Providence
1801 Lind Avenue SW
Renton, WA 98057
Providence.org

June 16, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Request for Information; Health Technology Ecosystem (RIN: 0938-AV68)

Dear Administrator Oz:

On behalf of Providence, thank you for the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) and the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) on opportunities to improve data interoperability and the broader health technology infrastructure for Medicare beneficiaries.

Providence recommends all patient identities be certified as an OpenID Provider allowing patients to use a single federated credential to authenticate and authorize data exchange between payers, providers, and patient-facing applications. As such, ONC Health IT certification 170.315(d)(1) should be updated to mandate OIDC certification for patient authentication and any relying party integrated applications. Specifically, EMR applications such as patient portals (e.g. MyChart) need to support OIDC as a relying party and certify any patient identity they expose (e.g. MyChart Login) as an OpenID Provider.

CMS has a powerful opportunity to accelerate healthcare innovation by ensuring Bulk FHIR APIs function effectively at scale. When providers can access timely, population-level data, providers are better equipped to improve care quality, collaborate with payers, and drive system-wide transformation.

Providence supports the Administration's efforts to empower patients through the effective and responsible adoption of technology in healthcare. Our responses to the request for information are below.

Patient Needs

PC-1. What health management or care navigation apps would help you understand and manage your (or your loved ones) health needs, as well as the actions you should take?

a. **What are the top things you would like to be able to do for your or your loved ones' health that can be enabled by digital health products?**

Apps that sit on top of the personal health record are critical to streamline patient care. The difficulty that we have is bringing together data for all my family members into one application. Patients should be able to manage their family's visits, their benefits information, schedules with doctors, and ancillary services such as imaging, using a single login credential. OpenID Connect is the widely established de facto standard and allows different organizations with potentially competing interests to interoperate.

Regardless of which health system provides care, patients would like to follow up with physicians, track their medications, vital signs, and lab results over time, using a single credential.

PC-5. What can CMS and its partners do to encourage patient and caregiver interest in these digital health products?

a. **What role, if any, should CMS have in reviewing or approving digital health products on the basis of their efficacy, quality or impact or both on health outcomes (not approving in the sense of a coverage determination)? What criteria should be used if there is a review process? What technology solutions, policy changes, or program design changes can increase patient and caregiver adoption of digital health products (for example, enhancements to data access, reimbursement adjustments, or new beneficiary communications)?**

To encourage patients and caregivers to be interested in digital health products, the data should be available using data standards and modern APIs. This means allowing patients to use a single trusted credential such as login.gov, Id.me, or Clear, to access provider, payer, and other patient facing applications. Furthermore, the most common data elements described by USCDI and USCDI+ should be made available in standard formats like FHIR. The de facto identity federation standard (OIDC) should be used to ensure the right for patients to choose how their data is used and preserved, and as a single player in the health technology ecosystem cannot gatekeep access by alternative solutions. CMS should also establish certification opportunities so that digital health apps, including phone-based apps, can track compliance and how proactively they are protecting patients data. CMS should also encourage data quality initiatives like the PIQI framework and promote the adoption of data standards.

b. **What changes would enable timely access to high quality CMS and provider generated data on patients?**

The most important thing we can do to enable timely access to high quality CMS and provider generated data on patients is to streamline EHR patient access.

Patients are often required to key in their usernames and passwords multiple times to get access to their clinical data: once for the app they are using and again to connect to their EHR. This is a direct result of a short lifetime for access tokens – often requiring multiple logins during a single session. A single patient credential (OIDC) that can federate between payer, provider, and other health applications eliminates this friction.

PC-7. If CMS were to collect real-world data on digital health products' impact on health outcomes and related costs once they are released into the market, what would be the best means of doing so?

If CMS would like to collect real world data, one option is to ask patients for consent to use their data for those purposes. Patients should also be given the opportunity to opt out. Another option is to fund EHRs to create APIs that expose de-identified USCDI data to responsible organizations. CMS could then access information from either a patient's personal health record or through the locations where the data is housed that the patient has granted access to. The key to most of these innovations is to make it easier for patients to access and aggregate their own data through a single digital credential that federates between health applications (OIDC). For too long, we've made it difficult for them and then blamed them for not interacting with their data.

