

Response to CMS/ASTP/ONC Request for Information (RFI)

Health Technology Ecosystem:

Digital Health, Interoperability, and Value-Based Care

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Executive Summary

SOMOS is a mission-driven healthcare enterprise composed of **SOMOS Community Care**, a not-for-profit Community-based Organization (CBO), and **SOMOS Innovation**, its for-profit Management Services Organization (MSO) and digital health infrastructure partner supporting the Independent Practice Associations (IPA). Together, SOMOS supports a physician-led, community-based network of over **2,400 independent preventive and primary care providers** who serve more than **2 million Medicaid and Medicare beneficiaries** across New York City—many from historically underserved, immigrant, and minority communities.

Our integrated digital health ecosystem—including tools such as **MediFlow** (for SDOH screening and coordination), **CertifyMe** (for identity verification and onboarding), and **QR+** (for quality reporting and risk adjustment)—has enabled SOMOS to succeed in full-risk, value-based Medicaid models. These tools support real-time data exchange, close care gaps, and empower both patients and providers.

In this response to the CMS/ASTP/ONC Request for Information, SOMOS offers **actionable policy recommendations** informed by hands-on experience delivering culturally competent, tech-enabled care. Our recommendations address several key areas:

- Strengthening **interoperability** through open API enforcement and FHIR endpoint standardization
- Supporting **trusted digital identity adoption** (e.g., Login.gov, ID.me) for patients and providers
- Advancing **TEFCA integration** into Medicare tools to unify access and patient records
- Incentivizing **HIE and QHIN participation** for small and safety-net providers
- Funding **technical assistance and infrastructure** for smaller payers and community-based practices

SOMOS is committed to helping CMS realize a **patient-centered, equitable, and interoperable digital health ecosystem**—one that bridges clinical, administrative, and social domains to improve care navigation, reduce disparities, and deliver meaningful results in value-based care.

Introduction: SOMOS – Who We Are In Detail

SOMOS is a physician-led, community-based value-based care organization serving over 2 million Medicaid and Medicare beneficiaries in New York. Our network of 2,500+ providers – largely independent primary care physicians (PCPs) in underserved communities – has implemented a nationally recognized model of digital health-enabled, preventive care. Through initiatives launched under New York’s DSRIP Medicaid reform and ongoing Medicare ACO programs, SOMOS has achieved **tangible improvements in outcomes and cost**: for example, a 22% reduction in preventable hospital readmissions (2015–2020) and significant decreases in diabetes complications among Medicaid patients. SOMOS’s Medicare ACO has generated shared savings for 9 consecutive years, ranking 3rd out of 38 ACOs in New York in 2022 with a 9.82% savings rate (nearly \$19 million total savings). These results underscore SOMOS’s leadership in leveraging technology and community-based care to **save lives, enhance quality, and reduce costs**.

Digital Health Infrastructure

SOMOS has built an integrated digital health ecosystem aligned with the 21st Century Cures Act and federal interoperability initiatives. Key components of our platform include:

- **MediFlow:** A digital risk stratification and population health analytics engine (available via web and mobile) that utilizes social data to identify high-risk patients for proactive intervention. MediFlow’s AI-driven algorithms enable care managers to prioritize outreach based on a patient’s social and digital determinants of health (SDOH, DDOH), contributing to reductions in hospital utilization and improved preventive care.
- **CertifyMe:** A patient-facing mobile application that streamlines Medicaid enrollment and recertification and connects users with social services. By integrating with state Medicaid systems, CertifyMe has helped thousands of vulnerable patients maintain coverage and access to support and services patients deserve. This prevents coverage gaps, supporting continuity of care.
- **SOMOS QR+:** A quality reporting and optimization dashboard (available via web and mobile) that lets providers track care gaps and risk adjustment coding in real time. QR+ aims to integrate with EHRs (e.g. MDLand, eClinicalWorks) via FHIR APIs to pull patient data and displays actionable alerts for screenings, immunizations, and chronic disease management. This tool has boosted performance on HEDIS and CMS quality measures – for example, contributing to high screening rates and accurate coding that underpin our shared savings success.
- **CareFlow (Collaboration):** An intuitive care coordination and administrative platform (in partnership with CareCloud’s CareFlow) that automates referrals, insurance eligibility checks, and prior authorization workflows. By interfacing with payer systems, CareFlow has **reduced administrative burden** on our small practices – speeding up referral processing and freeing up providers to focus on care.
- **EHR Integration (MDLand and eCW):** We partner with multiple EHRs, with the deepest collaborations with **MDLand** and **eClinicalWorks** – ONC-certified EHR

vendors used by our network – to ensure data interoperability. Through health information exchange (HIE) connections and vendor APIs, SOMOS aggregates clinical data across 400+ independent clinics. This unified data approach gives providers a 360° view of patient history regardless of site and supports seamless care transitions. We also connect to regional HIE networks (e.g. Healthix) and national networks (Carequality/CommonWell) to pull hospital records, lab results, and specialist notes into the primary care workflow.

- **FindHelp Social Care Link:** SOMOS integrates the **FindHelp.org** platform to **link patients with community-based organizations**. Our care managers use this tool to electronically refer patients to food pantries, legal aid, shelters, and other services, and to receive status updates. Embedding social referral capability into our care management system has addressed critical needs related to the social determinants of health (over thousands of social service referrals facilitated) and improved patient trust and engagement in healthcare.

Summary of Capabilities and Partnerships

The table below summarizes SOMOS’s core digital health tools, their purposes, and partnerships:

Platform / Tool	Purpose & Functionality	Key Integrations	Impact / Use Case
MediFlow (proprietary; mobile-, web-based)	AI-driven risk stratification for population health management. Analyzes SDOH data to flag high-risk patients and predict utilization . Multilingual, easy-to-use for underserved populations.	- Data obtained directly from patients through Medicaid and MSSP SDOH screenings	Enabled targeted care management (e.g. intensive home outreach for top 5% risk patients), contributing to 22% fewer readmissions and better chronic care outcomes.
CertifyMe (proprietary; mobile-, web-based)	Medicaid enrollment and renewal , with patient education and social service navigation. Multilingual, easy-to-use for underserved populations.	- NY State Medicaid enrollment system for community resources	Increased Medicaid coverage continuity (reducing churn) and connected patients to benefits (e.g. SNAP, housing). Empowers patients to manage coverage, leading to more consistent primary care utilization.
SOMOS QR+ (proprietary;	Quality & Risk Dashboard for	- FHIR API integration with EHRs (pulls	Improved gap closure rates (e.g. screening and

Platform / Tool	Purpose & Functionality	Key Integrations	Impact / Use Case
mobile-, web-based)	providers. Shows real-time quality measure performance, open care gaps, and suspected risk adjustment conditions for each patient.	problem lists, labs, meds)- CMS Claims (Blue Button) for preventive services history	immunization rates rose significantly). Helped physicians optimize coding and documentation, supporting more accurate risk scores and contributing to our MSSP shared savings ranking.
CareFlow (partnered)	Workflow platform for referrals, pre-authorizations, and eligibility checks to streamline administrative tasks.	- Linked to major Medicaid and MA plan portals- Integrated with practice management systems	Shortened referral turnaround times and ensured patients complete specialist visits. Reduced admin workload on small practices by automating authorization approvals (fewer phone calls/faxes).
FindHelp.org SDOH Network (partnered; web-based)	Social care referral integration to address social needs (housing, food, transportation, etc.). Allows bi-directional communication with CBOs.	- API integration in care management system- CBOs in NYC area	Over 5,000 social needs referrals facilitated (e.g. food deliveries, legal aid), resulting in better medication adherence and appointment follow-through. Enhances whole-person care and patient satisfaction.
Interoperable EHR Connectivity (partnered)	Health information exchange across providers and settings. Ensures data liquidity for care coordination and patient access.	- MDLand and eClinicalWorks EHRs (ONC certified) used by network- Regional HIE (Healthix) and national networks (Carequality) participation- CMS Blue Button® 2.0 for Medicare FFS claims	Comprehensive longitudinal health records available at point of care. For example, PCPs receive hospital ADT notifications and discharge summaries via HIE, enabling 48-hour post-discharge follow-ups. Data exchange reduces duplicate tests and empowers patients to have their records follow them.

Approach to Policy Recommendations

In the responses below, SOMOS offers practical, **implementation-ready recommendations** to CMS/HHS. These reflect our on-the-ground experience deploying interoperable digital tools in value-based care arrangements. We emphasize policies that align with the RFI's goals:

1. **Drive adoption of digital health apps**
2. **Strengthen interoperability via open standards (FHIR, APIs)**
3. **Address barriers like information blocking**
4. **Reduce provider burden**

Our comments are organized by RFI question (e.g., PC-1 through PC-14, PA-1 through PA-7). Each answer is labeled according to the question and provides SOMOS's perspective and recommendations.

Patient & Caregivers

The following section relates to use cases and workflows that involve patients and caregivers.

Patient Needs

PC-1 through PC-7

PC-1. Apps for Health Management and Care Navigation

Question: “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 you or your loved ones' health that can be enabled by digital health products? b. If you had a personal assistant to support your health needs, what are the top things you would ask them to help with? In your response, please consider tasks that could be supported or facilitated by software solutions in the future.”

SOMOS Perspective

Patients – especially in underserved and elderly populations – benefit most from **interactive, easy-to-use, user-friendly mobile apps that integrate medical, administrative, and self-care functions**. From our experience, the top capabilities patients and caregivers want include:

- Unified Health Information Access:** A single app to view **all personal health data** (medications, diagnoses, lab results, visit summaries) across providers. Today, data often lives in siloed patient portals. It would be transformative to have an app that aggregates data via secure APIs from multiple sources (hospitals, clinics, pharmacies) into one personal health record. *Current possibility:* Third-party apps (like Apple Health) can pull data from FHIR APIs of some health systems – for example, Medicare’s Blue Button API connects claims data to patient apps. *Near future:* Broader adoption of FHIR Patient Access APIs by all providers and payers so that a patient’s longitudinal record can be assembled seamlessly. *Valuable but hard:* Real-time universal health record access, including unstructured notes and images, from any provider nationwide (this depends on full network interoperability and patient identity solutions, as discussed in PC-10/PC-14).
- Care Navigation & Reminders:** Tools that guide patients on **what actions to take for their health**. *Top user needs:* medication reminders, appointment scheduling and follow-ups, and personalized health education. For example, an app that not only reminds someone to take their blood pressure medication, but also prompts them to schedule a quarterly hypertension check-up and offers a one-click way to book or request a telehealth consult. *Possible today:* Many apps send medication reminders and some provider portals offer appointment requests. Our SOMOS QR+ platform also pushes preventive care reminders to providers to relay to patients. *Near future:* Integration of scheduling APIs so that patients can directly book or change appointments across different clinics through one interface (this requires providers to expose scheduling endpoints, see PR-4). Also, AI-driven “health coach” features that monitor patient data (like glucometer readings via Bluetooth) and suggest actions (e.g. “Your blood sugar is high, consider scheduling a dietician visit”). *Hard but valuable:* A truly intelligent navigator that synthesizes all of a patient’s data and circumstances to proactively recommend care (e.g. alert a caregiver that an Alzheimer’s patient hasn’t refilled a prescription and provide one-tap options to coordinate a refill or doctor’s visit). Achieving this will require advanced AI, widespread data sharing, and careful personalization.

- **Benefits and Administrative Management:** Patients frequently struggle with the administrative side of healthcare. An ideal app lets them **manage insurance/benefits (eligibility, claims, bills)** and **find community resources**. Our **CertifyMe** app is a step in this direction – it guides Medicaid patients through enrollment and renewal and connects to social services. *Possible today:* Insurance company apps often show digital ID cards and claim status; and tools like FindHelp (embedded in CertifyMe) let patients search for community support programs. *Near future:* Greater integration so that, for example, when a patient’s income or address changes, an app could automatically update their Medicaid and schedule any required renewal steps. Also, an integrated health & social needs “to-do list” for patients and caregivers could be developed (combining medical appointments, medication pickups, and social service appointments in one calendar). *Hard but valuable:* Auto-navigation of healthcare bureaucracy – e.g., an AI assistant that completes forms, applies for financial assistance programs on behalf of the patient, and negotiates billing issues. This is ambitious but would dramatically reduce barriers to care.
- **Caregiver Coordination:** Many patients rely on family caregivers who need access to information and guidance. Apps should screen for social and medical needs before they become detrimental to a patient’s health and facilitate navigation to the resource needed. This form of support is achievable with **shared access** (with consent) so that caregivers can help manage an elder’s appointments, medications, and monitor their status. *Possible today:* Our **MediFlow** app/web portal is seamless in its capability to screen a patient for SDOH and provide access to a care coordinator to navigate the needs of the patient. *Near future:* More robust caregiver modes in apps (e.g., a mother can toggle to view her aging parent’s care plan and receive alerts). *Hard:* Nationwide standards for health proxies in digital tools (including legal and privacy considerations) – essential for scalability but requires policy framework.

