What are the potential downsides?*

d. *How would encouraging the use of CSPs improve access to health information?*

e. *What role should CMS/payers, providers, and app developers have in driving adoption?*

f. *How can CMS encourage patients to get digital identity credentials?*

DaVita supports the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-63-3 and Federal Information Processing Standard (FIPS) 201 credentials/standards to allow federated access to machine-readable data across various FHIR endpoints. These standards provide a robust framework for identity assurance and authentication that would significantly streamline patient access while maintaining the highest security standards. NIST SP 800-63-3's tiered approach to digital identity verification enables risk-based authentication, allowing patients to establish their identity once through a trusted credential service provider and then seamlessly access multiple healthcare systems without repeated verification processes. FIPS 201 standards, originally developed for federal employees, provide proven cryptographic protections and multi-factor authentication capabilities that can be adapted for healthcare use.

Together, these standards would enable true single sign-on (SSO) functionality across the healthcare ecosystem, eliminating the current fragmented approach where patients must navigate multiple authentication systems. Today's access is time-consuming and suffers from the need for multiple logins and patient portals, which only allow a patient to get a limited data set of information—human-readable, not machine-readable data. By implementing federated identity management based on these established standards, patients could greatly benefit from a single sign-on experience that provides seamless access to comprehensive, machine-readable health data across all their providers. CMS should explore ways to streamline the login points for patients by adopting these proven federal standards, which would reduce administrative burden, improve patient experience, and facilitate better care coordination through enhanced data accessibility.

Providers

1. Digital Health Apps

Q: 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?

DaVita supports the adoption of a strong regulatory framework to govern the safe and effective use of digital health applications. However, the current ecosystem—particularly regarding certification and data access—often present barriers to innovation and real-world deployment. One key challenge is the continued presence of closed or fragmented EHR ecosystems that limit third-party access to patient data. Despite FHIR-based API requirements, many certified EHRs still control access through proprietary gateways or business agreements, undermining the promise of open innovation. To address this, CMS should work with ONC to strengthen API certification criteria, including testing for usability, endpoint transparency, and third-party developer access. Additionally, CMS could incentivize providers and platforms that participate in truly open API environments, reducing friction for developers and accelerating the adoption of high-value applications that improve care delivery and patient outcomes.

The healthcare technology landscape suffers from a lack of standardized return on investment (OI) metrics to demonstrate the value of innovative applications, while a fragmented vendor landscape offers numerous point solutions rather than integrated platforms. High switching costs and vendor lock-in discourage experimentation with innovative solutions. Limited reimbursement models fail to recognize the value of digital health innovations, which is particularly the case for smaller and rural providers who lack the resources to invest without clear financial incentives.

Costs are a major prohibitive factor with innovative application utilization. There are currently no incentives or support for rural or smaller providers to build the necessary infrastructure to develop, deploy, or utilize innovative applications. Additionally, multiple systems, apps, and programs are already required, but are not interoperable, making it extremely hard to connect the linkage dots for any provider. Other obstacles, such as data quality, completeness, and timeliness, could be addressed by some of the suggested processes and technologies in this RFI.

Q: 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?

There is a significant need for a standard native format, like a FHIR-based infrastructure, to build on. Developers require access to data to build digital products on top of that data. The inability to create action-oriented messages, such as scheduling appointments or ordering labs in EMRs, reduces opportunities to achieve the promise of better patient and physician experience through automation.

2. Data Exchange

Q; 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?

CMS could support the development of patient-specific data repositories or a Patient Health Record (PHR) by creating a comprehensive, patient-controlled health record using modern FHIR (Fast Healthcare Interoperability Resources) standards. The success of CMS's Blue Button 2.0 API, which already provides over sixty million Medicare beneficiaries with access to their Part A, B, and D data through standardized APIs, demonstrates both the technical feasibility and patient demand for such services. A modernized PHR built on FHIR standards would serve as a centralized data repository that patient's control, containing not only Medicare claims data but also laboratory results, clinical notes, imaging reports, and other comprehensive health information from multiple sources.

This approach would significantly reduce the burden on providers by creating a single, standardized interface for data sharing rather than requiring them to maintain multiple proprietary connections. Applications could integrate PHR data with EHR systems to import current health information, allowing patients to share health information such as current medications, lab results, and medical imaging with providers while giving caregivers an accurate picture of a patient's health data to facilitate care coordination.