2. **Data Access and Integration**

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

The following information is not readily available to patients, but they often can access it, and it is helpful:

- Visit summaries
- lab results
- Prescriptions
- Diagnosis
- Procedures.
- Communications from the doctor

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)?**
Provider general schedule availability is not currently exposed through data standards such as FHIR and would promote better adoption of covered services, and more choice for patients on which providers and health apps best meet their needs. Messaging between patients and physicians is currently not exposed via FHIR. Patients are exponentially increasing their digital message interactions with providers (aka in basket message burden), yet this data is still locked behind proprietary data formats and APIs in EMRs. This prevents app developers from creating innovative new solutions to manage demand and streamline care delivery.

b. **What are specific sources, other than claims and clinical data, that would be of highest value, and why?**
As above, provider schedule availability, and transparent data standards and APIs for in basket messaging between patients and their providers.

PC-12. What are the most valuable operational health data use cases for patients and caregivers that, if addressed, would create more efficient care navigation or eliminate barriers to competition among providers or both?

(1) Ensuring EMRs support federation with standard digital credentials (OIDC) so that patients can seamlessly navigate between payer, provider, and other health applications.
   - This is not possible today because several EMRs only support proprietary credentials for their patient portals.

(2) Viewing provider schedules
   - Currently, it is only possible to view booked appointments using FHIR APIs
   - Provider availability is locked behind proprietary EMR APIs, and so cannot be widely propagated in digital health ecosystems. Exposing such data is a core component of patients being able to access care.

(3) Patient and provider messaging
   - Currently patient and provider messaging is locked behind proprietary EMR APIs. Patients can only send a message to their provider through an EMR-controlled patient portal, and no applications can access this data. This use case needs to be exposed to app developers as a way to promote access and route patients to a wider range of services, even those provided outside of the EMR.

Information Blocking and Digital Identity

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

What are the challenges today in getting patients/caregivers to sign up and use digital identity credentials?
EMR portals, which form the vast majority of provider interactions, do not accept patient credentials using standard established protocols such as OIDC. This adds needless friction to all patient digital interactions because a different credential must be used for payers, providers, and ancillary services like labs and imaging.

What could be the benefits to patients/caregivers if digital identity credentials were more widely used?
There are multiple benefits we anticipate as a result of greater adoption of digital identity credentials – Including: Wider access to care by more patients, better health outcomes and an increase in care gap closure, a decrease in administrative costs for providers and payers since patients are more likely to choose covered preventative services, less effort is required to "chase" care gaps to meet quality measures, and expensive unplanned care such as ER visits are reduced.

What are the potential downsides?
If a single patient credential is compromised, it exposes an attacker to a wider set of data and services. At the same time, reducing patient access to a single credential makes it easier for CSPs to apply relevant cyber security measures and detect and counter nefarious activity.

Digital Health Apps

PR-1. What can CMS and its partners do to encourage providers, including those in rural areas, to leverage approved (see description in PC-5) digital health products for their patients?
The most important step we can take to encourage providers to utilize digital health products is to make it easier to get that data out of EHRs. Opportunities for innovation are limited if EHRs act as gatekeepers, making it difficult or impossible to access data on behalf of patients.

a. What are the current obstacles?

The obstacles that prevent patients from accessing digital health products include:

- Most payments for healthcare services come from health plans and not directly from patients, meaning that the financial incentives to create patient-facing digital products are limited.
- Difficulty getting data out of the EHR in a standardized format (like FHIR) that digital health products could incorporate into their systems.
- Most EHR vendors have their own proprietary sets of non-standard APIs, and digital health companies must manage that complexity.
- Fees that EHRs charge companies that manage digital health products to gain access to patient data (i.e., API Marketplace fees).
- Third party applications are not covered under HIPAA. Without certification approaches or clear guidelines for these products, it is difficult to trust vendors and their applications with sensitive patient data.
- EHRs do not support patient access using established federation standards such as OIDC, which makes it impossible for patients to use established national credentials (CSPs) such as login.gov, id.me, and Clear.

b. What information should providers share with patients when using digital products in the provision of their care?