Recommendations to CMS

1. CMS should **encourage development of “one-stop-shop” patient/caregiver apps** through policy and partnerships. This can include funding pilot programs or challenges for integrated navigation apps, requiring open APIs so apps can pull data from EHRs and payers, and ensuring patients have access rights under the 21st Century Cures Act. Notably, **CMS’s Blue Button 2.0** has shown how opening data (claims) spurred at least 75 consumer-facing applications; similar efforts for clinical data via FHIR and for scheduling/administrative tasks would catalyze innovation.
2. We also recommend CMS **promote app libraries or an “approved digital product” list** (as hinted in PC-5/PR-1) so providers and patients know which apps are safe and effective. By addressing privacy/security and interoperability, these apps can empower patients to manage health needs confidently, ultimately leading to more informed decisions and better outcomes.
3. Lastly, we recommend CMS **encourage the adoption of patient/caregiver apps that facilitate screening and navigation for preventive care coordination** before the full burden of disease sets in. By addressing clinical usability, workflow integration, and

upstream risk identification, these tools can support earlier interventions, reduce avoidable utilization, and help shift the care paradigm toward health maintenance rather than crisis management.

PC-2. Access to Health Information in One Place

Question: *Do you have easy access to your own and all your loved ones' health information in one location (for example, in a single patient portal or another software system)? a. If so, what are some examples of benefits it has provided? b. If not, in what contexts or for what workflows would it be most valuable to use one portal or system to access all such health information? c. Were there particular data types, such as x-rays or specific test results, that were unavailable? What are the obstacles to accessing your own or your loved ones' complete health information electronically and using it for managing health conditions or finding the best care (for example, limitations in functionality, user friendliness, or access to basic technology infrastructure)?"*

SOMOS Perspective

Most patients and caregivers **do not yet have a single, unified view** of all their health information. In our patient population, it's common for an individual to juggle multiple portals – one for their primary care clinic, another for a specialist practice, perhaps a hospital's portal for lab results, and separate insurer portals for claims or prior authorizations. This fragmentation creates significant challenges:

- **Incomplete Information and Delays:** When records are spread out, patients often miss important details. For example, an elderly patient may not realize a specialist updated their medication because it's noted only in the specialist's portal that the patient rarely checks. Caregivers find it difficult to piece together a comprehensive medication list or history for their family members. This can lead to medication errors or duplicated tests if one provider is unaware of another provider's actions. We have encountered patients bringing stacks of printouts from different portals to appointments, hoping our physicians can reconcile them – an inefficient and error-prone process.
- **Engagement and Self-Management Barriers:** The friction of managing multiple accounts (remembering different usernames/passwords and website links) discourages patients from regularly accessing their health data. In our community surveys, many patients indicate they simply **"wait for the doctor to tell me"** rather than proactively reviewing their results or care plans online, because the portals are too confusing or siloed. The lack of unified access thus undermines the spirit of the Cures Act's information-sharing – the data exists, but it's not readily usable by patients when scattered.
- **Limited API:** Some data types, like radiology images or full specialist notes, are often unavailable in third-party aggregators or missing from payer-access APIs, limiting their value for managing complex conditions.

Those who *do* manage to aggregate their data (for instance, tech-savvy patients using third-party aggregator apps or downloading records to create personal files) report clear benefits: **better coordination and peace of mind**. They can double-check their immunizations, share a comprehensive history with a new specialist, and monitor chronic conditions across providers. In one case, a caregiver using an aggregate app was able to spot that her father's cardiologist and endocrinologist had prescribed potentially interacting medications – she brought this up to the

care team, potentially preventing an adverse drug event. This exemplifies how unified access can improve safety and patient empowerment.

Recommendations to CMS

We urge CMS to **accelerate policies enabling one-stop access**. Key steps include:

- **Enforce and Expand API Requirements:** Building on existing Patient Access API rules for payers, require that certified EHRs and healthcare providers offer FHIR APIs that allow patients to pull *all* their health data into the application of their choice—such as an app offered by a community-embedded healthcare system like SOMOS, which is integrated with a patient’s full network of healthcare providers to better facilitate coordinated and optimal care. While hospitals and clinics technically must provide data via portal or APIs now, the reality is inconsistent. Stronger enforcement of information blocking regulations (with clear penalties for providers who refuse to share data at a patient’s request) is needed to ensure patient-designated apps can retrieve data from any provider’s EHR **without special effort**.
 - **Promotion of Aggregator Tools:** CMS and ONC could collaborate on a **consumer-friendly aggregation solution**. For example, integrate Medicare’s Blue Button data with a patient’s provider data. Perhaps Medicare could extend Blue Button to allow beneficiaries to import their clinical data from connected providers (leveraging networks like TEFCA or CommonWell). Alternatively, support development of third-party platforms that many providers can trust and connect with (similar to how VA and DoD adopted **Login.gov** for identity – a common platform for all, see PC-14). If patients had a widely accepted “personal health record” app, endorsed by HHS, they might use it as the go-to repository.
 - **Educate Patients and Providers:** Lack of awareness is a barrier. CMS should run educational campaigns, so **patients know their rights** to access unified records and how to use available tools. At the same time, encourage providers to actively assist patients in setting up aggregate access. For instance, in our network, we train care coordinators to help patients download their health data, link portals during visits and complete digital health screens to facilitate care navigation. Making this a routine part of care (and perhaps reimbursable as digital navigation support) would help especially elderly or low-tech patients. At SOMOS, we are already implementing structured programs to educate both patients and healthcare providers on the appropriate and effective use of digital health tools, ensuring these technologies are employed in ways that meet the unique needs of our diverse and underserved population
-

Impact

If all health information can be easily accessed in one location, patients and caregivers will experience better continuity. They can catch discrepancies (as in the med interaction example), adhere to treatments (since they can review instructions and follow results over time), and

smoothly transition between providers (because they carry their record with them). It will also enhance competition and quality: patients can more readily seek second opinions or switch providers if they aren't locked into a single portal, and providers will know that **data transparency is the norm**, prompting them to focus on patient experience and outcomes.

In summary, unified access is not yet a reality for most, but through robust implementation of interoperability (APIs, directories, identity solutions) and stakeholder education, CMS can make the vision of a **single patient health record** come to fruition. This aligns directly with the goal of a patient-centric, digital health ecosystem where information flows securely to where it's needed.

PC-3. Supporting Health Management and Care Navigation Apps for Medicare Beneficiaries

Question: “Are you aware of health management, care navigation, or personal health record apps that would be useful to Medicare beneficiaries and their caregivers?”

SOMOS Perspective

We have developed a suite of digital applications that support health management, care navigation, and personal health records for Medicaid and Medicare beneficiaries and their caregivers. These tools are designed with a community-based, equity-oriented approach in mind, ensuring they are accessible and useful to diverse patient populations. Key SOMOS digital health tools include:

- **MediFlow:** A patient-centered health screening app that helps beneficiaries and their caregivers organize and “**navigate the system**” of care, specifically designed for the 1115 Waiver. MediFlow provides users with a **personalized care screening platform** – allowing them to determine eligibility for social and medical services, and connect with care coordinators or community health workers. This proactive support helps patients screen for social and medical needs at home or in the community instead of in the hospital, aligning with SOMOS’s goal of improving health and quality of life in the community. Early outcomes indicate that MediFlow users have increased digital participation and adherence to follow up, as the app empowers patients to stay on top of their care plan. ***Real-world example:** A 50-year-old Spanish-speaking Medicaid beneficiary with social care needs was guided by her care manager in learning how to use MediFlow. With this support, she successfully completed the digital screening tool, which identified her eligibility for transportation services under the 1115 Waiver—enabling her to attend church every Sunday for the remainder of the month.*
- **CertifyMe:** A streamlined **care navigation and documentation tool** that assists Medicare beneficiaries in managing important health-related documents and program enrollments. CertifyMe simplifies complex processes such as **Medicaid recertification, eligibility verification, and access to social services**, which are especially critical for dually eligible individuals. Through a user-friendly mobile interface, patients and caregivers can receive guidance on renewing benefits (e.g. Medicaid or Medicare Savings Programs), digitally upload required documents, and “certify” their information for submission. By reducing paperwork burdens, CertifyMe helps vulnerable beneficiaries maintain continuity of coverage and care. This tool has been *piloted in underserved communities* to great effect – caregivers report that CertifyMe has **cut through red tape and prevented lapses in coverage**, ensuring patients don’t miss out on needed services. In essence, CertifyMe functions as a digital care navigation assistant, empowering patients and families to navigate healthcare administration so they can focus on health and wellness. ***Real-world example:** A caregiver helping an older adult with limited English proficiency can use CertifyMe to get step-by-step assistance (in their native language) for renewing the patient’s Medicaid eligibility or obtaining a transportation benefit authorization.*

- SOMOS QR+:** A robust **quality and risk management platform** that integrates data from nearly all health plans to provide real-time insights and decision support. Currently used by SOMOS physicians and care teams, QR+ aggregates Medicare and Medicaid patient data (e.g. claims, lab results, care gaps) into interactive dashboards and smart alerts. This tool directly benefits Medicare beneficiaries by enabling proactive outreach and tailored interventions. **Providers receive “smart alerts” about care gaps or needed services** (for example, a reminder that a diabetic Medicare patient is overdue for an eye exam), and can then coordinate with the patient or caregiver to close those gaps. Workflows are streamlined so that high-need patients don’t fall through the cracks – e.g., if an elderly patient with congestive heart failure misses a specialist appointment, QR+ flags it and a care coordinator can follow up the same day. By transforming healthcare delivery with real-time, unified data, SOMOS QR+ helps improve preventive care and chronic disease management for our Medicare population. **Real-world outcome:** *In 2024, SOMOS practices using QR+ achieved higher rates of cancer screenings and diabetes control than those without, because clinicians were promptly alerted to patient needs and caregivers were engaged to support follow-up.* Medicare beneficiaries experience better outcomes as a result – fewer complications and hospitalizations – thanks to this data-driven, **“streamlined workflow”** approach.
- Health Catalyst (CareFlow):** A **leading provider of data and analytics platforms** for healthcare organizations, combining enterprise-grade data infrastructure with actionable analytics and expert services to help healthcare providers improve patient care and operational outcomes. Their “catalyst” is the ability to transform raw data into measurable value across the continuum of healthcare. Extremely useful in identifying and coordinating care management to our most venerable communities.

Relevance for Specific Medicare Populations

SOMOS’s digital tools are purpose-built to address the needs of populations often overlooked in health tech innovation – including dually eligible beneficiaries, underserved or multilingual communities, and patients with chronic conditions:

- Dually Eligible Beneficiaries (Medicare-Medicaid):** Duals often navigate multiple systems and face socioeconomic challenges. MediFlow and CertifyMe are especially useful for this group by bridging Medicare and Medicaid services. MediFlow can screen eligibility and assist in a *unified care plan* that accounts for benefits from both programs, while CertifyMe assists with Medicaid redeterminations and service authorizations (capturing those in need and preventing loss of coverage due to administrative hurdles). Together, these tools tackle the fragmentation duals experience – for example, helping a low-income senior coordinate a Medicare-paid specialist visit with a Medicaid-funded transportation benefit. Additionally, SOMOS QR+ identifies high-risk dual eligibles and prompts care managers to connect them with appropriate supports (medical or social). This deliberate focus on duals reflects SOMOS’s commitment to **whole-person care** that spans clinical and social needs. By tailoring digital health interventions to dual eligibles, SOMOS helps reduce health disparities and improve outcomes in this vulnerable group

(e.g. better medication adherence and fewer readmissions for those using our apps versus those who don't).

- Underserved & Multilingual Populations:** As a network serving over 1 million patients in New York's underserved communities, SOMOS ensures its digital tools are culturally and linguistically accessible. All apps (MediFlow, CertifyMe, etc.) offer **multilingual support** – for instance, Spanish and Chinese translations – since our providers “share your culture and speak your language”. The content and interface are designed for users with varying health literacy. This is crucial for building trust and adoption among communities that traditionally face barriers to technology. Moreover, our tools incorporate connections to community resources (via platforms like FindHelp.org) so that social needs – food, housing, transportation – are addressed alongside medical care. This **holistic approach** aligns with SOMOS's model of “going beyond medicine” as a social care network. ***Real-World Example:** A Haitian-American Medicare beneficiary with limited English can use MediFlow in Creole (with help from a community health worker) to screen for housing insecurity and potentially be navigated to rental assistance through the app's integration with the social service platform Findhelp.* By meeting patients where they are – with language-appropriate, community-based digital support – SOMOS's apps help **close the equity gap** in digital health access.
- High-Need Patients with Chronic Conditions:** Patients managing multiple chronic illnesses benefit from organized, real-time coordination. CareFlow gives care coordinators a **care management health hub** to track medication adherence, appointments with different specialists, and treatment and lab data (like blood glucose logs). It can help care coordinators tailor **reminders and educational content** to help patients recognize early symptoms and seek timely care (echoing SOMOS's “Quality Corner” approach of educating patients to prevent emergencies). For caregivers of frail elders or those with dementia, MediFlow serves as a screening tool – family members can determine eligible services for their loved one. Meanwhile, SOMOS QR+ ensures that **care teams are coordinated:** primary care and specialists see the same up-to-date information on the patient's conditions and treatments. This reduces duplicative tests and medication conflicts. By having “the right health information when and where you need it” via these digital platforms, patients with chronic conditions experience safer, more seamless care transitions. In fact, early data shows that high-need Medicare patients enrolled in SOMOS's digital care management program (leveraging these tools) have improved control of conditions like diabetes and hypertension compared to baseline. In short, the apps act as a **24/7 care navigation assistant** for those who need frequent healthcare interactions, improving self-management and caregiver engagement.

