



To: The Centers for Medicare & Medicaid Services (CMS), the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC)

From: ChenMed

Date: June 16, 2025

Subject: RFI Response - Advancing Digital Health, Interoperability, and Value-Based Care:

The ChenMed Perspective

Executive Summary

ChenMed is a physician-led, full financial risk, primary care organization serving high-acuity, low-income seniors across 12 states. Our patients average five major chronic conditions, with 80% qualifying for the "Extra Help" low-income subsidy (LIS). We see them monthly to proactively manage their complex needs.

For us, data gaps aren't just technical inconveniences—they're direct threats to patient safety and the sustainability of value-based care. Every missing hospital record, delayed ADT notification, specialist's order, or fragmented medication list—as well as every MAO membership, quality, risk adjustment or other data file that is provided in variable formats with variable data definitions on a variable cadence—translates into missed interventions, duplicative costs, administrative complexities, and most importantly lost opportunities to manage high-risk diseases and to build a different kind of patient care model: one focused on accountability, prevention, and delivering "More Good Days" for America's most vulnerable seniors.

Below we provide an overview of our perspectives then direct answers to selected questions from the RFI that were most relevant to ChenMed and providers like us. We welcome the opportunity to further discuss any of these questions or issues the Administration would like to have our perspective on that we did not proactively opt to include in our RFI response.

Why Data Access Matters for ChenMed

ChenMed's primary care providers coordinate all aspects of patient care and are fully accountable for the total cost of care, unlike fee-for-service providers who are incentivized by volume rather than outcomes. To deliver effective, wraparound care and manage costs, ChenMed (and any provider aiming to take accountability for a population, as CMS wants



providers to do) requires comprehensive, real-time data from all providers to meet regulatory and quality standards.

The Challenge: Fragmented, Delayed, and Incomplete Data

Inconsistent Participation and Data Quality:

Many hospitals and providers do not participate in state and regional Health Information Exchanges (HIEs), and those that do often provide inconsistent or incomplete data. As a multi-state provider, we must contract with multiple HIE vendors to achieve even partial coverage, which creates operational complexity and leaves gaps in care. ***In Georgia, for example, we must interface with three different HIEs to cover our patient population.***

Delayed and Indirect MA Encounter Data:

Another significant barrier is the lack of direct, timely access to MA encounter data. Today, full-risk providers, like ChenMed, must often obtain outside-of-the-primary-care-setting, encounter data for their aligned patients, through MAOs, hospitals or other providers, including specialists. However, the data is typically incomplete, and the lag in time it takes to access the data makes it clinically irrelevant for proactive care management, risk adjustment, and quality measurement. Additionally, each MAO has its own process and cadence for data sharing, and the data may be incomplete or formatted inconsistently, adding administrative burden and risk.

Manual, Error-Prone Processes:

We receive millions of faxed documents annually, which must be manually reviewed and uploaded to EHRs. Critical data elements are not systematically integrated, further limiting our ability to deliver comprehensive, personalized care.

The Solutions:

(1) Real-Time, Direct Access to MA Encounter Data

All CMS interoperability projects—including TEFCA, Blue Button 2.0, Data at the Point of Care (DPC), and APIs—should provide direct, near real-time access to MA encounter data for providers, not just FFS data. This access should be:

- **Immediate and Direct from CMS:**

Providers need to access MA encounter data directly from CMS, bypassing the delays and inconsistencies that is the current state. This will allow full risk providers to identify and act on health events as they happen, close care gaps, and coordinate care across all settings.

- **Comprehensive and Standardized:**

The data should include all clinical, demographic, and administrative fields, formatted using open APIs (FHIR and others) for both bulk and patient-level queries. This supports advanced analytics, population health management, and seamless integration with EHRs.

- **Integrated with Other Data Types:**

MA encounter data should be combined with social determinants, care plans, and remote monitoring data to enable whole-person care and support the highest standards of value-based care.

(2) Standardization of Data Files (content, format, and cadence) MAOs Should Provide to CMS and Their Downstream Entities Such as Delegated Risk Providers:

- **Clear Content and Format Requirements:**

MAOs should submit standardized data files such as MA-02, MA-04, Monthly Membership Records (MMRs), Model Output Reports (MORs), Quality Files, and Service Fund Files to CMS and downstream entities. These files should follow fixed-width or machine-readable layouts with specific data elements and naming conventions to ensure consistency and usability.