Providers and their EHR vendors should share any USCDI and USCDI+ data with their partners using APIs that could be easily integrated into a digital health tool. For any non-USCDI data, providers should have flexibility in how to share the data from the patient chart. This could include recordings, images, lab results, treatment plans, and so on.

c. What responsibilities do providers have when recommending use of a digital product by a patient?

Because patients who engage with digital health products can have better outcomes, providers have a responsibility to understand and recommend products that are most likely to lead to the best outcomes for an individual patient. Providers might "prescribe" such tools to patients and strive to incorporate data from those tools into provider workflows if possible.

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?

The biggest obstacle preventing innovative applications

- Patients have to login to multiple applications, often with different credentials to get access to the data.
- Access tokens expire so quickly that patients often have to log in multiple times during one session.

In general, mandating identity federation using open standards (OIDC) alleviates these obstacles by allowing a single patient identity to work across provider, payer, and other health applications.

PR-3. How important is it for healthcare delivery and interoperability in urban and rural areas that all data in an EHR system be accessible for exchange, regardless of storage format (for example, scanned documents, faxed records, lab results, free text notes, structured data fields)? Please address all of the following:

a. **Current challenges in accessing different data formats.**
   Externally resulted data is stored as a document within our EMR and information is keyed into an external results console. Although the clinical information is often reconciled – The applicable codes that would result in quality gap closure are often unavailable. This results in providers closing less quality gaps in Value-Based Care arrangements and creates administrative burden associated with "chart chasing" for payers.
b. **Impact on patient care quality.**
   Real-time access to clinical information at point of care will have tremendous impact on reducing administrative burden associated with data integration into an EMR as well as a potential to decrease repetitive tests due to a lack of timely information.
c. **Technical barriers to full data accessibility.**
   There hasn't been enough testing with attachments to detail technical barriers. A Diagnostic Report in FHIR may be an option but requires additional real-world implementation.
d. **Cost or privacy implications of making all data formats interoperable.**
   There is an associated cost with implementing interoperable solutions – including purchasing a FHIR server, cloud compute costs, and vendor and/or FTE support. There also needs to be additional guidance at both the federal and state levels on acceptable privacy practices, including: what data is permissible for exchange in various operational scenarios between payers and providers.

e. **Priority level compared to other interoperability needs.**
Creating the opportunity to integrate all of the patient's pertinent clinical data into a providers workflow in real-time should be the highest priority for all of us. We would not only be removing the burden associated with manual integration but we would also be creating a ecosystem where providers have access to the right information at the right time to make the best decisions for their patients.

Data Exchange

PR-5. Which of the following FHIR APIs and capabilities do you already support or utilize in your provider organization's systems, directly or through an intermediary? For each, describe the transaction model, use case, whether you use individual queries or bulk transactions, and any constraints:

a. **Patient Access API**
b. **Standardized API for Patient and Population Services**
c. **Provider Directory API**
Providence supports the Providence Directory API and has implemented SMART on FHIR apps. We are also working with payers to implement the Provider Access and Prior Authorization APIs. We have experimented with Bulk FHIR through our EMR, but it is not usable in real-world applications. However, Bulk as a standard outside of the EMR has been successfully implemented in real-world use cases by Providence and other healthcare organizations.

d. **Provider Access API**
Providence is ready to engage in testing with our payer partners whenever they are ready. With the 2027 deadline in mind – We have not been able to identify a payer within our 7 states that is ready to exchange data via Provider Access API for encounter or claims information at this time. However, we anticipate this will change in the near future.

e. **Payer-to-Payer API**
f. **Prior Authorization API**
Providence has engaged in conversations with multiple payers and vendors and is in the process of evaluating the best option for implementation. The concern here is that most vendors do not represent multiple payers within our market and we as a provider organization cannot implement dozens (or hundreds) of different solutions. The goal is administrative simplification – not adding new workflows for each payer we engage with. We advocate for a payer-agnostic prior authorization option from EMR vendors to further aid in reducing administrative burden associated with prior authorization processes.

g. **Bulk FHIR – Do you support Group ID-based access filtering for population-specific queries?**
We have tested the Bulk API available through our EMR vendor. Unfortunately, our testing was unsuccessful as the process to create a group is extremely manual and involves multiple teams within an enterprise. Groups are also limited to one thousand patients. When testing a single patient with multiple years of history within our organization – The bulk query ran for a period of days without completion. We are aware that multiple organizations have had the same experience with a variety of certified EMRs.

