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VIA ELECTRONIC SUBMISSION THROUGH www.regulations.gov

Mehmet Oz, M.D.
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0042-NC
P.O. Box 8013
Baltimore, MD 21244-8013.

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

Dear Dr. Oz:

The US Oncology Network (The Network) is pleased to provide comments to the U.S. Centers for Medicare & Medicaid Services (CMS), Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC) (collectively, ASTP/ONC), and the Department of Health and Human Services (HHS) to the **Request for Information (RFI) on the Health Technology Ecosystem.**

The Network is the nation's largest network of independent, community-based oncology physicians. Bringing together more than 3,200 like-minded providers, The Network treats more than 1.8 million cancer patients a year nationwide at over 700 sites of care in 30 states. These providers share a common vision of expanding patient access to high quality, state-of-the-art care close to home and at lower costs for both patients and our entire healthcare system. Our mission is to help patients fight cancer as effectively and efficiently as possible.

The Network establishes long-term relationships with independent oncology practices to support their administrative functions. Under this arrangement, physicians continue to own their practices and retain complete decision-making authority regarding patient care, while gaining critical access to expertise in oncology practice management and delivery of value-based care. This support has resulted in The Network practices playing a central role in The Centers for Medicare and Medicaid Innovation's (CMMI) Oncology Care Model (OCM) and the subsequent Enhancing Oncology Model (EOM). The Network participants in the OCM saved CMS $333 million and just realized an additional savings of $44 million in the first performance period in the EOM against the benchmark. The Network is committed to protecting high quality care, improving the patient experience, while saving the system money.

The Network remains a thought leader and partner to CMS in oncology value-based care. Providers in The Network comprise about 50% of the EOM model with a footprint of 10 Network practices out of the 31 practices currently participating across the nation. The Network team meets with CMMI EOM program leaders regularly to share feedback on operationalizing components of the model and the impacts to providers and patient care. The team welcomes additional collaborative touch points to impact oncology care more broadly given The Network's proven track record of success.

Additionally, The Network's partnership with the Sarah Cannon Research Institute (SCRI) enables practices to offer their patients access to state-of-the-art clinical trials in a community setting. We also help community-based oncology practices more effectively manage costs, including drug inventory and technology expenses.

The Network shares the administration's commitment to ensuring the delivery of high quality and efficient cancer care. Our comments address four broad themes raised in the RFI:

- Provider adoption of digital tools;
- Payer alignment;
- Technology-Vendor Accountability; and
- Evolution of Value-Based Care

Provider Adoption of Digital Tools

Regarding what CMS and its partners do to encourage providers to leverage approved digital health products for their patients, including those in rural areas, **The Network recommends that CMS consider establishing a non-governmental body to certify such products.** Additionally, value-based care (VBC) programs and Medicare Advantage (MA) participants should be incentivized to include measures that can be captured through digital health technologies, ensuring alignment with evidence-based data standards. VBC programs should place greater emphasis on electronic patient-reported outcomes (ePROs) that are collected via these tools, as they offer valuable insights into patient experience and outcomes. Payment incentives—such as those tied to VBC contracts or STAR ratings—could also reward providers for engaging patients in the use of digital health platforms, including tools like MyChart.

One of the most significant obstacles to the effective use of innovative applications in physician workflows is the lack of integration and interoperability across systems. Standalone or siloed technologies that do not integrate with electronic health records (EHRs) often lead to duplicative documentation—or worse, missed documentation—which can negatively impact patient care and treatment decisions.

This interoperability challenge is largely due to the absence of standardized coding requirements and certification mandates, which prevents seamless data exchange between systems. In the area of quality measurement, the continued reliance on registry-based measures that require manual data extraction further compounds the problem. These outdated methods are particularly burdensome when incorporated into regulated VBC programs.

To address these issues, CMS should prioritize the adoption of electronic quality measures (eCQMs), with a strong emphasis on outcome-based metrics. National VBC programs should be built around these digital measures to reduce administrative burden and improve data accuracy. Furthermore, CMS must modernize its quality measure development and testing platforms to support innovation and the evolution of digital quality measurement. This modernization is essential to enabling scalable, efficient, and clinically meaningful reporting that aligns with the goals of value-based care.