- **Defined Submission Cadence and Timeliness:**

Data files should be submitted on a regular, predefined schedule (e.g., monthly, though it is important that some are daily or as often as real time alerts—each data file type should be mapped to a mandated minimum cadence and timeliness factor) to ensure timely availability for care management and risk adjustment. Retroactive adjustments and updates should be incorporated promptly to maintain data accuracy.

- **Comprehensive Data Elements:**

Files should include detailed beneficiary information, eligibility, risk scores, encounter data, diagnoses, and payment events to support advanced analytics, financial reconciliation, and audit readiness.

- **Standardized Data Exchange Protocols:**

Use secure, standardized protocols such as Enterprise File Transfer (EFT) and adhere to CMS instructions for data transmission to ensure reliable, compliant delivery.

- **Support for Data Validation and Audit Readiness:**

Data submissions should enable validation, error correction, and audit processes, ensuring compliance and accuracy for both CMS and delegated entities.

- **Alignment with Regulatory Requirements:**

Data file standards and submission processes should comply with CMS regulations (e.g., 42 CFR 422.310) and support downstream use by delegated risk providers.

- **Facilitation of Integration and Interoperability:**

Standardized files should be compatible with existing CMS systems and support



integration with provider and payer analytics platforms, enabling seamless data flow and operational efficiency.

- **Continuous Improvement and Feedback:**

CMS should provide clear guidance, updates, and support to MAOs to maintain and improve data file standards and submission quality over time, incorporating feedback from providers and delegated entities.

RESPONSES TO SELECTED RFI QUESTIONS:

PC-9. Given that the Blue Button 2.0 API only includes basic patient demographic, 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?

The most significant limitation of the current API—for full financial risk providers who are assigned to Medicare Advantage beneficiaries—is the lack of available MA data, which restricts its applicability to only Traditional Medicare. This omission prevents ChenMed from fully leveraging the API's potential.

b. What suggestions do you have to improve the Blue Button 2.0 API experience?

We propose the following could improve the Blue Button 2.0 API experience:

- Inclusion of Medicare Advantage patient data: This addition would significantly expand the API's scope and enable more comprehensive digital products for patients and caretakers.
- Additionally, the addition of MA data is ideally aligned with the same amount of time that it takes FFS data to become available. Because currently it is 18 months before MAO's provide CMS with complete encounter data.
- Patient-level condition data: We suggest incorporating patient-level condition data, like the data provided in the MOR and MAO-004 files by payers. This would provide a more detailed understanding of patients' health status and enable more effective care coordination.

c. Is there non-CMS data that should be included in the API?

We propose incorporating the following non-CMS data sources:

Provider directory:

- A centralized location for provider data, including: NPIs, Names, Taxonomies, Addresses, TINs, Provider license, and credentialing information. (This would help ensure the accuracy and reliability of provider data.)



- Facility-to-provider and provider-to-facility mapping: (This data would facilitate more efficient care coordination and navigation).
- Medication Data:
 - Including generic and brand medication names, along with NDCs, (this would enhance the API's value for medication management and adherence applications).
 - An option to consider in providing medication data could be to provide MAO bid information / formulary information - to inform providers easily where every Rx for every health plan, for every year.
- Digitally enables beneficiaries to easily enable Directed Right of Access authorizing aligned providers to access their healthcare data from other providers and hospitals, labs etc., through any digital health portal.

PC-10. How is the Trusted Exchange Framework and Common Agreement™ (TEFCA™) currently helping to advance patient access to health information in the real world?

a. Please provide specific examples.

We haven't seen enough advancement in patients' access to health information. HIE integrations and National Ping for emergency care enhancement provide some value: providers now have access to patients arriving at a hospital, reason for admission, and discharge summaries, but not in a standard way. Not all hospitals participate, and not all hospitals provide the same level of detail. TEFCA will support the pursuit of getting all hospitals (and hopefully all practices) to provide the same patient data. This has also given way to disconnected ways patients access their health information. Different apps for different providers plus different apps for different payors, without a consolidated view. Patients are left with multiple apps/portals to access their data across payors, providers, and specialists.

b. What changes would you suggest?

- Lower barriers to QHIN entry to enable easier access to become and/or join designated QHINs. This would provide more options and lower costs as well as enable smaller technology companies/providers to join independently.
- Accelerate implementation timelines with stronger incentives for early adoption. Until we accelerate implementation of timelines with stronger incentives for early adoption, many will not adhere to the framework.
- Enhance data element requirements to include social determinants and care plan information. These are part of patient care and can help us greatly in delivering custom care plans for our patients.

c. What use cases could have a significant impact if implemented through TEFCA?