Integration with Third-Party Apps and Platforms

In addition to its in-house tools, SOMOS recognizes the value of partnering with and endorsing established health applications that Medicare beneficiaries already use or trust. Notably:

- Apple Health:** Many Medicare beneficiaries or their adult children use smartphones; the Apple Health app (on iPhone/iOS) can serve as a **personal health record aggregator**.

SOMOS encourages patients to link Apple Health with their providers and devices – for example, to import lab results or share step counts and heart rate data with clinicians for remote monitoring. Our future updates aim to enable *seamless data sharing* from MediFlow into Apple Health’s secure HealthKit platform. By leveraging Apple Health’s broad adoption, we make it easier for tech-savvy seniors and caregivers to **view all their health data in one place** and even share select Health app data with doctors for more informed care decisions (a capability Apple began offering with iOS 15). This kind of integration meets patients where they are technologically, enhancing engagement without requiring entirely new systems.

- CMS Blue Button 2.0:** SOMOS supports Medicare’s Blue Button 2.0 API as a key enabler of beneficiary access to health records. Blue Button 2.0 is a standards-based API that delivers **Medicare Part A, B, and D claims data for over 60 million people with Medicare**. It allows beneficiaries to **share their Medicare data with third-party applications** of their choice and gives beneficiaries and their caregivers more control over their health information. In practice, SOMOS’s MediFlow app can potentially be designed to use Blue Button data (with the patient’s consent) to pull in a beneficiary’s past diagnoses, medications, and procedures, and screen for future medical and social needs. This is incredibly useful for care coordination – for example, if a patient just joined a SOMOS-affiliated practice, their history from Medicare claims (e.g. last year’s hospital visits or specialist consults) can be reviewed in MediFlow by their care manager. We also educate patients about Medicare’s own Blue Button tools (like the claims download on MyMedicare.gov and authorized apps) so that **caregivers can obtain a complete picture of their loved one’s medical history**. By embracing Blue Button, we ensure our apps complement and enhance the personal health record access that CMS already provides to beneficiaries.
- FindHelp (formerly Aunt Bertha) Social Care Network:** Health is more than clinical care – it’s about **social support**, and SOMOS has integrated with FindHelp.org to connect patients to community resources. In fact, SOMOS Community Care operates a Social Care Network by FindHelp as part of its care model. Through our navigation apps, patients or their care coordinators can **search for free or reduced-cost services like medical care, food, housing, transportation, and more** in their area. For instance, a caregiver using the MediFlow app can tap into the SOMOS Social Care Network to find a local Meals on Wheels program or a senior center, directly from the app’s interface. This integration with FindHelp ensures that digital health management isn’t happening in a vacuum – **social needs are identified and addressed alongside medical needs**, reinforcing the community-based approach to wellbeing. By endorsing tools like FindHelp, SOMOS helps Medicare beneficiaries access a full range of supports to remain healthy and independent at home.

SOMOS’s Future Digital Health Roadmap

Looking ahead, SOMOS is committed to expanding the functionality of these tools to further enhance care navigation, data access, and patient empowerment. Key roadmap priorities include:

- **Advanced Care Navigation Features:** Building on MediFlow, we plan to introduce richer navigation aids – for example, **integrated provider directories and appointment schedulers** that help patients find specialists, schedule visits, and get reminders in one place. We are also exploring AI-driven chatbots within the app to answer common questions (“What should I do if I miss a dose of my medication?”) and to triage requests to the appropriate care team members. These enhancements will make the navigation experience even more *personalized and on-demand* for Medicare beneficiaries.
- **Personal Health Record (PHR) Access & Portability:** We envision our apps evolving into a **unified personal health record hub** for patients. This means patients will be able to easily access **all their health information** – from primary care visits, hospitals, to home health – aggregated in one app. To achieve this, we’re working on deeper integration with health information exchanges and patient portals. A priority is enabling **patient-directed data exchange**: allowing the beneficiary to download or share their medical records with a click (for instance, sharing their medication list and summary with a new specialist or with a caregiver). Our approach aligns with federal interoperability efforts, ensuring data is portable and belongs to the patient. Eventually, a caregiver using a proxy login could pull up their mother’s complete health record on a single digital health tool, rather than juggling multiple portals.
- **TEFCA Integration (Nationwide Health Information Exchange):** SOMOS is preparing to connect our systems with the Trusted Exchange Framework and Common Agreement (TEFCA) network, which will go live nationwide. TEFCA will make it easier for patients and providers to **access and securely exchange health information** across different networks. By plugging into a “**network-of-networks**”, our apps could retrieve a Medicare beneficiary’s records from any participating hospital or clinic in the country. This is especially impactful for patients who travel or live part-time out of state, or those who see providers outside the SOMOS network. TEFCA’s **Individual Access Services** will allow patients (and their authorized caregivers) to gather health data from disparate sources into their chosen app. We fully intend for MediFlow to be such an app – “**an app of your choice**” that patients can use to access unified records without logging into each provider’s portal. Additionally, TEFCA will enable **caregivers to access information (with permission) to support their loved ones**, which dovetails with our caregiver access features. In summary, TEFCA integration will elevate our platform into a truly interoperable resource, giving Medicare beneficiaries and their families the right health information when and where they need it.
- **Caregiver Access & Proxy Functionality:** Recognizing the vital role of caregivers, we are expanding features that allow **secure caregiver access** to patient information. This includes developing proxy accounts or linked profiles in MediFlow so that, for example, an adult child can assist an elderly parent’s screening or message the care team on their behalf (with the patient’s consent). We are also looking at tailored interfaces or “**caregiver mode**” views that highlight what a caregiver needs (e.g., care plan tasks, upcoming appointments, or any new alerts on their loved one’s health status). Through policy guidance and robust privacy controls, SOMOS will ensure caregivers can be partners in care while respecting patient preferences. Ultimately, easier caregiver access means better supported patients – a goal that CMS and ONC also emphasize in interoperability rules and that TEFCA will facilitate.

- **Enhanced Patient-Directed Exchange:** Alongside caregiver features, our roadmap prioritizes giving patients even more direct control over their data sharing. We plan to implement **granular data sharing controls** (mirroring Blue Button’s direction) so that a beneficiary using our app can decide which data to share and with whom – for instance, sharing their latest blood sugar readings with their endocrinologist, or granting a specialist one-time access to their full medication history. We are also monitoring innovations like **consent-based exchange and health information proxies** to incorporate best practices for patient-directed exchange. SOMOS will continue to advocate for and adopt standards (like FHIR-based APIs) that make patient-mediated data exchange straightforward. In practical terms, this means a Medicare patient could use our tool to *send* their personal health record to a new provider or download it for their own records, fulfilling the promise that patients **truly own their health data**.

Policy Recommendations for CMS

To support broader adoption of community-oriented digital tools like those developed by SOMOS, we offer the following policy considerations and recommendations:

- **Incentivize Integration of Community-Based Digital Tools in Care Delivery:** CMS can modify payment models (ACOs, value-based purchasing, or chronic care management fees) to **reward providers for utilizing digital navigation and health management tools** that demonstrably improve patient outcomes. For example, CMS could allow documentation from apps like MediFlow (e.g., patient-reported data or care coordination activities) to count toward quality measures or care management billing requirements. Providing *explicit recognition and reimbursement* for the time and effort practices spend on digital outreach and patient coaching will encourage more providers to adopt such tools for Medicare patients.
- **Support Multilingual and Culturally Tailored Health IT:** CMS should promote standards and perhaps certification criteria that **digital health apps be accessible in multiple languages and usable by people with varying health literacy**. This might include updating the **Medicare Blue Button app guidelines** or future ETF (Electronic Health Record Technology) certification to require language support and readable design. Additionally, CMS could fund pilot programs or challenge grants for development of apps that serve non-English-speaking Medicare populations. SOMOS’s experience shows that culturally competent digital engagement (in patients’ own languages, by providers they trust) drives higher utilization and better health outcomes. Federal support in the form of technical assistance or recognition (e.g., an “Interoperability and Health Equity” award) could accelerate industry efforts to build equity-oriented tools.
- **Expand Beneficiary Access to Data (Blue Button & TEFCA Participation):** CMS should continue to expand the Blue Button 2.0 program and ensure robust implementation of **TEFCA’s Individual Access Services**. In particular, we recommend that CMS **streamline the process for beneficiaries to authorize apps to retrieve their Medicare data**, and conduct outreach so more patients know about these options. CMS could also require Medicare Advantage plans and state Medicaid agencies to offer

analogous APIs, so dual eligibles can get **complete data in one place**. By mandating that plans participate in data exchange (e.g., through TEFCA or FHIR APIs) and allowing community providers to access that data with patient consent, CMS will empower innovations like SOMOS's MediFlow to provide a truly comprehensive personal health record. We also encourage CMS to collaborate with ONC to ensure that **caregivers' access rights** are considered – for instance, promoting development of standard processes for proxy access consistent with HIPAA, so that caregivers can leverage digital tools on behalf of patients when needed (with appropriate privacy safeguards).

- **Encourage Social Determinants of Health Integration:** CMS can support adoption of tools that address social needs by integrating social determinants of health (SDOH) into care planning. We applaud initiatives like **Accountable Health Communities** and recommend expanding them. For digital tools, CMS could issue guidance or best practices on using screening data and referral platforms (like FindHelp) in conjunction with EHRs. Policy might include **allowing certain social services referrals or activities to count in risk adjustment or quality scoring**, which would motivate healthcare organizations to use digital social care referral tools. By valuing SDOH interventions in Medicare quality programs, CMS would drive broader use of community resource directories and closed-loop referral technology, extending what SOMOS has done locally to a national scale.
- **Facilitate Public-Private Collaboration and Innovation Pilots:** CMS should continue to leverage demonstration projects and Innovation Center models to test community-based digital solutions. We recommend dedicated pilot programs (through CMMI or Medicaid waivers for duals) that fund **community-led organizations or physician networks to develop digital health navigation pilots**. These pilots could evaluate outcomes like reduced hospitalization rates or improved patient satisfaction when using apps such as MediFlow. CMS could also convene an innovation collaborative for providers in safety-net or minority communities to share successful practices in digital engagement of Medicare beneficiaries. Furthermore, **grant funding or technical support** for smaller practices (who might lack resources) to adopt proven apps could be transformative. By partnering with groups like SOMOS that have deep community ties, CMS can accelerate adoption of tech that is **designed for health equity from the ground up**.

Conclusion and Call to Action

SOMOS is keenly aware of – and actively developing – digital health management, care navigation, and personal health record tools that benefit Medicare beneficiaries and their caregivers. Our existing apps like MediFlow, CertifyMe, and SOMOS QR+ are already demonstrating how technology can empower patients and families, particularly in underserved, multicultural communities and among high-need populations. We also embrace third-party solutions (Apple Health, Blue Button, FindHelp) to ensure a well-rounded digital ecosystem for our patients. Looking forward, we will expand these capabilities with full interoperability (e.g. TEFCA) and caregiver-friendly features, aiming to make patient-directed exchange a reality. **CMS can play a pivotal role** in this transformation by adopting policies that support and scale

community-based, equity-oriented digital tools. By aligning incentives and standards with what front-line innovators are doing, CMS will help millions of Medicare beneficiaries – especially the most vulnerable – to experience more navigable, personalized, and equitable healthcare in the digital age.

PC-4. CMS's Role in Catalyzing Unmet App Functions

Question: “What features are missing from apps you use or that you are aware of today? a. What apps should exist but do not yet? Why do you believe they do not exist yet? b. What set of workflows do you believe CMS is uniquely positioned to offer?”

SOMOS Perspective

Many current consumer health apps are *fragmented* and siloed, treating fitness, nutrition, and mental wellness separately. Patients increasingly need integrated apps that manage the “whole person.” For example, a single platform might combine medication management, care navigation, and alerts for changes in health status, adapting recommendations across domains (e.g. adjusting diet or activity if stress rises). **Cultural and language support** is also missing. Apps rarely provide multi-language interfaces or culturally relevant content for communities like SOMOS serves. The JMIR review on digital health among diverse populations found that “*cultural and linguistic perspectives should be considered in the design and delivery*” of apps to make them acceptable and accessible.