As CMS explores ways to simplify clinical quality data responsibilities for providers, **The Network sees clear benefits in the use of Bulk FHIR data exports—particularly in reducing administrative burden and minimizing manual data entry errors.** However, there are important concerns that must be addressed. Providers are understandably hesitant to transmit clinical data that could impact their performance in VBC programs without a reliable mechanism to validate the data being submitted on their behalf. To build trust and ensure accuracy, providers must have the ability to review and verify the data prior to submission, as well as access to the

methodologies CMS uses to aggregate and calculate quality measures. Transparency and visibility into these processes are essential for ensuring that the data is accurate, actionable, and appropriate for use in performance-based programs.

Payer Alignment

In response to CMS's inquiry regarding how payers can help simplify clinical quality data responsibilities for providers, **The Network believes that both provider- and payer-side solutions are necessary.** While advances in electronic health record (EHR) technology that enable bulk extraction of clinical quality data are promising, their effectiveness depends on broader systemic changes. Specifically, CMS should require healthcare technology vendors to adopt standardized code sets and demonstrate interoperability through certification. Without these foundational requirements, data exchange will remain fragmented and inefficient.

Clinicians must have the ability to understand and validate their performance data before it is shared with payers—whether CMS or commercial insurers. Trust in the data is essential, particularly when it influences reimbursement, shared savings, prior authorization decisions, and ultimately, patient care. At the same time, payers should take greater responsibility for providing timely, actionable analytics back to providers. This would support appropriate utilization, cost management, and improvements in patient outcomes through evidence-based, outcomes-driven quality measures.

To streamline provider responsibilities and maximize the value of technology investments, it is essential to consolidate interoperability and quality reporting requirements across CMS and commercial payers. The current fragmentation—where separate quality measures exist for different programs—creates unnecessary duplication and administrative burdens. This inefficiency is largely driven by the continued reliance on registry-based specifications and the lack of universally adopted electronic clinical quality measures (eCQMs) and digital quality measure standards.

A key step forward is the elimination of registry-based measures in favor of standardized eCQMs and digital quality measures. CMS should also require EHR vendors to support coding and quality measures that are directly relevant to their user base. For example, oncology-specific EHRs should be mandated to support all oncology-designated measures under national regulatory frameworks such as MIPS.

Additionally, the current Promoting Interoperability requirements do not meaningfully demonstrate data exchange or improve clinical outcomes. A more effective approach would be to integrate and promote Interoperability with quality measurement in a way that drives real-time data sharing, care coordination, and actionable insights. This alignment would not only simplify reporting processes but also ensure that technology investments serve both regulatory compliance and clinical care improvement.

Technology Vendors and Accountability

In response to what short-term (within the next two years) and longer-term steps CMS can take to stimulate developer interest in building digital health products for Medicare beneficiaries and caregivers, **The Network recommends a multi-pronged approach that addresses both immediate barriers and foundational infrastructure needs.**

In the short term, CMS should focus on reducing the financial and regulatory friction that currently discourages developers from engaging with Medicare data systems. One of the most pressing issues is the presence of

compounding fees associated with data exchange. These include charges such as "2 cents per ping" to surface data to patients and "7 cents" for provider-directed sharing, which can quickly accumulate and deter innovation. Eliminating or subsidizing these fees would significantly lower the cost of entry for developers. Additionally, CMS should clarify data access rights for certified agents and subcontractors to reduce legal uncertainty and foster a more transparent and developer-friendly environment. To further encourage innovation, CMS could fund pilot programs that demonstrate the value of digital health tools, particularly within Medicare Advantage, thereby showcasing real-world benefits and building trust among stakeholders.

Looking to the longer term, **CMS should consider establishing a universal patient identifier (UPI) to support secure, tokenized data exchange.** A UPI would streamline identity verification and facilitate seamless interoperability across systems. To ensure neutrality and trust, CMS should create a central, independent body to manage the identity and consent infrastructure associated with the UPI. Furthermore, CMS can draw inspiration from the Department of Veterans Affairs' MHS GENESIS Patient Portal, which successfully integrates with the Department of Defense and U.S. Coast Guard systems. Emulating this model would promote continuity of care and simplify development for vendors working across federal health systems.