- **MRR (Medical Record Retrieval)** would allow both payors and VBC providers the ability to search and have full access to medical history for entire patient panels from all providers.
- **National ADT** to ensure sharing of medical information at admission is available immediately and discharge activities (visit follow ups, specialist appointments) can be scheduled without manual intervention. Not all HIE integration enables National Ping.
- **Centralized immunization registration**, allowing VBC/providers a single source of vaccine registration and retrieval nationally.
- **Care coordination for traveling patients** ensuring continuity of care for Medicare beneficiaries with multiple residences.

d. What standards are you aware of that are currently working well to advance access and existing exchange purposes?

HL7, FHIR, DICOM, CPT, CDA, LOINC, SNOMED, ICD, ISO.

e. What standards are you aware of that are not currently in wide use, but could improve data access and integration?

FHIR.

f. Are there redundant standards, protocols, or channels that should be consolidated?

HL7 to FHIR (HL7 has been utilized as more of a guideline than a standard, so each integration typically requires customization), such as for CDA to FHIR or faxing documents to FHIR.

g. Are there adequate alternatives outside of TEFCA for achieving widespread patient access to their health information?

While there are a number of private networks, health information exchanges (HIEs), and vendor-specific solutions that facilitate the exchange of patient health data, none of these alternatives offer the comprehensive, standardized, and truly national approach that TEFCA is designed to deliver. The current landscape is fragmented: each state, and sometimes even individual cities, requires providers to contract with multiple HIEs or networks to achieve even partial coverage for their patient panels. For example, at ChenMed, we operate in 12 states and must interface with multiple HIEs in a single state



just to cover all our patients' providers. This patchwork approach results in inconsistent data availability, variable data quality, and significant administrative overhead.

Limitations of Existing Alternatives:

- **Inconsistent Participation and Coverage:**
Not all hospitals, providers, or regions participate in private HIEs or vendor networks. This leaves gaps in data, especially for patients who travel, move, or receive care from multiple systems. For a national provider or a patient with multiple residences, this means there is no guarantee their information will follow them or be accessible in real time.
- **Lack of Standardization:**
Data formats, access protocols, and the types of information exchanged vary widely between networks. This inconsistency creates challenges for both patients and providers in accessing, interpreting, and using health information across different care settings.
- **Administrative Complexity and Cost:**
Providers must manage multiple contracts, interfaces, and technical integrations, which increases administrative burden and cost. This complexity can be prohibitive for smaller practices or technology vendors, and it creates barriers to innovation and competition.
- **Patient Experience:**
Patients today are often left with multiple portals—one for their insurer, one for their PCP, and others for each specialist or hospital system. This fragmentation makes it difficult for patients to access their complete health record, manage their care, or share information with new providers.

A Standardized National Network Is Needed:

If it's TEFCA, or some other trusted interoperable network, nationwide interoperability is imperative to advancing better care delivery. The goals of establishing any single, trusted framework and set of standards for health information exchange, should include:

- **Ensure Consistency and Coverage:**
Require participation from all hospitals and, ultimately, all providers, ensuring that patient data is available wherever care is delivered, regardless of geography or network affiliation.
- **Standardize Data Exchange:**
Mandate the use of common standards (such as FHIR), and ensure that data is exchanged in a consistent, usable format, supporting both clinical care and patient access.



- **Reduce Administrative Burden:**

A national framework eliminates the need for providers and vendors to manage dozens of separate contracts and technical integrations, lowering costs and freeing up resources for patient care.

- **Empower Patients:**

Includes a single portal or access point where patients can view and manage their health information from all sources—insurers, PCPs, specialists, hospitals, and even devices—enabling true patient empowerment and engagement.

PC-11. How are health information exchanges (HIEs) currently helping to advance patient access to health information in the real world?

Health Information Exchanges (HIEs) have become an increasingly important part of the healthcare data ecosystem, especially for organizations like ChenMed that serve high-risk, high-need populations across multiple states.

- **Value:**

HIE-powered event notifications, such as ADT (Admission, Discharge, Transfer) alerts, are important to our care teams to receive real-time updates when a patient is hospitalized or discharged. When available, this allows for immediate outreach, rapid follow-up, and proactive care management, which is critical for reducing unnecessary hospital readmissions and improving patient outcomes.