In practice, we believe apps for patients should exist that integrate social needs (housing, food support, transportation), connect with community resources, and facilitate communication between patients, caregivers, and providers in the patient’s preferred language. These do not yet exist widely because developers have historically lacked incentives or frameworks to build for underserved groups: technical barriers (data fragmentation) and uncertainty around funding have slowed culturally-tailored innovation.

- *Examples of missing app features:* Multi-lingual interfaces, voice-assisted navigation, in-app translation; built-in SDOH screening (e.g. linking to food banks, housing referrals); integrated telehealth scheduling and follow-up; shared care plans for providers, patients, and caregivers; and automatic medication reconciliation across providers. Current solutions tend to silo these functions or target tech-savvy users only.
-

Workflows CMS Can Offer

CMS can uniquely enable seamless data-driven workflows by leveraging its infrastructure. For example, the Blue Button 2.0 and Patient Access APIs now give Medicare patients access to claims and encounter data, which can feed directly into apps (e.g. auto-populating a medication list or alerting to missing preventive services). CMS also mandates a **Provider Directory API**, which could power appointment-scheduling tools and provider-finder features for beneficiaries. In value-based care models, CMS can encourage workflows that integrate app data into care coordination: for instance, CMS could add digital health usage metrics into ACO or MA quality measures to incentivize providers to recommend vetted apps. Finally, CMS’s oversight of telehealth and remote monitoring payments means it can incorporate digital tools into clinical

workflows via reimbursement (for example, expanding CPT codes for remote monitoring and making them widely available).

In summary, CMS can catalyze unmet app functions by:

1. **Enforcing open APIs and expanding data** in those APIs (so apps can access claims, lab results, immunizations, etc.).
2. **Promoting directories and scheduling tools** through the Provider Directory API
3. **Aligning payment and care models** (MA/ACO, SSBCI) to reward the use of high-value digital health workflows that improve patient outcomes.

PC-5. Strategies to Promote Adoption and Trust in Digital Health Tools

Question: “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)? b. What changes would enable timely access to high quality CMS and provider generated data on patients?”

SOMOS Perspective

To increase patient and caregiver adoption of digital health products, CMS and partners must focus on **outreach, education, and trust-building**, especially for older and diverse populations. We suggest:

- **Community engagement and multi-language outreach:** Leverage trusted community networks (like SOMOS’s 2,500 local providers) to educate patients about digital tools. Provide information in multiple languages and formats (flyers, webinars, helplines) to raise awareness. Use culturally tailored messaging (as SOMOS does with health fairs and targeted media) so that seniors see the relevance of these tools. CMS might fund digital literacy programs (through Senior Medicare Patrols or community centers) to train inexperienced users.
- **Transparency and endorsement:** Establish a voluntary CMS “recognition” or certification program for digital tools that meet quality, privacy, and usability standards. CMS should clearly state the *criteria* (evidence of effectiveness, data security, accessibility for seniors, evidence of cultural tailoring, etc.) and publicize a “trusted apps” list. This builds trust and gives patients confidence in recommended tools. (This is akin to FDA precertification concepts, but focused on CMS’s role in patient decision-making.)
- **Reimbursement and incentives:** Expand coverage for validated digital therapeutics and remote monitoring tools by adding reimbursement pathways (as CMS has done for RPM/RVD codes). For example, encourage MA plans to include evidence-based apps as Supplemental Benefits. By directly paying for apps that reduce hospitalizations or improve chronic care, CMS signals their value.
- **Data access enhancements:** Ensure that patients and caregivers can easily share CMS data with apps. For instance, improve the Blue Button 2.0 experience (lower technical hurdles and broaden the data scope), and educate beneficiaries on how to authorize apps to retrieve their data. By reducing technical friction, CMS can make apps more attractive.
- **Digital identity and ease of use:** Encourage use of secure digital identity services (Login.gov, ID.me) so patients can sign into health apps without juggling new passwords. CMS could include clear guidance on using these services in beneficiary

communications. Simplifying login builds trust and lowers adoption barriers for older adults.

Regarding CMS’s Role in Reviewing Apps (Efficacy/Quality)

CMS need not perform formal regulatory approval (that is FDA’s domain), but it *can* support evaluation frameworks. For example, CMS could partner with ONC/HHS to convene stakeholder panels that review evidence for consumer apps (similar to the CMS Real-World Data guidance), and publish guidance on which types of evidence are needed. Criteria should include demonstrated health outcomes (ideally from peer-reviewed studies or registries), robust privacy/security measures, and accessibility (e.g. compliance with the Web Content Accessibility Guidelines). Technology solutions might include a CMS-supported registry or database of digital health studies (linking apps to outcomes data), or an API for reporting usage and results to CMS. Program design changes could involve embedding app adoption in Medicare care management (e.g. requiring care coordinators to introduce digital tools where appropriate).

Timely access to CMS/provider data: To facilitate digital tools, CMS should expand timely data availability. This could involve:

1. *Broadening APIs:* Add more data to patient APIs (e.g. Part C MA encounter data, Part D pharmacy data, provider quality metrics) so apps have the latest information.
2. *Data sharing infrastructure:* Implement the Humana-recommended “shared repository” idea: create a national or state-level health data hub where patient histories (with patient consent) are stored once and accessible by new providers/insurers. This would reduce delays when a beneficiary transitions between plans or providers.
3. *Incentives for interoperability:* As Humana suggests, provide subsidies or add-on payments to help small practices upgrade EHRs for interoperability. CMS could also require near–real-time claims transmission or faster enrollment transactions. Together, these changes would give patients, caregivers, and apps access to up-to-date medical information for more effective use.

PC-6. Making Digital Health Tools Usable for Every Medicare Beneficiary

Question: “What features are most important to make digital health products accessible and easy to use for Medicare beneficiaries and caregivers, particularly those with limited prior experience using digital tools and services?”

SOMOS Perspective

Inclusivity is paramount. Digital health tools must be designed with the **elderly and inexperienced user** in mind. Best practices include:

- **Simple, user-friendly interface:** Use large fonts, high-contrast colors, clear icons, and minimal clutter. Avoid complex menus or small text. Use plain language. Provide one-step workflows (e.g. one tap to call doctor, simple toggles for reminders).
- **Multimodal input and support:** Incorporate voice control or audio prompts (for those with vision issues), and offer the option for text-to-speech. Provide captioning or sign-language videos for the hearing-impaired. These features accommodate declining vision/hearing and motor skills.
- **Multilingual and culturally tailored content:** Offer the app interface and help materials in the beneficiary’s preferred language. Include images or examples that reflect diverse cultures. As the JMIR review notes, “*cultural and linguistic perspectives should be considered in the design and delivery of DHTs*” by involving target communities in development. SOMOS’s experience is that trust is built when tools speak the patient’s language and respect cultural norms.
- **Caregiver integration:** Enable shared access so family members or caregivers can help manage the app (with patient permission). For example, allow a trusted caregiver to receive medication alerts or read test results for a patient with limited literacy or dexterity.
- **Trust and privacy cues:** Clearly display privacy information (HIPAA compliance, data use policies) in simple terms. If an app is endorsed or recognized by CMS/ONC, make that visible. Patients are more likely to use technology when they feel their data are secure.
- **Training and support:** Pair apps with helplines or tutorials. For example, provide “*app coaches*” through community organizations or include an in-app walkthrough. SOMOS’s community health workers could help patients set up new apps during visits.
- **Offline functionality:** Many seniors have limited internet or data plans. Apps should cache essential information and function offline when possible. This ensures continuity even with poor connectivity.

By prioritizing these features, digital tools will be **accessible and engaging** for Medicare beneficiaries with low tech experience, reducing frustration and drop-off.

PC-7. Measuring the Real-World Impact of Digital Health Tools

Question: *“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?”*

SOMOS Perspective

To evaluate digital tools post-market, CMS should leverage real-world data and rigorous study designs. Possible approaches include:

- **Claims- and EHR-based evaluation:** Link app usage to Medicare claims and clinical data (with patient consent or in pilot studies). For instance, use new billing codes or EHR entries that indicate a patient is using a specific app, then track outcomes (hospitalizations, lab control, ER visits) over time compared to similar non-users. The CMS framework for evidence (e.g. HARPER+ RWD protocols) suggests standardized methods for such studies.
- **Prospective registries and post-market studies:** Require (or encourage) digital health developers to collect patient outcomes in real-world settings. For example, if a diabetes management app is deployed, CMS could ask for a registry where consenting users share blood-glucose readings and healthcare utilization. These data could feed into national research databases or CMS pilot evaluations.
- **Quality metrics and feedback loops:** Incorporate digital tool effects into existing quality programs. For example, ACOs or MA plans could report on improvements linked to app use (e.g. percentage of hypertensive patients who achieve control with a digital coaching program). Over time, CMS can analyze these aggregated metrics to gauge impact.
- **Patient-reported outcomes:** Use surveys or app-based questionnaires—similar to the SOMOS MediFlow app—to capture patient experiences (e.g. adherence, quality of life). CMS could deploy optional annual surveys asking about digital tool use and perceived benefits, then link to claims data.
- **Cross-sector partnerships:** Partner with AHRQ, PCORI, or NIH to fund real-world studies of digital interventions in Medicare populations. Shared learning networks (like Health Care Payment Learning & Action Network) could disseminate findings on what works.

In all cases, a **systematic framework** is needed. CMS’s recent draft guidance (HARPER+) emphasizes upfront protocol design and transparency. CMS could require that CMS-funded evaluations (e.g. in pilots or demonstration projects) use such standards, ensuring evidence is reliable. Ultimately, the best approach is a mix of routinely collected data (claims/EHR) and dedicated studies, analyzed with agreed-upon best practices, to measure health outcomes and cost effects of digital tools once they are in use.

Data Access & Integration

PC-8 through PC-12

PC-8. Unlocking the Full Value of Health Data: Improving Access, Integration, and Usability for Patients and Innovators

Question: *“In your experience, what health data is readily available and valuable to patients or their caregivers or both? a. What data is valuable, but hard for patients and caregivers, or app developers and other technical vendors, to access for appropriate and valuable use (for example, claims data, clinical data, encounter notes, operative reports, appointment schedules, prices)? b. What are specific sources, other than claims and clinical data, that would be of highest value, and why? c. What specific opportunities and challenges exist to improve accessibility, interoperability and integration of clinical data from different sources to enable more meaningful clinical research and generation of actionable evidence?”*

SOMOS Perspective

We believe that unlocking the full value of health data begins with making it truly patient-centered, equitable, and accessible across the care continuum. In our experience, patients and caregivers benefit most from timely access to basic clinical summaries, lab results, and medication histories, which we actively facilitate through our care coordination platforms. However, high-value data—such as encounter notes, real-time claims data, operative reports, and appointment schedules—remain fragmented or delayed, limiting their use for care planning, health literacy, and innovation.

Readily Available Valuable Data

Due to recent rulemaking, certain data are accessible to patients. For example, Medicare beneficiaries can already obtain their Part A, B, and D claims and coverage information via the Blue Button 2.0 API. Many patients also have portal access to basic clinical data like lab results, immunizations, and allergies (depending on the provider). CMS also requires that payers provide a FHIR-based Patient Access API so patients can view claims, encounters, and cost information. Additionally, provider directories (contact info, specialties, locations) are available via API, helping patients find and schedule care. Publicly reported data—such as Medicare hospital star ratings, cost reports, and quality metrics—are freely posted on CMS sites and sometimes consumed by consumer apps. In summary, core insurance data and some provider information are now available, which is valuable for care navigation and understanding services.

Valuable Data that is Hard to Access

Despite improvements, many useful data remain difficult for patients and developers to obtain. Key examples include:

- **Clinical narrative and unstructured data:** Encounter notes, imaging and pathology reports, and detailed care plans are rarely patient-accessible. These rich details often remain locked in EHRs or paper/PDF form.
- **Social and behavioral determinants:** Data about income, education, housing, food security, and transportation (the social drivers of health) are highly valuable but not captured or shared broadly. Even though SOMOS providers routinely address SDOH, there is no unified data feed for these non-medical factors.
- **Appointment and scheduling data:** Real-time provider schedules, wait times, and referral completions are not exposed via current APIs, yet would help patients navigate care.
- **Medication data beyond claims:** Out-of-pocket prescriptions, cash-pay medications, over-the-counter supplements, and community pharmacy records are not fully in Medicare data, causing gaps (e.g. HEDIS measures miss non-Part D fills).
- **Cost estimates and price data:** While the Hospital Price Transparency rule mandates machine-readable charge lists, those files are complex and only cover hospital services. Patients lack easy access to personalized cost estimates (e.g. bound estimates from providers, out-of-pocket calculators).
- **Patient-generated health data (PGHD):** Data from wearable devices, home monitoring, or wellness apps (steps, sleep, diet logs) are rarely integrated into health records, yet could inform care.
- **Behavioral and specialty data:** Mental health and substance use treatment records are often segregated by regulation, making them hard for apps to access comprehensively (even though these are high-need areas for seniors).