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?
The most impactful strategy CMS can implement is to support providers in making comprehensive healthcare data available is to make Bulk FHIR APIs work in real-world circumstances, meaning that it should work for large populations. Because it is prohibitively difficult for most provider organizations and their vendor partners to get patient data in bulk out of the EHR, clinical quality suffers, innovation stalls, and the providers cannot effectively partner with payers and other organizations to better serve their patients.

The primary reason Bulk FHIR APIs are not adequately responsive is that the data is extracted directly from the EHRs' production environments. These systems are architected to support EHR operations, not bulk data sharing. Systems that request Bulk FHIR data must wait around while each patient's data is compiled in memory and converted to a FHIR format. If the process is disrupted for any reason along the way, it starts over, often without any feedback on why.

Here are a few additional issues commonly seen with Bulk FHIR APIs:

- Providers cannot use Member Attribution (ATR) lists to dynamically identify the population for which they need to extract bulk data.
- Each group of patients must be pre-defined and managed manually inside of the EHR
- Users cannot use subscription services to extract incremental bulk data on an ongoing basis.
- Support of parameters within the Bulk FHIR request/response process do not adequately support the ability to 'limit' search and select criteria on request submission, and thusly review, parse and distribute unnecessary / unneeded data as part of the current solution architecture

We are not asking that EHRs adopt a particular technology stack. We simply need timely access to the patient populations' data in a national standard format. EHR vendors could accomplish this by offloading the Bulk FHIR functionality to modern systems that are designed for scale and responsiveness, or they could pursue other options that deliver the same result.

Data recency is critical for patient care and population management. Pulling data for individual patients in a standard format should happen in a matter of seconds. Incremental Bulk FHIR data requests for populations should generally be filled in less than 24 hours. And any APIs developed to comply with the 170.315 (g)(10) criterion should be at least as responsive as similar proprietary APIs available through EHR vendors' API marketplaces.

It is also imperative that bulk export be a general-purpose capability to accommodate changes in organizations' data requirements without necessitating vendor development and system upgrades. While it's possible that a set of performant, use case specific FHIR exports could be created with less development effort, such a rigid approach would lock provider organizations and their partners into a narrow set of pre-defined capabilities, limiting innovation (such as pilot programs) and slowing the ability of the healthcare system to adapt to changing needs.

Here is a list of our Bulk FHIR API functionality requests:

- Providers should have at least two options for extracting Bulk FHIR data:
    - Internal rosters – EHR vendors should have an efficient and easy-to-manage process to dynamically tag populations in the EHR. The EHRs' provider clients should be able to reference those population tags in their API calls to extract the bulk data.
    - External rosters - Providers should be able to use their own Member Attribution (ATR) rosters to identify the populations for a bulk data extract. Member rosters should not

need to live inside the EHR. They could be submitted through the API call when requesting bulk data.

- Providers should have the ability to pull the USCDI dataset for a population described by a roster, and they should have the ability to pull only the FHIR resources required for a particular use case.
- EHR vendors should develop subscription services for sharing incremental data on a consistent ongoing basis for patient groups that can be managed dynamically.
- The Bulk FHIR APIs should be well documented.
- The Bulk FHIR APIs should have robust error handling capabilities.
- The Bulk FHIR APIs should support parameters that limit the data search and selection of FHIR Resources with large datasets.

We ask that certified EHR vendors support a robust bulk data exchange toolset – using HL7® FHIR standards – that can support any of the data elements defined in the United States Core Data for Interoperability (USCDI) as well as USCDI+ datasets. Because the technology and the data standards needed to efficiently exchange these data elements are commonly in use today, we believe Epic, Oracle, Meditech, Altera and the certified EHRs should have this functionality in place with less than a year of focused effort.