Current regulatory requirements already mandate that FHIR APIs support USCDIv3 and SMART 2.0 standards for 2025. 2025 is on FHIR - Dynamic Health IT, creating a foundation for standardized data exchange. CMS should build on this by providing technical assistance and potentially financial incentives for smaller and rural providers to implement these standards. CMS could also establish regional health information exchange hubs that smaller providers can connect to, reducing individual infrastructure costs while maintaining interoperability.

3. Technical Standards and Certification

Health IT Certification Program

Q: TD-9. Regarding certification of health IT:

a. *What are the benefits of redefining certification to prioritize API-enabled capabilities over software functionality?*

b. *What would be the drawbacks?*

c. *How could ASTP/ONC revise health IT certification criteria to require APIs to consistently support exchanging data from all aspects of the patient's chart (for example, faxed records, free text, discrete data)?*

d. *What policy changes could CMS make so that providers are motivated to respond to API-based data requests with the best possible coverage and quality of data?*

e. *How could EHRs capable of bulk data transfer be used to reduce the burden on providers for reporting quality performance data to CMS? What capabilities are needed to show benefit? What concerns are there with this approach?*

Clinical Data Repository (CDR)

CMS created the Clinical Data Repository (CDR) to allow multiple data sources to be fed into a central location. The entire data pool can be segmented and accessed by those who need any of the data it contains. When CMS first proposed the ESRD Quality Reporting System (EQRS), it highlighted the CDR and dialysis organizations' ability to access the EQRS and other ESRD data. CMS intended CDR to address the major limitation of the prior system, namely, access to the data. Since that time, the CDR has come online, and the data from EQRS feeds into it; however, dialysis organizations continue to be denied access.

Granting dialysis organizations CDR access would achieve many of the Administration's goals. It could reduce costs, reporting burden, and make data access/reporting more efficient. CMS could accomplish this objective in a couple of ways. Creation/maintenance of multiple datasets and reports within ESRD data systems could be ended to allow system contractors to focus efforts in other areas or have their scope reduced. The data from multiple government agencies/contractors (e.g., NHSN, UNOS, SSA, CDC, etc.) could be fed to it, again reducing reporting needs from those agencies. Aggregating the data into a single pool would also allow the various systems to access the data, which would eliminate the cost of collecting these same data points in each separate system. Additionally, this approach could reduce potential data discrepancies, and the systems/resources needed to manage any differences. It would also reduce the reporting burden experienced by dialysis organizations, which currently must input the same data into multiple systems with different reporting requirements.

Granting dialysis organizations CDR access would also diminish the burden on CMS's ESRD Program. Over the past several years, dialysis organizations have requested access to the CDR to allow us to use our resources to create reports tailored to our specific needs. Electronic access to the data electronically in bulk would permit us to extract the necessary data at the required frequency. From there, we can internally manage the incorporation of the data into our systems and reporting structures.

4. Data Exchange

Q: TD-13. What new opportunities and advancements could emerge with APIs providing access to the entirety of a patient's electronic health information (EHI)?

a. *What are the primary obstacles to this?*

b. *What are the primary tradeoffs between USCDI and full EHI, especially given more flexible data processing capabilities today?*

While the U.S. Core Data for Interoperability (USCDI) has provided an important foundation for standardizing the content of health data exchanged across the ecosystem, its impact is constrained without robust mechanisms to ensure the data's quality, integrity, and traceability. As CMS considers how to advance the goals of trusted data exchange, we urge greater attention to enforcing data quality and provenance standards, beyond mere inclusion in content specifications.

Provenance metadata, including source system of record, author organization, timestamps, and data modification history, is essential for trust, auditability, and downstream clinical and administrative decision-making. While USCDI includes a provenance data class, it is often not implemented consistently and is frequently lost when data passes through aggregators or intermediaries. Similarly, there are currently no consistent requirements or enforcement mechanisms to ensure the accuracy, completeness, and consistency of the clinical or administrative data exchanged under federal interoperability programs.