- **Availability and Coverage:**

The availability of HIE data varies significantly by geography. In some states and cities, HIE participation is robust and covers the majority of hospitals and providers, making the data more actionable for population health management. However, in other regions, coverage is fragmented, and we are forced to contract with multiple HIE vendors to achieve even partial data completeness. ***For example, in Georgia, we must interface with three separate HIEs just to ensure comprehensive access for our patient population.***

- **Accuracy and Data Quality:**

Where HIE participation is stronger, the data is somewhat timely and accurate. However, data quality can be inconsistent, with challenges related to patient matching, incomplete records, and variable submission standards. Inaccurate or delayed data can lead to missed interventions, improper treatment plans, and increased costs. Ongoing data quality monitoring and standardized patient matching protocols are essential for maximizing the value of HIEs.

b. What changes would you suggest?

To unlock the full potential of HIEs for advancing patient access and care quality, several improvements are needed:

- **Broader and Standardized Participation:**
CMS and ONC/ASTP should require all hospitals, health systems, and major ambulatory providers to participate in HIEs and submit standardized data elements. This would ensure comprehensive coverage and data consistency across regions.
- **Data Cleanup and Deduplication:**
HIEs that provide automated data cleanup, deduplication, and normalization services dramatically reduce noise and administrative burden for value-based care organizations. These features should be standard across all HIEs to ensure that providers receive clean, actionable data.
- **Enhanced Data Quality Protocols:**
Implementing advanced patient matching algorithms, regular data audits, and standardized data entry methods can improve data accuracy and reduce errors related to incomplete or mismatched records.
- **Incentives for Participation and Use:**
Financial and regulatory incentives should be offered to encourage provider participation, especially in regions with historically low HIE engagement. Training and technical support should be provided to help providers integrate HIE data into their clinical workflows.

d. What is the ongoing role of HIEs amidst other entities facilitating data exchange and broader frameworks for data exchange (for example, vendor health information networks, TEFCA, private exchange networks, etc.)?

HIEs should serve as **regional aggregation points** that connect seamlessly to national frameworks like TEFCA, while maintaining specialized capabilities for local care coordination, public health reporting, and community-specific needs.

- **Reducing Complexity:**
Direct integration with every provider and payer is time-consuming and costly at-scale. HIEs simplify this by acting as trusted intermediaries, enabling quick and reliable access to health information for value-based care organizations and primary care teams.
- **Supporting Local and National Needs:**
While TEFCA and national networks aim to standardize and scale data exchange, HIEs can tailor solutions for unique local challenges, such as supporting public health surveillance, integrating social determinants data, and facilitating community-based care coordination.

- **Bridging Gaps in Interoperability:**

HIEs can help bridge gaps where national networks or vendor-specific solutions fall short, ensuring that no patient or provider is left behind due to geography or technology limitations.

- **Continuous Innovation:**

As technology and care models evolve, HIEs can pilot and scale new solutions—such as AI-powered data cleaning, blockchain-based security, or advanced patient matching—that can later be adopted nationally.

PC-13. How can CMS encourage patients and caregivers to submit information blocking complaints to ASTP/ONC's Information Blocking Portal? What would be the impact? Would increasing reporting of complaints advance or negatively impact data exchange?

Make the process simple, visible, and accessible through all portals. Educate patients on their rights and the impact of data access. Increased reporting could highlight systemic issues and drive improvements but should be balanced to avoid overwhelming providers with non-actionable complaints.

E. Technology Vendors, Data Providers, and Networks

TD-6. What unique interoperability functions does TEFCA perform?

The Trusted Exchange Framework and Common Agreement (TEFCA) is poised to fundamentally transform the landscape of health information exchange in the United States by addressing critical gaps that current, fragmented systems cannot solve—especially for organizations like ChenMed that operate across multiple states and manage highly mobile, high-risk patient populations.