In short, much of the data that patients and caregivers would find valuable either reside outside CMS systems or are not easily shareable. For example, hospital charge transparency files exist but aren't integrated into personal health apps, and socially-relevant data are not in any standard medical record.

Opportunities and Challenges for Integration

There are exciting advances to build on. CMS has led interoperability initiatives (identifying HL7 FHIR R4 as the standard for API exchange), and HHS/ONC has launched TEFCA and the Trusted Exchange Framework to connect health networks. These could enable broader exchange of clinical data if widely adopted. National initiatives like Blue Button 2.0 and Patient Access APIs already show what is possible.

However, challenges remain. Technically, many providers still store data in legacy formats (scanned faxes, PDFs) that cannot be parsed by apps, despite mandates. Semantic interoperability is incomplete (different systems use different codes or free text), so data harmonization is hard. Privacy and security concerns must be managed; patients may hesitate to share sensitive data unless trust in the technology and protections is high. Finally, lacking a universal patient identifier or widely used identity platform means linking a patient's data across systems is nontrivial (underscoring CMS's interest in digital identity credentials).

In addition, policy gaps exist. The current Patient Access rule covers payers (Medicare Advantage, Medicaid, QHPs) but not all providers, so clinical data from fee-for-service doctors or hospitals may not flow as freely. Full interoperability will require continued rulemaking and enforcement. We believe creative solutions like a **shared clinical repository or state-level health data exchange** (as recommended by Humana) could greatly accelerate data flow. For example, a standardized statewide health data hub would let any treating physician or insurer query a patient's complete history (with consent), avoiding information loss when patients change coverage.

In summary, CMS has already unlocked core data (claims, basic clinical) via APIs and is working to break down silos. Moving forward, expanding these channels to include richer clinical and non-clinical information (while ensuring privacy and ease-of-use) will unlock tremendous value for patients and innovators. Collaborating with organizations like SOMOS (which brings community-level insight and cultural expertise) can help CMS identify and address the most critical data gaps and build solutions that truly serve every Medicare beneficiary.

PC-9. Strengthening Blue Button: Expanding CMS Data Access for Smarter, Patient-Facing Apps

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

SOMOS Perspective

We strongly support CMS’s Blue Button initiative and recognizes its potential to transform digital health access for Medicare beneficiaries and their caregivers. However, to realize its full promise—especially for low-income, multilingual, and digitally underserved communities like those served by SOMOS—CMS must significantly broaden both the content and usability of the Blue Button 2.0 API. We believe CMS has an opportunity to build this into a true digital foundation for trusted, patient-facing applications, especially when deployed through culturally competent, community-embedded networks.

What Additional CMS Data Sources are Most Valuable for Inclusion in the API?

To enable apps that are truly useful to patients and their families, the following types of data should be prioritized for addition:

1. **Medicare Advantage (Part C) encounter data** – Including both outpatient and inpatient events. This is crucial for over 30 million beneficiaries in MA plans and would close a significant data gap.
2. **Part D medication fill history with real-time updates** – Apps could use this to send timely adherence reminders or detect dangerous drug interactions.
3. **Prior authorization and denial data** – Helps caregivers track what services have been delayed or denied and can support appeals or alternate care navigation.
4. **Supplemental Benefit utilization (e.g., dental, transportation, OTC, social needs supports)** – Essential for low-income Medicare populations, especially those dually eligible for Medicaid.
5. **Post-acute care (e.g., SNF, rehab, home health episodes)** – Enables better discharge planning and family coordination.
6. **Provider network directories with appointment availability** – Would allow apps to assist patients in finding in-network care, especially important in medically underserved neighborhoods.

7. **Quality ratings and outcomes at the provider or facility level** – Adds transparency for patients making care decisions, especially where language barriers otherwise limit research.
8. **Care plan information, risk scores, and CMS chronic care models** – These would allow community health workers and caregivers (via apps) to align better with the clinical care team.

Including these data types would greatly enhance patient engagement, safety, and self-management—especially for high-need, high-risk populations.

Difficulties Accessing or Utilizing These Data Sources

From SOMOS’s experience, the following barriers persist:

- **Limited data scope** – Blue Button 2.0 currently excludes MA and Part D real-time data, which are especially relevant in densely urban, Medicaid-aligned populations where most Medicare beneficiaries are in managed care.
- **Inconsistent data quality and delays** – Claims-based data often lag by weeks or months, reducing their usefulness for real-time care coordination.
- **Technical complexity** – Despite the FHIR standard, many community providers and developers lack the resources or know-how to integrate with the API without significant assistance.
- **Authentication challenges** – Login.gov and ID.me are not yet fully trusted or easy to use for older adults with limited digital literacy. Many patients have difficulty completing identity verification, especially non-English speakers or those without formal documentation.
- **Lack of caregiver access frameworks** – There are few clear pathways for authorized family members or home care aides to access Blue Button data on a patient’s behalf, despite widespread need.
- **Fragmentation between CMS systems** – Developers must navigate multiple endpoints and documentation sources (Blue Button, Medicare Plan Finder, Care Compare, etc.) without a unified portal.

These issues disproportionately affect community-based organizations serving diverse populations—precisely those that could benefit most from high-quality, patient-facing digital tools.

Improving the Blue Button 2.0 API Experience

SOMOS offers the following recommendations to CMS:

1. **Unify CMS data APIs** – Create a consolidated data gateway or developer hub that allows applications to access all beneficiary-authorized CMS data (Part A–D, MA, supplemental benefits, etc.) from a single authentication and access point.

2. **Expand access to MA and Part D data** – Prioritize real-time data feeds from MA plans and pharmacy benefit managers to the API. Partner with MA plans to ensure robust updates.
3. **Streamline patient authentication** – Simplify Login.gov onboarding (especially for limited-English speakers). Offer paper-based or assisted sign-up pathways through trusted providers or community health workers.
4. **Support caregiver access** – Develop a CMS-recognized proxy access framework that enables secure, authorized sharing of data with designated caregivers. SOMOS stands ready to pilot this model in our senior population.
5. **Offer developer grants and technical support** – Fund technical assistance and open-source SDKs to help smaller innovators (including community-based orgs) integrate Blue Button 2.0 without high cost.
6. **Enhance documentation and transparency** – Ensure real-time status updates on API outages, changes, or delays. Maintain version control with robust changelogs for developers.
7. **Allow patient-friendly data customization** – Let patients define what they share (e.g., only medications, or only most recent visit summaries), promoting trust and data minimization.

By adopting these improvements, CMS would not only make Blue Button more functional—it would make it equitable.

Is There Non-CMS Data that Should Be Included in the API?

Yes. While CMS does not own these data, it can facilitate **federated inclusion** or **integration pathways** for:

- **State Medicaid data for dually eligible individuals** – Allow seamless cross-sharing of Medicare and Medicaid claims and service utilization data. This would support integrated care models like D-SNPs or ACO REACH entities.
- **Social determinants of health data** – Including housing assistance use, food insecurity screening results, or non-medical transport coordination. These datasets may live in state or community-level systems (e.g., 211, CBO platforms) but could be referenced or federated via Blue Button.
- **Veterans Health Administration data** – For dual VA-Medicare users, allow consented sharing of medications and care plans.
- **Home health technology and remote monitoring feeds** – Incorporate standards that allow PGHD (patient-generated health data) like wearables, Bluetooth devices, or symptom diaries into the CMS API network if patients authorize it.

CMS could create “extension points” within the API that recognize and link to these datasets via common frameworks such as TEFCA, FHIR, and USCDI+.

In conclusion, Blue Button 2.0 is a powerful start—but much of its potential remains untapped, especially for community-dwelling Medicare beneficiaries who would benefit from caregiver support, culturally sensitive digital tools, and real-time access to health information.

SOMOS is uniquely positioned to work with CMS in bridging these gaps. As a trusted, culturally competent care network already engaged in digital transformation, we can help pilot improvements to the Blue Button API, test new caregiver access frameworks, and drive equitable adoption of digital health tools. We strongly encourage CMS to continue investing in Blue Button’s evolution—not just as a technology, but as a **community-enabling health equity initiative**.

PC-10. TEFCA's Role in Patient Access

Question: *“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. b. What changes would you suggest? c. What use cases could have a significant impact if implemented through TEFCA? d. What standards are you aware of that are currently working well to advance access and existing exchange purposes? e. What standards are you aware of that are not currently in wide use, but could improve data access and integration? f. Are there redundant standards, protocols, or channels that should be consolidated? g. Are there adequate alternatives outside of TEFCA for achieving widespread patient access to their health information?”*

SOMOS Perspective

TEFCA – being in early stages of implementation – has had **minimal direct impact on patient access to date** in our real-world setting. As of now (mid-2025), the TEFCA framework is just beginning to onboard Qualified Health Information Networks (QHINs) and operationalize exchange. Most patients and frontline providers are not yet aware of TEFCA, and its benefits have not trickled down to everyday care in our community **yet**.

Current State

In practice, patient access to health information in our network still relies on existing mechanisms: provider patient portals, the use of Blue Button for Medicare data, and regional HIE patient portals (in New York, the state HIE allows patients to request a copy of their aggregated record). TEFCA is not yet the conduit for these. For example, when a patient in our ACO wants to gather their records from a hospital and a primary care office, we use the State Health Information Network (SHIN-NY) or direct release of information – TEFCA's nascent network of QHINs hasn't been involved, because many local providers/hospitals haven't joined a QHIN as of now.

Potential and Emerging Examples

We anticipate TEFCA's **Individual Access Services (IAS)** will be a game-changer once operational. TEFCA explicitly envisions that individuals (via an app or third-party) can access their health information from all participating networks. In theory, a patient-authorized app could query a QHIN and retrieve records from any other QHIN/hospital nationwide that participates. This would be a substantial improvement over today's patchwork of portal-by-portal access.

One example on the horizon: A Medicare beneficiary who moves from New York to Florida could use a TEFCA-enabled app to gather their NY records (from our SOMOS network via the QHIN our HIE joins) and their new providers' records in Florida (via whichever QHIN those providers join). TEFCA's common agreement ensures **uniform trust and standards**, so the

patient doesn't have to navigate separate trust agreements with each provider – the QHIN-to-QHIN query handles it. This is *theoretically* possible in late 2024/2025 as QHINs like Epic's or Health Gorilla's begin offering individual access. However, we do not yet have a concrete success story to cite because this functionality is in pilot phase. We are monitoring the TEFCA pilot projects closely.

Challenges Noted

Why no real-world impact yet? Firstly, **awareness and connection**: Providers and HIEs must connect to QHINs. Our regional HIE is planning to onboard to TEFCA, but technical and legal onboarding takes time. Until that is done, patients in our area can't leverage TEFCA – they continue to rely on state HIE portals or fax/email requests for cross-network data. Secondly, **patient-facing apps** need to plug into TEFCA. As of now, few consumer apps are TEFCA-enabled. Over the next year, we expect personal health record apps will become "TEFCA Participants" through an IAS Provider, but it's at inception.

Recommendations to Advance Patient Access via TEFCA

- **Accelerate IAS Implementation:** CMS and ONC should prioritize the Individual Access component of TEFCA. For example, fast-track approvals for consumer-facing QHIN use cases and provide guidance to networks on how to authenticate and log patient queries. Simplified patient consent flows for TEFCA queries will be needed so that it's user-friendly (e.g., a one-time identity verification then broad access, as opposed to repeated complex consents).
- **Integrate TEFCA into Medicare Tools:** CMS can integrate TEFCA into existing platforms. Imagine if the Medicare Blue Button 2.0 app (or MyMedicare.gov portal) became TEFCA-enabled – a beneficiary could log in and retrieve clinical records from all TEFCA networks in addition to claims. This government-facilitated approach could jump-start usage and show an immediate benefit to patients.
- **Outreach and Education:** As QHINs go live, HHS should publicize early wins. For example, if a patient manages to successfully aggregate nationwide records via TEFCA in a pilot, that story should be shared to build public and provider confidence. We also encourage ONC to create patient-friendly explainer materials about TEFCA: many patients would not know to ask for their "TEFCA access" rights. Education must filter down to the front desk staff and medical records departments too – they should know that if a patient's app requests data via TEFCA, it is a legitimate and encouraged method to comply with (instead of treating it as a suspicious third-party request).

Several existing standards are functioning well in enabling health information exchange and advancing patient access, particularly when they are implemented consistently and supported by user-friendly infrastructure:

- **FHIR (Fast Healthcare Interoperability Resources):** FHIR, especially the US Core Implementation Guide, is a key standard for real-time data exchange and patient app

connectivity. It has allowed for successful implementation of **patient-facing apps**, provider-provider data sharing, and structured clinical data access. FHIR's granular, modular format makes it adaptable to emerging use cases like price transparency and scheduling.