Building on this vision of a centralized, interoperable infrastructure, **CMS should consider transitioning to a national registry model—developed in partnership with the CDC—for capturing cancer, immunization, syndromic surveillance, and electronic case reporting (eCR) data**. CMS is already demonstrating success with eCR through a single national point of submission, with the CDC and the Association of Immunization Managers (AIM) leading the effort. Expanding this approach to include cancer, immunization, and syndromic data would reduce the burden on providers, eliminate inefficiencies associated with fragmented, state-level reporting systems, and improve the accuracy, timeliness, and accessibility of public health data. A centralized, standardized registry infrastructure would not only reduce waste but also enhance the nation's ability to act swiftly and effectively in response to emerging health threats.

Together, these short- and long-term strategies would create a more attractive and supportive environment for developers, ultimately benefiting Medicare beneficiaries and their caregivers through improved digital health solutions.

In response to what degree the United States Core Data for Interoperability (USCDI) has improved interoperability and exchange—and what its limitations are—**The Network acknowledges that while USCDI has laid a foundational framework for standardized data exchange, its utility remains limited in certain specialty areas.** Specifically, USCDI does not yet contain the full extent of data elements needed to support comprehensive interoperability in fields such as oncology and genomics. For these domains, expanded data sets under USCDI+, such as Minimal Common Oncology Data Elements (mCODE), are essential. Significant progress has been made in developing these extensions, particularly in oncology, and more recently in genomics. However, the adoption and implementation of these expanded datasets remain inconsistent and underwhelming.

This gap is not solely due to limitations in the USCDI format itself, but rather in how it is utilized and enforced. Currently, there are no mandates or certification requirements compelling vendors to adopt USCDI+ standards, which results in a lack of incentive to implement them. For example, in the context of Merit-based Incentive Payment System (MIPS) and cancer registries, mandating the use of mCODE and USCDI+ could significantly enhance interoperability, reduce clinician burden, and improve the quality and consistency of cancer registry

data. At present, reporting requirements vary by state and are often burdensome, but this could be remedied if all systems adopted a common data standard that enabled national aggregation.

Regarding the potential expansion of USCDI, adding more data elements would indeed add value, particularly for specialty care and research. However, this expansion must be carefully scoped to avoid overwhelming implementers. One way to address this challenge is through modular implementation pathways, where additional data elements are phased in based on clinical relevance and readiness. Finally, with the rapid advancement of language models and natural language processing, there is growing interest in exploring less structured but non-proprietary formats that could improve data coverage. While such formats may require more processing by the receiver, they could offer a flexible complement to structured standards like USCDI, especially in capturing nuanced clinical information.

In response to how increased use of bulk FHIR APIs could improve use cases and data flow, as well as what potential disadvantages might arise, **The Network recognizes both the strategic value and the inherent risks of bulk data exchange.** Bulk FHIR APIs offer significant advantages, particularly for hospitals and health systems that may not be receiving the data they need from their current electronic health record (EHR) systems. By enabling the export of large volumes of data, bulk FHIR supports greater data portability, allowing providers to migrate or share data across systems more efficiently. This capability not only empowers healthcare organizations to make more informed decisions but also fosters competition among EHR vendors and technology developers, aligning with the goals of HIPAA and HITECH to promote interoperability and patient access.

However, while the potential for improved data flow and vendor competition is substantial, bulk data transfers are not without limitations. In many care settings, the volume of data exchanged through bulk APIs may exceed what is necessary for a specific patient interaction or care event. This can lead to inefficiencies and increased complexity in data management. More critically, bulk transfers raise heightened concerns around privacy and security. The larger the dataset being moved, the greater the risk of unauthorized access or data breaches, especially if robust safeguards are not in place.

Therefore, while bulk FHIR APIs can be a powerful tool for enhancing interoperability and driving innovation, their use must be carefully scoped and supported by strong governance frameworks. Balancing the benefits of data liquidity with the need for privacy, security, and relevance to clinical workflows will be essential to realizing their full potential.

In response to CMS's interest in seeking examples of practices that may constitute information blocking—including both non-responsiveness and actions that result in failure or unusable responses—The Network offers a perspective based on our experience as a Qualified Clinical Data Registry (QCDR) vendor supporting practices participating in the MIPS program. One of the most persistent challenges we encounter involves clinicians who use multiple EHR systems and struggle to access the full scope of clinical data required to meet MIPS quality reporting requirements. In particular, we have observed large hospital systems either ignoring or outright rejecting clinician requests to access their own patient data or to generate data exports necessary for MIPS participation.

