Dimer Health Response to RFI the Centers for Medicare and Medicaid Services CMS-0042-NC: Health Technology Ecosystem

Submitted by
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Collaborative input
Portions of this response were developed through a research collaboration between Dimer Health and the West Health Institute (WHI) (westhealth.org). The response is submitted solely by Dimer Health and does not necessarily reflect the views or endorsement of WHI.

Introduction: Dimer's Transitionist Medicine as a Model for CMS Innovation

Dimer Health is pleased to offer its response to the CMS Request for Information: Health Technology Ecosystem. Below, we provide responses to sections B, C, E & F of the RFI. Briefly, Dimer Health takes the position that the healthcare technology ecosystem must move beyond incremental optimization toward fully operational, patient-centered care transformation. We urge CMS not merely to encourage innovation in the abstract, but to reserve space within its digital strategy for entirely new models of care delivery. A critical example is Dimer's Transitionist model—a technology-enabled service line that bridges acute care, post-acute coordination, and population health.

Currently operating in New Jersey, New York, and Florida, Dimer Health distinguishes itself by the depth of data captured during transition periods of the patient care journey. This unique window yields insights unavailable elsewhere—not just patient interactions with the traditional healthcare services, but a holistic view of patient behavior, barriers to care, unmet needs, and responses to intervention. Dimer uses this real-time data to create personalized, adaptive care pathways, risk profiles and specific care needs. Our proprietary AI models continuously learn and refine care pathways, enabling us to remain engaged, predictive, and responsive to each patient's evolving needs. This fusion of clinical delivery and data intelligence positions Dimer Health as both a care provider and an insight engine—redefining transitional care and establishing a new standard for patient-centric medicine.

Because Value-Based Care (VBC) is firmly established in this RFI as a cornerstone of improved health outcomes, we would like to draw particular attention to our response to Section F. There, we underscore how Dimer Health, as a health-tech startup, grounds its operations in the theoretical constraints and opportunities that underpin VBC. These often overlooked considerations are not just academic—they are critical to enabling a sustainable transformation of our health care delivery system through technology.

Section B: Patients and Caregivers

The Transitionist approach specifically provides an operational framework responsive to the questions raised in Section B: Patients and Caregivers.

Patient Portals and Engagement (PC-3 to PC-4)

Dimer offers the perspective that patient context is everything. Specifically, for patients, caregivers, and personal assistants, Dimer's Transitionist care model necessitates much more than a traditional patient portal offered by most health systems.

Central to the Dimer app is a one-stop "tap for help" button that is available 24/7, providing immediate access to a clinician. Moreover, the clinician is supported by up-to-date insight into the patient's history—essentially a profile of where the patient is in their care transition. This is a richer, data-driven context compared to Personal Emergency Response System (PERS) buttons, for example—it is context-aware and designed specifically for the transitional phase of the patient journey. It is also more than just an on-demand service or even a 911-style call; it is meaningful precisely because it is embedded in real-time, contextual clinical data.

In addition, beyond the on-demand call button, the Dimer app supports AI-enabled workflows and real-time data access to deliver curated, patient-specific health information such as medications, tailored guidance, and decision support. This enhancement supports provider-initiated care interactions and is not a data dump. Patient-specificity means making sense of both clinical and community data, and rendering it actionable through a transitionist clinical lens—not simply forwarding files.

Unlike static portals that rely on patient-initiated searches, the Dimer app proactively flags gaps, escalating urgent needs to human clinicians in real time. The app also enables patients to ask questions and schedule in-person appointments, ensuring continuity of care.

Health Information Exchanges (PC-11)

As an experienced health-tech and data-centered healthcare startup, Dimer recognizes that Health information exchanges (HIEs) represent a valuable indicator of patient contact with the healthcare services available in the broader community, both within and beyond home networks. But context remains central to the patient/caregiver/assistant experience. Raw data signals are not inherently actionable. Indeed, raw ADT feeds, while representative of a wide network of patient care contacts do not in and of themselves provide an actionable basis for care redesign. Dimer suggests that CMS not only support the generation of real-time information, but also invest in the operational infrastructure required to translate that information into meaningful engagement.

Digital Identity and Adoption (PC-13 to PC-14)
Dimer applauds CMS for raising these issues—absent opt-in on a wider basis, the promise tech-enabled care transformation may be limited in scope. Dimer's experience suggests that patients need to first experience the level of engagement provided by the Transitionist model before they are likely to adopt tools like digital identity credentials. To put it plainly: patients will take the extra steps (as they do in banking or credit card access) once the benefits are tangible. There is a potential bootstrapping moment for patients in the sense that once they see the contrast—between, say, calling for help and being told to dial 911 or wait days for an appointment—they understand the value. And they opt in.