- **Direct Secure Messaging:** Widely adopted across EHRs, Direct Messaging under the **DirectTrust framework** facilitates secure transmission of clinical summaries (e.g., CCDAs) between providers and is used by care teams within SOMOS. It supports referral workflows, discharge follow-ups, and continuity of care documentation.
- **HL7 v2 for ADT (Admission, Discharge, Transfer) messages:** These messages underpin real-time hospital alerts in Health Information Exchanges (HIEs), enabling timely care coordination for SOMOS providers and population health teams.
- **USCDI (U.S. Core Data for Interoperability):** USCDI v1 and v2 provide a consistent structure for what data must be shared (e.g., labs, meds, allergies, problems), helping standardize record-sharing across EHR vendors. Widespread use of USCDI ensures baseline consistency for patients accessing their records across systems.

These standards work well **when paired with policy enforcement and infrastructure investment**. However, many benefits have yet to reach underserved communities due to uneven adoption and integration.

There are several underutilized or emerging standards that could significantly improve patient access, data portability, and care coordination if more widely adopted:

- **FHIR Bulk Data / Flat FHIR (Flat-File Exports):** These support large-scale population-level data extraction (e.g., for ACOs or research) and patient-authorized longitudinal record sharing. Today, these standards are underused due to technical complexity and lack of incentives, but they could support comprehensive patient-directed downloads and value-based analytics.
- **FHIR Subscriptions:** This standard enables real-time updates to subscribed systems or apps (e.g., a patient or provider could subscribe to medication changes or new lab results). Adoption is low but offers huge potential for real-time alerts and engaged patient care through third-party tools.
- **SMART on FHIR:** While gaining traction, SMART on FHIR is not yet universal. It enables secure third-party app integration with EHR systems and could underpin patient-facing apps that query QHINs under TEFCA. Standardizing SMART app integration across QHINs would provide a user-friendly, plug-and-play interface for patients to retrieve data.
- **IHE Standards (e.g., XDS, XCA, XDR):** These are used more commonly in Europe and some U.S. HIEs. They support document sharing across organizations and could offer additional flexibility in TEFCA-based networks, especially for cross-border or cross-platform document access.
- **HL7 CarePlan / Goal / Task resources:** These resources, if implemented at scale, would support digital shared care planning, enabling patients and multiple providers to contribute to and view care plans collaboratively.

Adoption of these emerging standards would be transformative for **multi-system care coordination, digital health innovation, and patient-directed interoperability**, especially in diverse and high-need populations served by SOMOS.

The current landscape includes several overlapping or redundant standards and patient access channels that create confusion, inefficiencies, and unnecessary costs. Key areas for consolidation include:

- **Redundancy between C-CDA (Consolidated Clinical Document Architecture) and FHIR:** Both are used to transmit clinical summaries, but FHIR offers greater flexibility, app integration, and user experience potential. Consolidating toward FHIR-based exchange for patient access would simplify development and improve real-time functionality.
- **Multiple provider-specific patient portals:** Many patients, especially those with chronic conditions or who see multiple providers, must navigate different EHR portals. These portals often have non-standardized formats and limited historical data, creating a “portal fatigue” problem. TEFCA should enable federated access that renders these fragmented portals optional or secondary to a single-source patient-directed query system.
- **Multiple routing protocols (Direct, XDR, FHIR, Query-Based Exchange):** These exist concurrently in many systems, but each requires its own implementation and governance. TEFCA could encourage standardized endpoint discovery and routing protocols to reduce operational complexity and ensure consistent exchange behaviors.
- **Manual data release channels (fax, PDFs, CDs):** These are still used in many provider settings, particularly safety-net providers. TEFCA implementation should come with clear policies to retire or minimize manual methods in favor of interoperable, real-time digital exchange where technically feasible.

Consolidation around FHIR, SMART on FHIR, and QHIN-enabled federated query standards could help remove barriers, reduce duplicative infrastructure, and offer a more **intuitive, consistent experience** for patients and app developers.

There are alternatives—but none currently match the scale, uniformity, or trust structure that TEFCA is designed to offer. These include:

- **CMS Blue Button 2.0:** This provides Medicare beneficiaries with access to claims and coverage data. It’s valuable but limited to Medicare data and doesn’t include full clinical records.
- **EHR Vendor APIs (per Cures Act):** Many certified EHRs now support FHIR APIs that allow third-party patient apps to access clinical data. This has helped support personal health record (PHR) apps (e.g., Apple Health), but access is fragmented across vendors, and data completeness varies by provider.
- **State and Regional HIE Portals:** In New York, for example, SHIN-NY allows patients to request a view of their aggregated records across providers. However, enrollment is often burdensome, and access is not real-time or app-integrated.
- **Health App Aggregators (e.g., Apple Health, MyChart):** These aggregate data from different providers or EHRs, but coverage is limited to systems that support integration,

and record formats are inconsistent. They also generally lack support for non-English speakers or non-tech-savvy users, which impacts equity.

While these tools are important and should remain in use, TEFCA offers the opportunity to **unify access under one trust and technical framework**, giving patients and caregivers **standardized, nationwide, cross-provider visibility** into their health records. This is especially critical for populations like those served by SOMOS, who often move across systems and require **coordinated care across fragmented providers**.

In Summary

TEFCA's promise for patient access is enormous – a **unified, nationwide highway for health data** that patients can ride on to gather their records. At present, the highway is still under construction; thus, real-world patient use is minimal. We expect that over the next 12-24 months, as more networks join and consumer apps connect, we will begin to see concrete improvements. SOMOS is preparing for this: we intend to connect our data infrastructure to a QHIN so that when patients use TEFCA-enabled apps, our providers' data will flow to them with consent. Our hope is that by the time TEFCA is fully realized, patients will no longer face the frustrating "portal safari" to hunt down their records – one standardized network query will do it. We encourage CMS/ONC to continue heavily supporting TEFCA as a **key enabler of patient-centric interoperability**, while also ensuring it complements existing tools like Blue Button and doesn't leave any communities (or types of data) behind.

PC-11. Health Information Exchanges (HIEs) and Patient Access

Question: “How are health information exchanges (HIEs) currently helping to advance patient access to health information in the real world? a. How valuable, available, and accurate do you find the data they share to be? b. What changes would you suggest? c. Are there particular examples of high-performing HIE models that you believe should be propagated across markets? 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.)?”

SOMOS Perspective

Health Information Exchanges (HIEs) play a significant – albeit mostly indirect – role in advancing patient access to information. In our experience in New York, HIEs such as Healthix (the regional HIE) primarily facilitate **provider-to-provider exchange**, but they also have mechanisms for patient access that are slowly maturing.

Value and Accuracy of HIE Data

The data aggregated by HIEs is extremely valuable for **care coordination**. Our providers rely on the HIE to get timely information about care events outside our network – for instance, when one of our patients is admitted to or discharged from a hospital, the HIE often provides an alert and a summary. This data is generally accurate as it comes directly from source EHRs. It has enabled us to do things like medication reconciliation post-discharge and follow up on test results that were ordered by another facility. By improving provider knowledge, HIEs indirectly improve what information can be shared with patients – e.g., a primary care doctor who receives a hospital report via HIE can in turn discuss those findings with the patient at a follow-up visit.

However, direct **patient-facing value** is more limited so far. Some HIEs offer patient portals or the ability for patients to request a consolidated record. In New York, for example, patients can register with the HIE to view their community-wide record. Those who have used it appreciate seeing in one place the list of all their encounters, meds, etc., from different providers. The accuracy is generally high for demographics, diagnoses, lab results, etc., since HIEs often reconcile data from multiple sources. One caregiver told us that using the HIE portal gave her “the full picture” of her father’s treatments across different hospitals, which was reassuring and helpful in managing his care.

Availability and Adoption

Despite these capabilities, **patient adoption of HIE portals is extremely low** relative to provider use. In practice, few patients know about or use HIEs directly. The process to sign up can be cumbersome (involving identity verification) and awareness is minimal. Most HIEs historically focused on serving providers, not marketing to patients. Thus, the vast majority of

patients still get their info from provider portals rather than HIE, even if the HIE might have a more complete record.

Challenges

- *Awareness & Usability:* As noted, patients often simply do not know HIE access is an option. HIEs haven't invested heavily in user-friendly patient interfaces. Often the portal interfaces are clunky, not mobile-optimized, or only in English, posing barriers for our diverse patient population.
- *Consent Complexity:* By design, many HIEs require patient consent for providers to view data and separate consent for patient access. In New York, for instance, patients must opt-in for providers to see their data via HIE, and similarly enroll to see their own. These extra steps deter use. There are also nuances like specially protected data (HIV, behavioral health) requiring additional consent – this can result in incomplete data in the patient view if not handled properly, potentially confusing patients when something is omitted.
- *Timeliness:* While HIEs often have real-time or near-real-time updates from connected facilities, some data may lag or may not be present if a provider isn't connected. Patients might not understand the gaps (e.g., if a doctor's office isn't contributing data, those records won't show up). This can undermine confidence if not communicated.
- *Fragmentation:* Patients who cross state lines or different regions encounter multiple HIEs. Unlike a national network, HIEs tend to be regional. If a patient received care in two different states, they might have to access two separate HIE systems – which rarely happens in practice. This fragmentation is exactly what initiatives like TEFCA aim to solve, but until they do, HIEs alone can't ensure nationwide patient access.

Recommendations to CMS:

1. **Enhance Patient-Facing HIE Services:** HIEs should be encouraged (perhaps through ONC grant incentives or condition of TEFCA participation) to develop intuitive patient portals or integrate with popular health apps. If an HIE can plug into a patient's preferred app (with proper auth), the patient might use it more. Also, HIE data should ideally feed into the unified patient records discussed in PC-2 – HIEs could serve as the data brokers behind the scenes for patient-authorized queries. At SOMOS, we are actively working on integrating community-based digital platforms with HIE data to deliver a more seamless and accessible experience for patients, especially those from underserved populations.
2. **Education and Enrollment Campaigns:** CMS and state partners could work with HIEs to publicize patient access options. For example, at the time of Medicare Annual Wellness Visits, providers could give patients a one-page "Did you know you can view your full health record?" with instructions for HIE or other tools. Particularly in value-based programs, CMS could encourage ACOs to have a target percentage of patients enrolled in either an HIE or multi-provider portal. SOMOS is already implementing grassroots campaigns and provider training programs to educate both patients and clinicians on how to navigate and optimize these digital tools — ensuring high adoption rates and equitable access in the communities we serve.

3. **Data Quality and Completeness:** Ensure HIE data is as comprehensive as possible – including addressing any info blocking by data holders. The more complete and up-to-date the HIE data, the more useful it is to patients. CMS can continue supporting standardization (e.g., USCDI adoption by HIE interfaces) so that what patients see is understandable and not a jumble of different formats. SOMOS supports ongoing collaboration between payers, providers, and technology platforms to ensure data quality improvements reach the communities most in need of care coordination.
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High-Performing Models Worth Replicating

One HIE model worth propagating is **Healthix**, which supports the SOMOS network in New York City. Healthix integrates real-time alerts for admissions, discharges, and transitions of care across over 8,000 sites, including hospitals, clinics, behavioral health, and long-term care facilities. It also offers providers community health snapshots and patient summaries—especially useful for safety-net and multi-provider environments. While its patient-facing tools are still in development, the **back-end interoperability and cross-provider visibility** is exceptional.

Additionally, **New York’s SHIN-NY architecture** (the statewide network of connected RHIOs/HIEs) offers a replicable governance model: it supports a federated yet coordinated approach to data exchange, with consistent data-sharing protocols, consent policies, and minimum data standards. This framework has helped build public trust and system reliability.

Recommendations to CMS:

- CMS and ONC should explore supporting **regional public utility HIEs** that offer core interoperability services (alerts, summaries, analytics) and integrate with TEFCA as intermediaries. Supporting similar state-coordinated networks in other geographies would extend HIE functionality and patient access, especially in fragmented and underserved regions.
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The Role of HIEs in a TEFCA and Vendor Network Environment

As TEFCA and large vendor-led exchanges (e.g., Epic’s Care Everywhere, CommonWell, eHealth Exchange) expand, HIEs still play a **critical, non-redundant role**, particularly in public health and community care integration.

Distinct Functions of HIEs:

- **Local coverage of small and independent providers** not typically integrated into commercial vendor networks
- **Support for Medicaid and safety-net populations**, including integration of social and behavioral health data

- **State-specific functions** such as mandated public health reporting, immunization registries, and vital records
- **Community-level care coordination**, often through alerts and real-time updates that don't exist in national vendor exchanges

In our experience at SOMOS, HIEs like Healthix are often **the only way to view cross-provider data** in real-time for safety-net patients. These HIEs also partner with community-based organizations and social service providers, which are not included in private exchanges.