This lack of cooperation directly undermines clinicians' ability to meet the >70% data completeness threshold required by CMS, resulting in penalties under the MIPS program. These penalties are especially concerning because there is currently no hardship exemption available for providers who are unable to aggregate data due

to EHR vendor or hospital non-responsiveness. As a result, clinicians are unfairly penalized for circumstances beyond their control—circumstances that clearly align with the definition of information blocking. These practices not only hinder interoperability but also compromise the integrity of federal quality reporting programs and place an undue burden on providers.

Value-Based Care

In support of advancing value-based care (VBC), **The Network would like to emphasizes the importance of removing unnecessary regulatory barriers that hinder the sharing of electronic protected health information (ePHI) among all entities involved in care coordination.** Facilitating seamless data exchange is essential to building value-based models and reimbursement structures that can effectively improve patient outcomes, control healthcare costs, and address health disparities. The Department should clarify that covered entities are permitted to disclose an individual's PHI to all parties engaged in coordinating and managing that individual's care. Furthermore, those receiving the information should be allowed to use it not only for individual-level care coordination and case management but also for population-level activities that can drive better outcomes across patient groups.

The Network operates a QCDR with CMS, which plays a critical role in helping clinicians meet reporting requirements under the Merit-Based Incentive Payment System (MIPS) within the Quality Payment Program (QPP). This infrastructure should be leveraged more broadly to promote provider- and data-driven insights sharing. **Importantly, The Network believes that VBC initiatives should be grounded in evidence generated by actual clinical practice and should originate from the provider side rather than the payer side.** Prioritizing quality as the foundation for VBC—before considering cost—ensures that the metrics used to evaluate care are closely tied to the care event and the clinical evidence surrounding treatment decisions. This approach is essential to accurately measuring and rewarding high-quality care.

From the perspective of our QCDR, one of the most pressing challenges faced by participants in CMS regulatory programs—particularly the MIPS program—is the lack of timely feedback, especially in the cost performance category. While vendors are required to provide feedback on quality, promoting interoperability, and improvement activities at least four times per year, CMS does not provide any feedback on the cost category until several months after the close of the performance period. This delay severely limits the ability of practices to learn from their performance and make meaningful improvements throughout the year.

As a result, practices are effectively flying blind when it comes to managing cost performance. Despite potentially strong performance in the quality, interoperability, and improvement activity categories, the cost category—accounting for 30% of the overall MIPS score—can dramatically alter a practice's final outcome. In some cases, this has led to practices anticipating a positive payment adjustment based on their known performance, only to receive a negative adjustment due to unexpected cost scores calculated retrospectively by CMS using claims data.

To ensure fairness and promote continuous improvement, CMS should be held to the same standard it imposes on vendors by providing cost performance feedback at least quarterly. This would give practices the opportunity to monitor their cost performance in real time, identify areas for improvement, and take corrective action before the end of the performance year. Timely, actionable feedback is essential to the success of value-based care and to the integrity of the MIPS program.

In response to how key themes and technologies such as artificial intelligence, population health analytics, risk stratification, care coordination, usability, quality measurement, and patient engagement can be better integrated into Alternative Payment Model (APM) requirements, **The Network recommends aligning APM program requirements with the dual goals of enabling interoperability and improving patient outcomes.** To meaningfully incorporate these technologies, performance metrics should prioritize patient-centered outcomes, particularly those captured through electronic patient-reported outcomes (ePROs) via API-enabled applications. Additionally, general outcome performance measures should be grounded in electronic clinical quality measures (eCQMs) and digital measure specifications to ensure consistency and scalability.

By embedding foundational interoperability capabilities into APM requirements, CMS can create an environment where vendor innovation is not only encouraged but necessary. When program performance assessments are tied directly to outcomes that matter to patients, technology developers are more likely to invest in tools that support care coordination, usability, and engagement. This approach ensures that artificial intelligence and analytics are applied in ways that are clinically relevant and actionable, ultimately driving improvements in both individual care and population health.

Conclusion

The Network believes that patient-centered healthcare interoperability can transform care delivery, improve outcomes for all, and empower patients to be active individuals in their healthcare journey. Our recommendations are common-sense outgrowths of the Department's completed and continuing efforts to promote interoperability, improve care coordination, and increase transparency in an otherwise siloed and opaque system that has stood too long in the way of value-based care. If you have questions or need further information, please contact Ben Jones, Senior Vice President, Marketing & Government Relations, at ben.jones@usoncology.com.

Sincerely,

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Senior Vice President, Payer and Care Transformation
The US Oncology Network