Current State and the Challenge for Value-Based Care Providers:

Today, value-based care (VBC) providers are forced to contract with dozens of state and regional Health Information Exchanges (HIEs) just to attempt comprehensive coverage for their patient panels. Even then, coverage is often incomplete and inconsistent. ***For example, if a patient's home is in Columbus, Ohio, but they travel to South Florida for the winter and present at a hospital there, the VBC provider may not receive an Admission, Discharge, Transfer (ADT) notification unless they've separately contracted with the relevant Florida HIEs. This means that critical care events may go unmonitored for weeks or months—until claims data eventually surfaces—undermining proactive care management, risk adjustment, and patient safety.***



TEFCA's Proposed Value Proposition:

- **National Coordination and Data Liquidity:**

TEFCA, if implemented effectively, could provide seamless, nationwide interoperability. Rather than piecemealing together a patchwork of HIE contracts. If fully realized, TEFCA could enable a VBC provider to receive real-time ADT alerts and other clinical data for their patients, regardless of where care is delivered.

- **Universal Access to Hospital and Specialist Records:**

Beyond just ADT notifications, if effectively implemented, TEFCA could enable direct access to hospital and specialist charts, labs, imaging, and care plans. This would allow providers to absorb comprehensive records into their own EHRs, supporting better disease identification, chronic disease management, and care coordination. The ability to see what tests, diagnoses, and treatments have already occurred—without waiting for claims data or duplicating work—reduces unnecessary testing, lowers costs, and improves patient safety.

- **Elimination of Redundant Testing and Administrative Overhead:**

If effectively implemented, TEFCA, providers may be able to access recent imaging, labs, and consult notes, avoiding costly and potentially harmful duplicate procedures.

- **Support for National Use Cases:**

If effectively implemented, TEFCA may eventually enable:

- **Medical Record Retrieval (MRR):** Full-panel, cross-provider record searches for risk adjustment, care management, and quality reporting.
- **National ADT ("National Ping"):** Real-time event notification for patients anywhere in the country, supporting timely intervention and follow-up.
- **Centralized Immunization Registry:** A single source for up-to-date vaccine data, critical for public health and care planning.
- **Care Coordination for Traveling Patients:** Continuity of care for snowbirds, seasonal workers, and patients with multiple homes.

Why TEFCA (Or Another National, Interoperable Network) Is Essential:

- **Consistency and Standardization:**

A national network like TEFCA, could ensure all participating entities adhere to common data standards (such as FHIR), security protocols, and governance structures, eliminating the variability that plagues today's HIE landscape.

- **Scalability for National Providers:**

For organizations like ChenMed, which operate in multiple states and serve a mobile population, a network with a national scope is the only viable path to truly scalable, efficient, and high-quality care coordination.

F. Value-Based Care Organizations

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?

First and most important is that the aperture for this question—and all questions in this section—should be both providers in APMs and MSSP in Traditional Medicare as well as those operating under a VBC (ideally full risk) arrangement within Medicare Advantage. For both programs, providers need the right thing to be easy (because they already have an incentive to lower population care costs, but it's hard to capitalize on all resources) and they need further incentives to invest in the process and technology changes necessary to capitalize.

Incentives needed:

- Reimbursement for digital engagement activities
- Quality bonuses tied to digital adoption rates
- Shared savings for technology investments
- Technical support and training

Current obstacles:

- Limited reimbursement for digital tools
- Integration challenges with existing systems
- Patient adoption barriers
- Regulatory uncertainty

VB-2. How can key themes and technologies such as artificial intelligence, population health analytics, risk stratification, care coordination, usability, quality measurement, and patient engagement be better integrated into APM requirements?

Advanced Payment Models (APMs) are most effective when they harness the full power of modern technology to drive better outcomes, lower costs, and improve patient and provider experience. To truly move the needle, these key themes and technologies must be woven into the fabric of APM requirements—not as optional add-ons, but as core enablers of high-value care. Critically, the greater the degree of full ownership of downside risk, the more a provider in an APM will naturally gravitate towards using these



things. It is critical that CMS continue to drive people toward true alternative payment model on a population capitation rather than something on a FFS chassis with only upside potential.

Recommendations for Integration:

1. **Align APM Incentives with Advanced Technology Adoption:**

APMs should include explicit incentives for providers who adopt and effectively use advanced technologies—such as AI, population health analytics, and risk stratification tools. These incentives should be tied not just to technology adoption, but to measurable improvements in outcomes (e.g., reduced hospitalizations, improved chronic disease control, higher patient satisfaction). This approach ensures that technology is used purposefully, not just for compliance.

2. **Embed Population Health Analytics and Risk Stratification in Care Management:**

Real-time analytics and risk stratification should be integrated into EHRs and care management platforms, allowing providers to proactively identify high-risk patients, predict adverse events, and enable targeted interventions. For example, predictive models can flag patients at risk for hospitalization, prompting timely outreach and care plan adjustments. These tools should be user-friendly and actionable at the point of care.