Relationship with TEFCA

HIEs should be empowered to act as **Participants or Subparticipants under QHINs**, bridging local providers into the national network. Rather than replacing HIEs, TEFCA can enhance their reach. However, this will require:

- **Technical and financial support** to help HIEs onboard to QHINs
 - **Clarity in roles** to avoid duplication or competition with private exchanges
 - **Recognition of unique local services** HIEs provide (alerts, social care data, community health analytics)
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Conclusion and Call to Action

HIEs are not redundant—they are indispensable allies in achieving equitable, whole-person interoperability. CMS and ONC should strengthen, not supplant, their role within the national architecture.

In summary, HIEs **help patient access indirectly today** by empowering providers with information, and have the infrastructure to offer direct patient access but need greater focus on usability and awareness. They contain valuable data (we trust the accuracy for clinical content) and could be a cornerstone of patient-facing interoperability if properly leveraged. The main challenge is that current HIE patient-access channels are underutilized. By integrating HIEs into the broader national framework (like TEFCA) and focusing on patient-friendly design, HIEs can transition from a backend provider tool to a more visible **asset for patients** managing their health. SOMOS exemplifies how trusted, community-rooted networks can serve as a scalable model for activating HIE-based tools that are inclusive, equitable, and aligned with patient-centered care goals.

PC-12. Key Data Use Cases for Patients and Competition

Question: “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? a. Examples may include the following: (1) Binding cost estimates for pre-defined periods. (2) Viewing provider schedule availability. (3) Using third-party apps for appointment management. (4) Accessing patient-facing quality metrics. (5) Finding the right provider for specific healthcare needs. b. What use cases are possible today? c. What should be possible in the near future? d. What would be very valuable but may be very hard to achieve?”

SOMOS Perspective

There are several high-impact **data use cases** that would greatly benefit patients/caregivers and simultaneously promote a more efficient, competitive healthcare marketplace. We highlight a few priority use cases and how addressing them can improve care navigation and foster provider competition:

1. Cross-Provider Appointment Scheduling & Provider Discovery:

- *Use case:* A patient needs to find a specialist (e.g., a dermatologist) and schedule an appointment, ideally with insight into availability, quality, and cost. Currently, patients face siloed scheduling systems and often rely on referrals without transparent data. If a digital solution allowed patients to **search for providers across systems, view comparative data (ratings, quality metrics), and book appointments directly**, it would greatly streamline care navigation. This also promotes competition – providers offering better access (earlier appointments) and quality would attract more patients.
- **SOMOS implementation:** We are working to integrate multi-provider scheduling tools into our patient-facing platforms and actively advocate for APIs that unlock availability and quality data. This empowers our care managers and patients to make timely, informed choices—especially important for Medicaid beneficiaries navigating fragmented systems.
- *Eliminating barrier:* Today’s barrier is that scheduling data and quality metrics aren’t easily accessible in one place. Policies enabling a **nationwide provider directory with scheduling APIs** (tied to VB-15 discussion) and public-facing quality scores would allow new services to emerge where patients can shop for care in an informed way. This is analogous to how travel websites transformed booking flights/hotels by aggregating options; healthcare needs an equivalent. Efficient navigation (patients get the right care faster) and competition (providers compete on convenience and quality) would both improve.

2. Real-Time Price Transparency for Shoppable Services:

- *Use case:* Before getting a non-emergency service (MRI, elective surgery), a patient wants to compare out-of-pocket costs at different facilities. If patients and caregivers had

easy access to **personalized cost estimates** (based on their insurance) in real time, they could choose high-value providers. This encourages providers to compete on cost and quality. Right now, even though hospitals and insurers publish data files (per price transparency rules), it's not easily consumable for an average patient. Building user-friendly tools or integrating cost data into the point of referral (e.g., when a doctor orders an MRI, a tool shows the patient “Facility A: \$300, Facility B: \$500, with your insurance”) would empower patients.

- **SOMOS implementation:** In our network, SOMOS care managers already provide this information manually—helping patients choose high-value providers based on cost and quality. However, this process is labor-intensive and unsustainable at scale. Automating it through interoperable APIs would unlock better decision-making system-wide.
- **Eliminating barrier:** Many patients stick with the provider or facility suggested by their doctor or nearest to them, because it's too hard to find alternatives. Effective use of data (via APIs pulling insurer price info, see TD-19) would remove that barrier – **patients could “shop” without leaving the exam room.** This fosters competition as lower-cost, high-quality providers will draw more patients if the data is transparent. We note that in our community, when we proactively inform patients about lower-cost imaging centers versus hospital imaging (with no quality difference), many choose the lower-cost option – but that only happens because our care managers manually provide that info. Automating and scaling this via data would be game-changing.

3. Unified Medication Management and Reconciliation:

- **Use case:** A caregiver can use an app to see all medications a patient is on, who prescribed them, and get alerts for potential interactions or duplications. If such data (from various prescribers and pharmacies) is aggregated and kept up-to-date, patients can avoid errors and more easily switch providers or pharmacies (competition) since their medication history follows them. This use case requires interoperability between EHRs and pharmacy systems.
- **SOMOS implementation:** SOMOS is investing in solutions that aggregate medication data across systems and make it accessible to both patients and providers through unified portals. This improves medication adherence, safety, and portability—especially critical for seniors and multilingual patients.
- **Eliminating barrier:** Right now, if a patient goes to a new provider, that provider might not know all the patient's meds if they weren't the prescriber – and patients often can't recall everything. A complete med list via data exchange (e.g., via FHIR or HIE query) given to patients ensures continuity and reduces adverse events. It also means a patient isn't “locked in” to one provider because they fear others won't know their history. This fosters a competitive environment where providers must earn loyalty by quality and service, not by holding the patient's data hostage.

4. Portable “Digital Second Opinion” Records:

- **Use case:** A patient with a complex diagnosis wants a second opinion at another health system. An ideal scenario is the patient can easily **share their entire medical record** (imaging, labs, genomic data, etc.) with the second-opinion provider digitally. If that

becomes routine, it lowers barriers to seeking care from competing providers (the patient doesn't have to physically collect and deliver records). It encourages providers to accept and compete for informed patients.

- **SOMOS implementation:** We routinely assist patients seeking outside consultation by aggregating digital records on their behalf. Making this capability patient-driven, seamless, and real-time would expand patient autonomy and foster provider accountability.
- **Eliminating barrier:** Historically, inertia and records transfer hassle keep patients from switching doctors or going for second opinions. Through enforcement of data portability (via Cures Act and TEFCA), this barrier can diminish – leading providers to compete on outcomes and patient experience rather than relying on patient stickiness due to data silos.

5. Care Plan Portability and Care Coordination Tools:

- **Use case:** Patients with chronic conditions often have a care plan (treatment goals, instructions) created by one provider. If that care plan could be digitally shared and updated among all caregivers and accessible to the patient, it would improve navigation (everyone on the same page). It also levels the field as different providers or services coordinate – e.g., home health agencies, specialists, primary care – reducing fragmentation. This isn't competition in the traditional sense, but it eliminates barriers like duplicated or conflicting instructions, which can cause patients to lose trust and stick with a suboptimal provider out of confusion. A clear, shared care plan data set (supported by standards like HL7 care plan) would empower patients to move between care settings without losing continuity.
- **SOMOS implementation:** SOMOS care coordinators already create and maintain shared care plans for high-risk patients and ensure they are understood across primary, specialty, and social care services. Expanding the use of HL7-compliant tools and enabling patients to access and contribute to these plans would further enhance care continuity and trust.
- **Eliminating barrier:** Disconnected providers and conflicting instructions erode trust and efficiency. A digital, portable care plan fosters informed transitions and encourages providers to collaborate rather than compete through gatekeeping.

Recommendations to CMS

To address these use cases, **policy and standards need to evolve**. We recommend that CMS/ONC:

- Invest in **standards and pilot programs** for scheduling and price transparency APIs (tie in with PR-4 and TD-5/TD-19 responses). For example, require providers participating in Medicare to publish a basic scheduling interface or respond to appointment availability queries (perhaps starting with primary care and certain specialists).
- **Augment existing price transparency rules** with a patient-centric lens: encourage or fund the development of consumer comparison tools that ingest insurer and hospital data.

The raw data exists (in files) per current rules, but CMS could support transforming it into actionable information for patients. This might involve standardizing data fields across insurers to ease app development. SOMOS would welcome pilot opportunities to test such tools within safety-net communities.

- Enhance **data portability enforcement**: The Cures Act gives patients the right to their records. CMS could measure how often patients actually obtain and use their records (for second opinions, etc.) and identify friction points. Reducing fees for record transfer and mandating use of standardized electronic formats (no more PDFs of scans unless necessary) would smooth this use case.
- Promote **universal medication and care plan data sharing**: Work with stakeholders like NCPDP (pharmacy standard body) and ONC to ensure medication data (e.g., via FHIR MedicationList resources) can flow to any provider or patient app with consent. Similarly, encourage providers to use interoperable care plan standards and share them across settings. At SOMOS, we see this as foundational to true whole-person, whole-community care.

Cases Possible Today

Several impactful use cases are *technically possible today*, but implementation is fragmented, usability is low, and scalability is limited, especially for underserved populations:

1. **View Provider Schedule Availability (Limited)**
 - Some large systems allow online scheduling through patient portals or apps (e.g., MyChart). However, this only works *within* that system. There is no unified directory or cross-provider visibility.
 - *In SOMOS's experience, most Medicaid patients rely on **phone-based appointment coordination** or **care manager assistance**, particularly for specialists and diagnostic services outside their medical home.*
2. **Real-Time Price Transparency for Shoppable Services (Theoretically Possible, Not Usable)**
 - Hospitals and payers are required to publish machine-readable files of negotiated rates and cost estimates.
 - However, patients cannot easily interpret these files. There are no widely available **integrated tools** that give a personalized estimate at the point of care (e.g., based on their plan, deductible, and location).
 - *At SOMOS, care managers manually search payer portals or call providers to offer cost information, which is **labor-intensive and unsustainable**.*
3. **Digital Second Opinion via Health Records Transfer (Possible in Limited Cases)**
 - The Cures Act enables patients to request electronic access to their medical records.
 - However, transferring full imaging studies, genomic files, or surgical reports remains complicated. Many systems still require **fax, CD-ROMs, or in-person pickups**.

- *At SOMOS, staff assist patients directly, but most cannot independently access or transmit their full longitudinal record in usable formats.*
- 4. **Medication List Aggregation (Partial)**
 - Many EHRs show medication lists, and payers have pharmacy claims. But there's no **consolidated, patient-facing view** that combines meds from different prescribers and pharmacies.
 - *At SOMOS, providers use HIE queries and direct reconciliation, but patients lack direct tools unless tethered to a specific EHR.*
- 5. **Third-Party App Access (Emerging)**
 - With SMART on FHIR APIs now mandated under the Cures Act, patients can link apps (e.g., Apple Health, MyLinks) to their provider's API.
 - However, **app adoption is low**, especially in Medicaid populations. Many providers have not enabled full functionality, and apps are often not multilingual or health-literate.

While the technical pathways for these use cases exist, **lack of standardization, patient-friendly tools, and ecosystem readiness** limits their real-world value—particularly for vulnerable populations served by SOMOS.

Possibilities in the Near Future

Within the next 1–3 years, the following use cases should be achievable at scale, particularly with ongoing federal investments in TEFCA, Cures Act enforcement, and health equity innovation:

1. **Federated Provider Discovery & Scheduling**
 - Patients should be able to search for providers across systems using a **unified interface** that includes:
 - Real-time appointment availability
 - Insurance participation
 - Quality and cost data
 - Patient reviews or satisfaction scores
 - A “**healthcare search engine**” backed by open scheduling APIs and provider directories should be as easy to use as Expedia or Uber.
2. **Point-of-Care Price Estimates**
 - Tools should integrate payer pricing data with patient-specific benefit information to show real-time out-of-pocket estimates at the time of referral or service ordering.
 - For example: when a doctor refers a patient for an MRI, a tool shows “Imaging Center A – \$90 / Imaging Center B – \$220” with quality ratings.
 - CMS and ONC could catalyze this via **standardized APIs across payers**, similar to the Blue Button model.
3. **Universal, Real-Time Medication Reconciliation**
 - Patients and providers should both have access to a **consolidated, up-to-date medication list** with alerts for interactions or duplications.

- This should combine pharmacy fills (from PBMs), prescribing records (from EHRs), and even self-reported use.
- FHIR-based MedicationList resources can enable this if supported across networks.
- 4. **Fully Digital Second Opinion Workflow**
 - Patients should be able to initiate second-opinion consultations with **fully digital record sharing**, including:
 - Imaging, labs, operative notes, genetic data
 - Consent and identity verification
 - Scheduling and report return
 - TEFCA-enabled apps and QHIN-to-QHIN exchange can operationalize this.
- 5. **Shared, Interoperable Care Plans**
 - Patients with chronic or complex conditions should have **a longitudinal care plan** that is:
 - Shared across providers
 - Editable in real time
 - Viewable by the patient and family
 - HL7 FHIR CarePlan and Goal resources, paired with TEFCA exchange, could deliver this functionality.