Section C: Providers

The Transitionist approach specifically provides an operational framework responsive to the questions raised in Section C: Providers.

Encouragement, obstacles and improvements (PR-1-PR-4)
Despite increased clinical integration and consolidation in many networks, healthcare service delivery is often constrained to operate in silos. These silos—defined by distinct service lines and narrow referral pathways—can be functional for certain workflows, but they fail many chronically ill, older adults who fall between the cracks. For these patients, the default can often become an ED visit and a revolving door of hospital-based care. This is precisely where Transitionist Medicine fits in: it facilitates patient-centeredness, not care-delivery-centeredness. Dimer cannot overemphasize that the most vulnerable patients are the ones who need this model the most. Ostensibly integrated clinical networks are not equipped to support the engagement, responsiveness, and navigation required outside of direct service episodes.

Data Strength vs. Patient-Centered Situational Awareness (PR-7)
Most integrated networks are strong in data access: patient portals, lab results, appointment scheduling, and referral follow-ups all function reasonably well. What is missing, however, in the Transitionist phase is the ability to detect patient needs early and respond with agility. This requires not just health information—which is often only generated when a clinical service is activated—but broader situational awareness.

There must be a lower barrier for patients, caregivers, or assistants to detect needs or flag concerns. And providers must be equipped with adequate situational awareness to know when where and for whom to initiate contact, evaluation and management. Neither side can be expected to hurdle over high-friction systems just to initiate care. In Dimer's view, this is not a patch to existing silos; it is a new paradigm—a Transitionist field of medicine and a service line in its own right--one that provides connectivity, engagement, and responsiveness precisely during the times when a patient is most vulnerable and least connected.

Interoperability and the Transitionist Model (PR-4)
In response to PR-4 and related interoperability questions, we urge CMS to recognize the Transitionist service line as a necessary link between traditional, siloed care structures. CMS can help facilitate interoperability between these emerging service lines and clinically integrated networks.

Information Blocking and Digital Identity (PR-9 to PR-14)
With respect to the provider perspectives on information blocking and identity protocols, we reiterate our above perspectives from the patient side, namely that experiencing the operational advantages will compel embrace and adoption.

Section E: Technology Vendors, Data Providers, and Networks

Currently, Dimer actively listens to ADT feeds across New Jersey, representing important input to its event-driven architecture. But Dimer's clinical intelligence model requires more than alerts—it requires context. ADT signals, for instance, are often unstructured and insufficient on their own. To deliver timely and meaningful action, Dimer could benefit from the ability to consume a more holistic picture of patient care needs:

- Structured EHR data (VB-3)
- Health Information Exchange feeds (TD-7)
- Care plans, notes, referrals, and outcomes (TD-13)

Our platform is built to synthesize these data sources and transform them into real-time engagement—not only for clinicians, but also for caregivers and patients, who are too often excluded from traditional handoff models. This connectivity is essential to delivering whole-person care. Our aspiration represents a village-level understanding of patient situational needs: knowing what is needed, where, why, and for whom. We strongly emphasize that whatever technical questions are asked—whether about APIs, formats, or export standards—they must not reinforce a siloed view of care. They must prioritize patient context, particularly in the Transitionist phase of care, where stakes are high, coordination is fragile, and legacy infrastructure falls short.

Section F: Value-Based Care Organizations

As indicated in our introduction, we applaud CMS's stated position that Value-Based Care (VBC) needs to be a cornerstone of health care delivery transformation. VBC specifically provides the incentives, the agency and the shared responsibility to make health care better. We would therefore embrace the opportunity to offer our perspective on how Dimer Health's approach to tech-enabled care delivery is deeply rooted in the theoretical constraints and opportunities that underpin VBC. While these may at first

appear abstract or academic, we believe they are an underappreciated but essential underpinning of sustainable transformation through technology.

Among the most important emerging themes in value-based care is the scope, focus, and critical limitations of risk adjustment (VB-2, VB-4, VB-6). Risk adjustment is central to VBC because it establishes the financial benchmarks for evaluating success and shared savings. But risk adjustment is fundamentally an actuarial—not operational—construct. It does not provide actionable guidance at the individual level. Instead, it offers an aggregated, population-level view of expected cost. This lack of predictive precision can leave providers feeling unmoored.