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

a. **What would be the benefits and downsides of using Bulk FHIR data exports from EHRs to CMS to simplify clinical quality data submissions? Can CMS reduce the burden on providers by performing quality metrics calculations leveraging Bulk FHIR data exports?**

We support the notion of simplifying clinical quality data responsibilities for providers, but providers that want to actively engage in improving their patients' clinical quality results should have the capacity to do so. For example, some providers might outsource clinical quality data exchange to their EHR vendors or other trusted entities. Other providers may want to take a more active role in making sure the data exchanged complies with state and federal laws and that their patients' privacy and consent requests are complied with.

One way to simplify clinical quality data responsibilities would be to make Bulk FHIR functionality work in real-world situations as described in PR-7. Another way would be to support clinical data quality initiatives that provide actionable feedback to those who create the data at the source. A third way would be to allow non-EHR vendors to have certified APIs that can exchange clinical data (make sure not to lose any value gained through the current CEHRT process). Lastly, we should create regional testing grounds to resolve identity, end point directory, data duplication, use case definition, consent and privacy, data standardization, and other foundational issues that are keeping the national data exchange networks from growing.

b. **In what ways can the interoperability and quality reporting responsibilities of providers be consolidated so investments can be dually purposed?**

The same data standards (i.e., FHIR, USCDI, Bulk FHIR (g)(10) APIs) should be used to support all clinical quality measures, including CMS measures, HEDIS measures, and other measures used to support Medicare Advantage, Commercial, and Medicaid contracts at the state and federal levels.

PR-9. How might CMS encourage providers to accept digital identity credentials (for example, CLEAR, ID.me, Login.gov) from patients and their partners instead of proprietary logins that need to be

tracked for each provider relationship?

d. What would providers need help with to accelerate the transition to a single set of trusted digital identity credentials for the patient to keep track of, instead of one for each provider?

It is currently not possible for providers to accept these credentials in patient portals because EMR vendors do not support the established identity federation standards such as OIDC. Therefore, OIDC for patient login must be mandated for ONC Health IT certification (170.315(d)(1)).

e. How might CMS balance patient privacy with convenience and access to digital health products and services that may lead to significant improvements in health?

The existing standards already provide viable privacy protection mechanisms that are well established in consumer industries (for example, oAuth2). These provide a mechanism to highlight the risk and digitally consent to data sharing.

PR-10. Regarding digital identity credentials (for example, CLEAR, Login.gov, ID.me, other NIST 800-63-3 IAL2/AAL2 CSPs):

a. **What are the challenges and benefits for providers?**
The challenge is that EMR patient portals cannot use them using industry standards such as OIDC. The benefits are that more patients will interact digitally which reduces costs and improves speed of care delivery and other relevant health outcomes. Furthermore, expensive unplanned care such as ER visits would be reduced.

b. **How would requiring their use improve access to health information?**
If patients can use a single credential for provider and payor workfows, they are more likely to choose covered preventative services, and less effort is required to "chase" care gaps to meet quality measures.

c. **What are the potential downsides?**
If a single patient credential is compromised, it exposes an attacker to a wider set of data and services. At the same time, reducing patient access to a single credential makes it easier for CSPs to apply relevant cyber security measures and detect and counter nefarious activity.

d. **Would combining FHIR addresses and identity improve data flow**
Yes.

PR-11. How could members of trust communities (for example, QHINs, participants and subparticipants in TEFCA, which requires Identity Assurance Level 2 (IAL2) via Credential Service Providers (CSPs)) better support the goals of reduced provider and patient burden while also enhancing identity management and security?

In the current TEFCA IAS implementation, patients can authorize access using CSPs, but these credentials cannot be used to act on the data via provider tools such as the EHR. EHR vendors must federate digital credentials for patient access using established protocols such as OIDC to enable the health technology digital ecosystem. Furthermore, security can be improved by retiring proprietary EHR patient identity solutions which are closed source and do not receive the same level of scrutiny by cyber security professionals as do solutions based off open standards.

Technology Vendors, Data Providers, and Networks

TD-1. What short term (in the next 2 years) and longer-term steps can CMS take to

stimulate developer interest in building digital health products for Medicare beneficiaries and caregivers?
CMS should implement a federated, modern identity solution. Furthermore, they should mandate certification of OIDC for patient identities as a part of ONC Health IT (170.315(d)(1)). Then, providers may use either the CMS identity, EMR patient identity, or any other standard identity provider interchangeably with any application in the health ecosystem.