3. **Enhance Care Coordination through a Primary Care-First Approach:**

APMs should emphasize the central role of primary care providers (PCPs) as the hub of patient care, particularly for chronic disease management. PCPs should be equipped and incentivized to use digital tools for proactive care planning, chronic care management, and seamless care transitions. When referrals are needed, APMs should encourage the use of preferred provider networks and require timely, electronic consult notes from specialists back to the PCP. Technology solutions can automate referral tracking, prompt specialists for updates, and ensure the PCP maintains oversight of the patient's journey.

4. **Incorporate AI for Proactive and Personalized Care:**

AI-powered tools embedded in EHRs can provide PCPs with concise summaries of a patient's recent history, flag gaps in care, and offer tailored recommendations. For example, before each visit, the EHR could surface key trends, recent labs, and overdue screenings, enabling the provider to focus on what matters most. AI can also support medication reconciliation, risk prediction, and early detection of complications.

5. **Tie Quality Measurement to Meaningful Outcomes:**

Quality measurement should move beyond process metrics to focus on outcomes that matter to patients and payers. Embedding analytics and real-time data from EHRs, and patient-reported outcomes ensures that quality gaps are identified and

addressed in real time. This continuous feedback loop keeps quality at the forefront of care delivery and supports ongoing improvements.

VB-3. What are essential health IT capabilities for value-based care arrangements?

Value-based care arrangements demand a robust, interoperable, and intelligent health IT infrastructure. The following capabilities are essential for organizations to succeed in these models:

- **Comprehensive Patient Record Search and Retrieval:**
Providers must be able to access a complete, longitudinal patient record—across all care settings, providers, and timeframes—at the point of care. This includes labs, imaging, consult notes, hospitalizations, and external data sources.
- **Clinical Decision Support:**
Embedded tools that surface evidence-based recommendations, flag care gaps, and support medication safety are critical for high-quality, efficient care.
- **Bi-Directional Care Coordination:**
Seamless, real-time communication between PCPs, specialists, hospitals, and care managers is essential for closing loops, avoiding duplicative testing, and ensuring that every provider is working from the same playbook.
- **Telehealth:**
Virtual care platforms must be fully integrated with EHRs and care management systems, enabling remote monitoring, follow-up, and engagement for patients who may have mobility, transportation, or geographic barriers.
- **Referral Management:**
Tools that track referrals, prompt timely consult notes, and ensure follow-up appointments are scheduled and completed.
- **Seamless Data Exchange:**
Interoperability with HIEs, TEFCA, and other networks is non-negotiable. Data must flow securely and reliably across organizational boundaries.
- **Security and Compliance:**
Robust data protection, audit trails, and regulatory compliance are foundational for trust and sustainability.
- **Claims Cycle Management:**
Integration of clinical and financial data enables accurate risk adjustment, quality reporting, and payment reconciliation.
- **National ADT and National Referral Management:**
Real-time admission, discharge, and transfer notifications, as well as national-scale referral tracking, are essential for timely intervention and care continuity.



- **Secure Messaging and Patient Empowerment Tools:**
Secure, HIPAA-compliant messaging between patients, caregivers, and care teams; easy access to visit summaries, care plans, and educational resources.
- **Standard, frictionless access to patient charts for all authorized users.**

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

Success in value-based care hinges on timely, accurate, and comprehensive data. The following data types are essential:

- **Near Real-Time Patient Summary Results:**
Up-to-date problem lists, allergies, and care plans that are accessible at every encounter.
- **Laboratory and Imaging Results:**
Timely access to all labs and imaging—regardless of where they were ordered or performed—prevents unnecessary repeat testing and supports informed decision-making.
- **Primary Care Provider (PCP) Notes and Discharge Summaries:**
Narrative documentation and structured summaries from all encounters, including hospitalizations and specialty visits, are critical for continuity and risk adjustment.
- **Medication Lists and Drug Interactions:**
Comprehensive, reconciled medication lists from all prescribers and pharmacies, with drug interaction checking and adherence tracking.
- **Quality Metrics for Specialists:**
Data on specialist performance, adherence to evidence-based guidelines, and outcomes for referred patients.
- **Admission, Discharge, and Transfer (ADT) Notifications:**
Real-time alerts for hospital and post-acute events enable timely follow-up and care coordination.
- **Social Determinants of Health:**
Data on housing, food security, transportation, and other factors that impact health outcomes and care planning.
- **Patient-Reported Outcomes and Experience Measures:**
Direct feedback from patients on their health status, satisfaction, and engagement.
- **Specifically, within Medicare Advantage: Key MAO Data on Patient Attribution, Stars Measures, MAO Supplemental Benefits & Charges to the Provider, and Utilization of Care (Encounters & Claims)**
Direct files in standard formats and cadence to know everything about the population and associated charges that the MAO knows from CMS and their own data sets.