A common misconception is that this limitation is temporary, and that policy reforms—especially e.g. reforms embracing artificial intelligence--may eventually raise risk adjustment to a level where it provides provider-side clarity in terms of who need what and when. Such a proposition is unlikely and arguably not even desirable. As McWilliams notes in his 2025 *Health Affairs Forefront* article, “Risk Adjustment Reform: Navigating Ideas And Tradeoffs”:

> Improving fit (often called predictive accuracy) to limit selection incentives tends to exacerbate other distortionary incentives; it comes at a cost. These tradeoffs motivate a broader framing of optimal risk adjustment as establishing a set of incentives to maximize an economic objective (e.g., efficiency) as opposed to a statistical one (e.g., R^2).

With the broader goals of the payment system in mind, value-based care requires not just data and scores, but the ability to understand and act on real-time needs. Risk is not the same as need. Even with the most sophisticated adjustments, risk scores will never provide an adequate provider-side framework for determining what resources should be deployed, where, and for whom.

Related perspectives are included by Crowley et al. in an article entitled *“New healthcare payment models: risk scores aren’t enough to guide resource allocation”* (*Scientific Reports*, May 2025). These recent articles converge on a critical insight: no payment model—nor any prospective risk stratification method—will tell providers what action to take, and when.

Provider-side guidance on who needs what and when must come from the provider side itself. With the incentives and agency offered to providers in VBC payment models, it is the providers that can be compelled to better understand patient care needs and to act on the needs. This is the foundation of patient-centered care. But providers cannot expect such guidance to be initiated by the payors and policy makers—it is up to the providers to embrace technology that supports adaptive, system-level resourcing

strategies that respond to endogenous signals—clinical or behavioral cues surfaced intentionally after group-level risk is established (VB-4).

This distinction lies at the heart of VB-2, VB-3, and VB-4. Risk scores may underpin financial contracts, but they are not sufficient to guide delivery. Once benchmarks are set, risk-bearing providers are uniquely positioned to interpret dynamic signals and respond accordingly. By designing systems that track needs and deploy resources in real time, VBC organizations can move beyond bearing risk to actively managing it (VB-3).

Importantly, cost-effective access to those endogenous signals is not easy to achieve. Care coordination is a standard feature of population health (VB-2), but as McWilliams warned in his 2016 *New England Journal of Medicine* article, "Cost Containment and the Tale of Care Coordination," clinical labor has a number-needed-to-treat problem. And in today's constrained labor market, the VBC ecosystem must shift toward scalable, automated, tech-enabled patient engagement. That is the core of Dimer's vision: a Transitionist tech-enabled model that is patient-centered, responsive, and context-aware at the point of need.

The technical standards and infrastructure outlined in VB-11 to VB-15 will certainly help. As noted above, ADT feeds are often unstructured and require context to be actionable. But the necessary shift to endogenous signaling will require more than plumbing—it will require AI-enabled tools that blend clinical signals with community context. And as Dimer indicates above, such contextual synthesis is not AI-enabled prognostication: it's a whole-person patient centered perspective that enables VBC.

An example (not yet fully operational but illustrative of our commitment) is Dimer's current collaboration with New Jersey Medicaid to reduce hospital readmissions:

- 2.4 million Medicaid members
- ~360,000 readmissions annually (15% readmission rate)
- ~120,000 considered avoidable
- Dimer aims to reach 50% of this cohort, representing up to $600 million in avoidable cost (VB-1)

As represented by this proposal before New Jersey, Dimer is not just about clinical automation—it's about community intelligence. Who missed a visit due to housing insecurity? Who is experiencing anxiety and cannot be put on hold or driven back to the ED to re-start the cycle of ED/Inpatient SNF visits? Who is experiencing caregiver burnout? What's preventing a follow-up? Dimer believes that its tech-enabled Transitionist model will deliver on the potential to save more than half a billion dollars in one state alone.

Conclusion and Imperative for Action

Success in value-based care will not come from simply expanding the infrastructure that moves clinical data faster. True success depends on dynamic, bidirectional engagement—systems that continuously sense, interpret, and respond to real-world signals from patients, caregivers, and communities. This RFI moves in the right direction with standards like those outlined in VB-11 to VB-15, but standards alone won't close the last-mile gap between population-level analytics and person-level action.

Dimer's Transitionist model was built for that gap. By fusing real-time clinical feeds with context-aware community insight, we turn endogenous signals into timely, proportional interventions—exactly the kind of response loop scalable VBC demands.

We support any effort—public or private—that moves us toward this future. Dimer happens to be focused on transitions, but the urgency of this model extends far beyond us. We ask CMS and its partners to treat this not as a pilot concept, but as a national imperative. It's not just a matter of innovation—it's a matter of service to the most vulnerable populations, and stewardship of our nation's healthcare finances.

We thank CMS, ASTP, and ONC for the opportunity to contribute and look forward to advancing this conversation together.