We encourage CMS to explore and implement policy levers to improve enforcement of data quality and provenance expectations, such as:

- Expanding API certification criteria to require support for and transmission of FHIR Provenance resources or equivalent metadata, ensuring that source attribution and authorship follow the data;
- Establishing participation requirements for trusted exchange networks (e.g., TEFCA QHINs) that obligate network participants and intermediaries to preserve data lineage and demonstrate baseline data quality controls;
- Embedding data quality accountability into CMS quality and value-based care programs, including through incentives or penalties tied to the integrity and usability of exchanged data; and

- Developing or endorsing testing and validation tools that assess real-world conformance to provenance and data quality standards across FHIR APIs and endpoints.

USCDI defines the minimum data elements required for interoperability. To realize its full potential, CMS should complement these content standards with policies that ensure the exchange of data with appropriate context, accuracy, and traceability. By leveraging tools such as API certification, program participation requirements, and quality-linked incentives, CMS can support more reliable, accountable data exchange across the ecosystem, benefiting both patients and providers. For example, the following areas would benefit from such interoperability:

Transplant

DaVita believes having standard APIs from other data sources would allow our systems to integrate more easily and facilitate the needed transparency to help with the transplant referral and waitlist maintenance process. This could be achieved, for example, through standard Blue Button-like APIs to allow patients to access and grant access to their data, ideally in a FHIR data format.

We also encourage a machine-readable policy specification API and a central database maintained by the OPTN that clearly defines individual transplant center selection criteria. The creation of API access to this database would also assist patients and other providers in the organ waitlisting process. Overall, more timely sharing of clinical information will better ensure that all providers have a complete understanding of a patient's health status, which is essential to ensuring a patient's initial placement on the waitlist as well as maintaining their waitlist status.

Surgical Access Coordination

Data interoperability is critical for timely surgical access coordination, particularly for dialysis patients requiring vascular access procedures. When nephrologists, vascular surgeons, and interventional radiologists have seamless access to a patient's complete medical history—including current lab values, medication lists, imaging studies, and prior surgical history—they can make informed decisions about optimal access placement and timing.

Transition into Dialysis

The transition from chronic kidney disease (CKD) management to dialysis initiation represents a critical juncture where data interoperability can significantly improve patient outcomes and experience. When nephrologists have access to comprehensive patient data from primary care providers, specialists, and hospitals, they can better predict dialysis timing, prepare patients and families through education programs, and coordinate preemptive access creation. Integrated data systems enable seamless transfer of medication histories, allergy information, and comorbidity management that impact dialysis prescription and treatment planning. This comprehensive data sharing reduces the

likelihood of urgent dialysis starts, minimizes hospitalizations during the transition period, and ensures continuity of care for complex medical conditions that require ongoing management alongside renal replacement therapy.

1. Digital Health Adoption

Q: 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*?

Broadly, there are multiple opportunities with expanded patient data access, such as surgical coordination, transplant, transitions into dialysis, monitoring, and early disease intervention.

A general kidney care use case could look like the following process:

- **Patient Healthcare Ecosystem:** Understand a specific patient's care patterns and care networks
- **Pathway to Optimal Start:** Monitor CKD education occurrence (if billed), vascular mapping, and access placement, related procedures
- **Identify Periods of Illness:** Follow patient comorbidities and patterns through claims submitted by all providers caring for a patient
- **Pre-transplant Evaluation Patterns:** Follow required testing, including stress tests, colonoscopy, lab testing, and HLA testing
- **Prescribing Patterns:** Follow patient comorbidities, refill patterns, high-risk medications, prescriber information
- **Analytics and Future Predictive Modeling:** Identify patterns of CKD to ESRD combined with comorbidities to understand specific populations and potentially aid in future prediction of conversion to ESRD

VBC Arrangements and MA

In our experience, there is extraordinarily little, if any, focus on aligning value-based arrangement specifications among MA plans. It is also challenging to gain alignment between MA plans and providers in securing data consistently and accurately, and the data formats and content vary meaningfully across value-based care arrangements.

Further challenges are tied to the balance of attributing a patient to a provider for management, where the identification generally takes place several months after the need

arose. In other words, attributing a patient from the onset of disease commonly puts the provider at least three months behind in engaging the patient due to the lag associated with patient identification. It would be helpful to have all payors conform, over time, to a standard set of data needed to streamline timely information for a health information exchange (HIE) or a risk-taking provider.