VB-11. What specific interoperability challenges have you encountered in implementing value-based care programs?

Interoperability remains one of the most significant obstacles to fully realizing the promise of value-based care. Despite advances in technology and policy, several persistent challenges continue to undermine our ability to deliver coordinated, high-quality, and cost-effective care:

- **Delayed Admission, Discharge, and Transfer (ADT) Notifications:**
Many emergency departments defer patient registration until hours into the encounter—even for non-life-threatening visits. Since ADT notifications are typically triggered by registration, this delay prevents value-based care (VBC) providers from intervening early to redirect care, prevent unnecessary admissions, or avoid duplicative procedures. Timely ADT data is essential for proactive care management, risk adjustment, and closing care gaps. When notifications are delayed, opportunities for intervention are lost, leading to higher costs and poorer outcomes.
- **Incomplete Data Sharing and Participation:**
Hospital and provider participation in data sharing is not universally required. For example, in Illinois, only Medicaid data sharing is mandated, leaving gaps for Medicare Advantage and commercial populations. This patchwork approach means that critical events and clinical information may never reach the care team, undermining both patient safety and the financial sustainability of VBC models.
- **Fragmented Systems and Manual Aggregation:**
Providers must often aggregate data from multiple sources—HIEs, EHRs, claims, and faxes—manually. This fragmentation leads to inefficiency, missed information, and increased administrative burden. It also frustrates patients, who expect their care teams to have a complete and up-to-date picture of their health.

These challenges are echoed across the industry. Recent studies highlight that only a minority of hospitals can exchange data with external organizations, and information blocking or lack of standardization remains widespread. Without a unified, real-time approach to data sharing, the full potential of value-based care cannot be realized.

VB-12. What technology standardization would preserve program-specific flexibility while promoting innovation in APM technology implementation?

Achieving the right balance between standardization and flexibility is critical for fostering both innovation and efficiency in Alternative Payment Model (APM) technology implementation. Over-standardization can stifle creativity and adaptability, while excessive flexibility can lead to inconsistency, inefficiency, and increased costs.

- **Core Standardization:**
CMS and ASTP/ONC should establish core standards for data exchange (such as FHIR and USCDI), identity management, and API interoperability. These standards ensure a baseline of compatibility, security, and data quality across all programs and vendors.
- **Program-Specific Flexibility:**
Within this standardized framework, APMs should retain the flexibility to tailor workflows, user interfaces, and analytics to their unique populations, care models, and local contexts. For example, a rural ACO may prioritize telehealth and remote monitoring, while an urban group may focus on complex care coordination.
- **An Iterative, Adaptive Approach:**
Technology standards should be periodically reviewed and updated to reflect advances in the field and evolving needs. An adaptive, modular approach—where new capabilities can be added without disrupting existing systems—will allow organizations to innovate while maintaining compliance.
- **Stakeholder Engagement:**
Ongoing collaboration with providers, payers, technology vendors, and patients is essential to ensure that standards support real-world needs and do not create unintended barriers to care or innovation.

VB-13. What improvements to existing criteria and standards would better support value-based care capabilities while reducing provider burden?

To support value-based care and reduce provider burden, improvements to criteria and standards should focus on unifying access, expanding relevant data elements, and streamlining compliance:

- **Nationwide FHIR ID Aggregation System:**
Implementing a single, unified FHIR-based patient identifier would allow value-based care entities to access patient data efficiently and reliably across all providers and settings. This would reduce duplication, improve patient matching, and empower confident, data-driven decision-making. A unified way of determining Member Attribution is crucial to reducing the burden on MA provider groups.
- **Transition from HL7 and CDA to FHIR:**
Consolidating legacy standards into FHIR would simplify integration, improve data consistency, and lower the technical barriers for smaller providers and technology vendors.
- **Expand USCDI to Include Social Needs, Care Plans, and Patient-Generated Data:**
The U.S. Core Data for Interoperability (USCDI) should be expanded to include

SDOH, care plans, and patient-reported outcomes. These data types are essential for holistic, person-centered care and for addressing the root causes of poor health.