TD-3. Regarding digital identity implementation:
a. What are the challenges and benefits?
EMR vendors do not support standard identities for patients as are typically implemented with OIDC in all other IT industries. Doing so would allow technology vendors to leverage the extensive industry implementations and security and compliance controls that already exist, significantly improving interoperability and reducing cyber security risk.

b. How would requiring digital identity credentials (for example, CLEAR, Login.gov, ID.me, other NIST 800-63-3 IAL2/AAL2 CSPs) impact cybersecurity and data exchange?
The vast majority of digital identity credentials in the wider IT industry are implemented with open standards such as OIDC. Therefore, such implementations are already well understood with significant expertise developed to manage cybersecurity threats and facilitate data exchange.

Value-Based Care Organizations

Digital Health Adoption

VB-1. What incentives could encourage APMs such as accountable care organizations (ACOs) or participants in Medicare Shared Savings Program (MSSP) to leverage digital health management and care navigation products more often and more effectively with their patients? What are the current obstacles preventing broader digital product adoption for patients in ACOs?
Financial incentives towards purchasing and maintaining VBC technology – specifically for quality measures, data aggregation, and exchange are ideal in promoting interoperability adoption. Providers – especially those within ACO-type networks often have multiple EHRs and other disparate data sources where integration, deduplication, and general maintenance are difficult. Creating an interoperability onramp for this space is extremely important.

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.**
All of the capabilities mentioned above are essential and for most of these examples, Da Vinci Implementation Guides (IGs) already exist that detail how to implement these real-world solutions to ensure success in Value-Based Care. However, Adoption has been low. With CMS' support this can change.

b. **What other health IT capabilities have proven valuable to succeeding in value-based care arrangements?**
A FHIR-based VBC interoperability strategy has been extremely important for Providence health. When we switched from exchanging supplemental data through proprietary legacy processes to utilizing the (g)(10) FHIR output and leverage exchange through APIs – we saw an increase of 40% gap closure across our Value-Based Care contracts. We are excited to replicate our bi-directional and standards-driven data exchange processes across all of our VBC payers – However, readiness at

the payer level is low. With the 2027 deadlines for implementing CMS' four mandates APIs– We anticipate that payers will leverage the ecosystem they are currently building to meet mandates and will be able to implement additional VBC use cases with minimal effort.

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

Member Attribution logic is at the top of the list and the exchange can be standardized through the adoption of the Da Vinci ATR IG. If a payer/provider participate in a Value-Based Care arrangement – The first step (post signing the contract) should be agreeing on the patient population covered in the partnership. The second would be claims data as most VBC agreements have a Total Cost of Care component. This can be successfully done by implementing Pdex and including financials as stipulated per the VBC contract. Third would be the exchange of supplemental quality data through Da Vinci's CDex/Bulk IGs initially and then CDex supporting direct query and task-based requests. To fully close the loop – payers should also exchange Gaps in Care data with providers through the DEQM IG and finally financial and performance data through the VBPR IG. This bi-directional exchange between payers and providers ensures that both parties have real-time actionable insights into the patients and members that they serve while creating the best pathway for VBC to be a sustainable financial model for all parties involved.

2. **Compliance and Certification**

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

The (g)(10) APIs are an important factor for VBC success – both for providers and payers. However, without the Bulk API functioning as stipulated by regulation – there isn't a path forward where payers can easily access the standardized data they need for their comprehensive populations. When we leverage the EHR certification tasked with capturing and storing health data accurately and add on API certification layer detailed with SLAs then we'll reduce the administrative burden tied to "chart chasing" and create an opportunity for both payers and providers to be successful in Value-Based Care.

Thank you for the opportunity to provide feedback on the proposed rule. We hope you find our input informative. For questions, please contact Jacquelyn Bombard, Chief Federal Relations Officer, at Jacquelyn.Bombard@Providence.org or 512.569.3105.

Sincerely,

Jacquelyn Bombard
Chief Federal Government Affairs Officer
Providence