- **Prioritize Open, FHIR-Based Standards:**

By making FHIR the default for all certified health IT, CMS and ASTP/ONC can reduce provider burden, accelerate innovation, and ensure that all stakeholders—regardless of size or geography—can participate in value-based care.

- **Automate and Simplify Quality Reporting:**

Leverage bulk FHIR APIs and automated data extraction to reduce manual reporting and documentation, freeing providers to focus on patient care.

VB-14. How could implementing digital identity credentials improve value-based care delivery and outcomes?

Digital identity credentials are a foundational technology for secure, accurate, and efficient healthcare delivery—especially in value-based care models that require seamless data exchange and care coordination.

- **Reduce Patient Duplication and Improve Matching:**

A single, robust digital identity for each patient would dramatically reduce duplicate records, mismatched data, and administrative errors. This ensures that every provider, across all systems, is working from the same, complete health record—improving safety, reducing redundant testing, and supporting better outcomes.

- **Streamline Patient Access and Consent:**

Digital credentials allow patients to authenticate themselves quickly and securely across multiple providers and platforms, reducing the friction of repeated registrations and consent forms. This makes it easier for patients to access their data, engage in their care, and authorize information sharing with new providers or family caregivers.

- **Enhance Security and Privacy:**

Advanced digital identity solutions, including multi-factor authentication and biometrics, protect patient data from unauthorized access and fraud while giving patients greater control over who can see their information.

- **Support Virtual Care and Mobility:**

As patients increasingly receive care across multiple settings—including telehealth, home care, and out-of-state providers—digital identity credentials ensure continuity and accuracy, regardless of where care is delivered.

- **Enable Population Health and Analytics:**

Accurate, unified patient identities are essential for effective population health management, risk stratification, and outcomes measurement in value-based care.



VB-15. How could a nationwide provider directory of FHIR endpoints help improve access to patient data and understanding of claims data sources? What key data elements would be necessary in a nationwide FHIR endpoints directory to maximize its effectiveness?

A nationwide provider directory of FHIR endpoints would be a powerful tool for improving interoperability, care coordination, and administrative efficiency—especially for multi-state organizations and patients who receive care across different health systems.

- **Improved Data Access and Care Coordination:**

By making it easy to discover and connect to any provider's FHIR endpoint, such a directory would streamline the process of exchanging patient data for referrals, transitions of care, and care coordination. This would be particularly valuable when a provider needs to access records from a known, specific provider to assist with ongoing care.

- **Understanding Claims Data Sources:**

A directory that links FHIR endpoints to claims data sources would help organizations trace the origin of clinical and financial data, supporting more accurate risk adjustment, quality measurement, and payment reconciliation.

- **Limitations and Use Cases:**

While a nationwide directory would be invaluable for targeted queries (e.g., retrieving data from a specific provider), it would be less useful for mass medical record retrieval (MRR) or use cases that require querying all hospitals nationally, due to the scale and potential cost of such operations.

Key Data Elements Needed:

- Provider name, National Provider Identifier (NPI), and Tax Identification Number (TIN)
- Physical location and specialty
- Endpoint URL and supported FHIR version F
- Types of data available (clinical, claims, scheduling, etc.)
- Response time capabilities and hours of operation
- Contact information for technical support

Conclusion

ChenMed's experience demonstrates that real-time, comprehensive, and standardized data access is not just a technical goal—it's foundational to patient safety, care quality, and the business sustainability of value-based care. Our PCPs can only deliver effective wraparound care when they have complete visibility into every hospital, specialist, and



pharmacy touchpoint. The current system's fragmentation and misaligned incentives between fee-for-service providers and full-risk organizations put patients at risk and threaten the promise of value-based care.

We have proven that with the right data, technology, and payment model, it's possible to deliver more good days, fewer hospitalizations, and higher satisfaction for the most clinically acute populations. But we cannot succeed alone. CMS and ASTP/ONC must act decisively to close persistent data and technology gaps. By adopting these recommendations—mandating real-time MA data access, lowering participation barriers, standardizing data elements, and prioritizing full-risk providers—CMS will improve outcomes, empower patients, and build a stronger, more Medicare program for the future.

Respectfully submitted,

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