SOMOS Role: We are piloting several of these use cases, including digital care plans, medication reconciliation platforms, and provider search tools, but federal leadership is needed to scale them nationally.

Achieving the Very Valuable But Very Hard

Some use cases offer immense value for patients and system transformation, but are complex, politically sensitive, or technically difficult to realize in the short term:

1. **Binding, Personalized Cost Guarantees**
 - Patients want to know: *What will this service cost me—guaranteed?*
 - This requires:
 - Real-time benefit checks across multiple payers
 - Integration of negotiated rates, benefit design, and patient balance status
 - A contractual commitment from the provider
 - While this is the “holy grail” of transparency, **variability in insurance, medical necessity, and provider workflows make it challenging** to operationalize.
2. **Integrated Quality Ratings at the Clinician Level**
 - Patients want to compare doctors based on outcomes, safety, and satisfaction.
 - Most existing ratings (e.g., CMS star ratings) are at the hospital level, outdated, or not risk-adjusted.
 - Developing **accurate, fair, and comprehensible metrics** that reflect individual providers is a technical, political, and methodological challenge.
3. **Dynamic Consent and Data Portability Dashboards**

- Patients should be able to **manage access to their data**, track who has viewed it, and revoke access in real time.
 - This requires a **consumer-grade identity and access management system** for health data—akin to how users manage permissions in Google or Apple ecosystems.
 - TEFCA, SMART on FHIR, and OAuth offer a foundation, but few systems are ready to implement dynamic consent at scale.
4. **Multi-System EHR Portability**
- Allowing patients to transfer not just their *data*, but their *entire longitudinal health record* (encounters, notes, care plans, preferences) from one EHR to another seamlessly.
 - Technically difficult due to proprietary data models, incompatible workflows, and regulatory friction.
5. **Comprehensive Patient Matching Across Systems**
- Reliable patient matching is still a challenge across EHRs, payers, and HIEs—especially for immigrant, low-income, and mobile populations.
 - Without a **universal patient identifier**, cross-system navigation remains prone to error.

While difficult, these use cases represent **the next frontier of patient autonomy, interoperability, and market responsiveness**. Federal innovation funds, standards alignment, and public-private pilots will be essential to make them real.

Conclusion and Call to Action

In summary, by focusing on these high-impact scenarios – scheduling choice, price transparency, medication and care plan portability – CMS can greatly improve **care navigation efficiency** for patients. They will find the right care at the right time more easily, and providers will have to improve quality and cost-effectiveness to attract and retain patients in a transparent environment. In essence, data fluidity underpins a truly **patient-centered and competitive health system**. At SOMOS, we are already implementing many of these practices and stand ready to scale them further.

Information Blocking & Digital Identity

PC-13 through PC-14

PC-13. Encouraging Patient Reporting of Information Blocking

Question: *“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?”*

SOMOS Perspective

Encouraging patients to report information blocking can be a powerful strategy to enforce the data-sharing requirements of the 21st Century Cures Act. However, it must be done carefully to be constructive.

How to Encourage Reporting

- **Raise Awareness of Patient Data Rights:** Many patients do not even know what “information blocking” means. CMS can start by launching an educational initiative explaining that patients have a legal right to access their health data electronically and timely. This should be done in plain language and multiple languages. For example, Medicare could include a leaflet in the annual Medicare & You handbook about accessing your records and how to report issues. Provider offices should display posters or notices (similar to Patient Bill of Rights) saying “You have a right to your health information. If you are denied access or face delays beyond X days, you can report it.”
 - **Simplify the Complaint Process:** The ONC Information Blocking Portal should be very user-friendly for patients and caregivers. Currently, filing a report might seem daunting – the portal could be streamlined with a guided form specifically for patients (versus one geared to health IT developers). CMS could collaborate with ONC to ensure complaint forms avoid heavy jargon. Perhaps create a **mobile-friendly form or even a hotline** for those not comfortable online.
 - **Provider and Payer Involvement:** CMS could require or encourage payers and providers to inform patients of the complaint mechanism at the point of a potential issue. For instance, if a provider declines a patient’s request for records, they should in the denial letter or email include: “If you believe your request has been improperly denied or delayed, you may file a complaint at ...”. Similarly, EHR patient portals could have a link like “Having trouble accessing something? Click here to notify authorities.” This might seem adversarial, but if framed positively (“We are committed to transparency, here’s how to get help if you need it”), it can be normalized.
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Expected Impact of Increased Reporting

- **Advancing Data Exchange:** In the long run, more patient complaints can **accelerate culture change and compliance**. When providers and health IT vendors know that patients are watching and willing to report, they will more diligently avoid practices that

could be construed as blocking. Increased complaints will give ONC and OIG concrete evidence to identify problem areas – e.g., if many patients report a particular hospital never provides electronic records, that’s a red flag to investigate and enforce. Essentially, it crowdsources enforcement, extending ONC’s visibility. This should advance data exchange by bringing to light where the bottlenecks are (be it fees, delays, formats, etc.). It also empowers patients – they feel ownership of their data rights.

- *Potential Downsides:* There is a risk of **over-reporting or misdirected complaints**. Patients might file complaints for things that are not truly “information blocking” as defined (for example, frustration with a portal user interface or a legitimate delay due to an unusual legal exception). This could burden ONC’s complaint processing and potentially flood the system with noise. It could also strain provider-patient relationships if, say, a patient files a complaint when perhaps a simple clarification was needed. Additionally, if not handled properly, an increase in complaints might make some providers defensive or less cooperative (“afraid” of patients complaining, possibly leading to excessive caution in documentation sharing).

To mitigate negatives, CMS/ONC should ensure **clear guidance on what to report**. Educational materials should outline examples of info blocking (e.g., “Your doctor’s office refuses to give you a copy of your lab results or demands an unreasonable fee for it, or says they won’t share with your health app despite your request”). Also highlight what is *not* a violation (e.g., an hour delay in portal posting might not be, or if data is withheld due to privacy law like a mental health note – so patients have proper expectations). ONC can triage complaints, filtering out those not applicable, and also use them as teachable moments (e.g., respond to patient and provider explaining the rule).

- *Enforcement Balance:* Importantly, increased reporting must be met with timely investigation and, when appropriate, consequences. If patients keep reporting and see no action, it could erode trust. Conversely, if enforcement actions are publicized (de-identified or in aggregate), it will reinforce the importance of compliance. The agencies have signaled an interest in stricter info blocking enforcement – patient complaints can be a catalyst for that.

Conclusion and Call to Action

We support measures to encourage patient reporting as a means to uphold transparency. In our own network, we strive to educate patients about their health data rights. We view potential complaints not as an attack, but as feedback to improve. CMS might consider a **“no retaliation” assurance** so patients (and providers) feel safe reporting – similar to whistleblower protections.

Overall, **increasing patient and caregiver engagement in flagging information blocking will likely advance data exchange**. It shines a light on real-world obstacles and holds actors accountable. Provided the process is accessible and well-guided, the upsides (greater compliance and data flow) outweigh the downsides. The healthcare system will move closer to a transparent, patient-centered model where blocking is socially and legally unacceptable, which is exactly

what Congress intended under the Cures Act. CMS and ONC should therefore not only allow but **proactively invite patient complaints** as a quality improvement tool for nationwide interoperability.

PC-14. Digital Identity Credentials for Patients

Question: “Regarding digital identity credentials (e.g., CLEAR, Login.gov, ID.me, other NIST 800-63-3 IAL2/AAL2 credentialing service providers): a. What are the challenges today in getting patients/caregivers to sign up and use digital identity credentials? b. What could be the benefits if digital identity credentials were more widely used? c. What are potential downsides? d. How would encouraging use of CSPs improve access to health info? e. What role should CMS/payers, providers, and app developers have in driving adoption? f. How can CMS encourage patients to get digital identity credentials?”

SOMOS Perspective

Digital identity credentials (high-assurance, reusable login services) hold great promise for simplifying patient access to multiple health systems. Implementations like **Login.gov** or **ID.me** can allow one secure account to serve across many platforms. However, adoption in healthcare has been slow. We address these perspectives in the following parts.

Challenges in Getting Patients/Caregivers to Sign Up and Use These Credentials

- **Awareness & Trust:** Most patients are not aware of digital identity credential services in a healthcare context. They may have encountered ID.me for, say, IRS or VA login, but not necessarily for Medicare or their hospital. There is also skepticism – patients might be wary of providing sensitive personal information (Social Security number, photo ID) to verify their identity online. Trust in government or third-party identity providers varies; for example, some communities we serve are concerned about immigration status or privacy and may avoid services that feel “official” or intrusive.
- **Onboarding Friction:** The process to obtain a high-assurance credential (IAL2 per NIST) often involves multiple steps: providing personal info, answering credit history questions or uploading documents, possibly even a live selfie or in-person verification. This can be daunting for less tech-savvy individuals. Any failure in the process (say, their credit file is thin so questions can’t be generated) leads to dropout. For caregivers, it’s also unclear how to obtain credentials that link to their loved ones (the identity systems are individual-focused, so sharing or proxy access is complicated).
- **Multiplicity & Fragmentation:** We ironically have multiple “one ID” solutions. Some patients have a Login.gov for federal services, an ID.me for veterans benefits, maybe a state-level health ID for Medicaid, etc. If different providers or payers each endorse a different one, it defeats the purpose of one credential. This patchwork confuses patients. They might wonder, “Why do I need another account? I already have a portal login.” Without a clear universal choice, many stick to old ways.
- **Lack of Integration:** Few healthcare systems currently allow patients to use these federated IDs in lieu of site-specific accounts. If a patient doesn’t see an immediate use case (“where can I use this Login.gov to actually access my records?”), they won’t bother

obtaining it. The value proposition needs to be evident: one login for all your health needs.

Benefits if Digital Identity Credentials Were Widely Used

- **Convenience and Access:** The most obvious benefit is that patients could maintain **one secure account** instead of juggling dozens of portal usernames and passwords. This greatly lowers the barrier to using digital services. For example, a senior could use one Login.gov account to access Medicare, their various provider portals, and health apps – no need to remember many passwords. This convenience likely increases patient engagement with their health information (since logon hassles are a known barrier).
 - **Seamless Data Exchange:** With a common identity, linking records from different sources becomes easier. For instance, if a patient consents, a provider could use the patient’s federated ID as a key to retrieve data from other sources (subject to appropriate matching of course). It’s not a national patient identifier, but it helps disambiguate identity in data exchange to some extent.
 - **Security Improvements:** These credential services are typically **multi-factor authenticated and meet high security standards**. They can reduce the risk of breaches compared to weaker, reused passwords on individual portals. A single strong credential (especially one vetted to IAL2 identity proofing) can cut down fraud – e.g., preventing impostors from easily creating fake accounts to steal records. The **VA’s adoption of Login.gov** saw huge success, with over 1,200 veterans signing up daily and praising the ease of one login. Veterans found it a “no-brainer” that improved convenience without sacrificing security. We anticipate similar reactions if widely available in Medicare/Medicaid contexts.
 - **Improved Care Coordination for Caregivers:** If caregivers could use one credential to access multiple loved ones’ records (with proper permissions), it would streamline their role. They wouldn’t need separate logins for each provider or each person they care for, potentially.
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Potential Downsides

- **Single Point of Failure:** Relying on one credential means if that account is compromised or the service is down, access to many services is lost simultaneously. Patients might be locked out of everything if, say, they forget that one password or if their Login.gov gets suspended due to suspicious activity. The impact is broader than a single portal password issue would be.
- **Privacy Concerns:** Some patients may not be comfortable with a third-party (be it a vendor like ID.me or the federal government via Login.gov) holding their identity info and tracking their logins across services. There’s fear of surveillance or data misuse (“will the government see what medical info I access?”). Handling and alleviating these privacy perceptions is crucial.

- **Exclusion of Some Groups:** The identity proofing process might inadvertently exclude or inconvenience marginalized groups. For instance, homeless individuals or those without credit history can't easily pass electronic verification. If healthcare access relies on such credentialing, we must ensure alternative pathways. Also, not everyone has a driver's license or mobile phone for multi-factor SMS. There's a risk that strict identity requirements could create **digital divide issues**, leaving some patients behind or forcing them to stick to in-person paper processes.
 - **Operational Challenges:** Healthcare providers will still need to link the federated identity to the correct medical record in their system. If that linking process fails (e.g., a patient uses a nickname on one and legal name on the other), it can cause confusion or even misidentification. Providers worry about liability: "If I accept a Login.gov login, how do I be sure it matches the right chart?" This is solvable but requires careful design and likely some manual initial setup for existing patients.
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How Would Encouraging Use of CSPs Improve Access to Health Information?

Encouraging use of **credential service providers (CSPs)** like Login.gov would improve access primarily by **lowering the login barrier and enabling cross-platform access**. Patients often cite forgetting passwords or difficulty logging in as reasons they don't access portals. If they have a single, easy-to-use login with one set of credentials, they will log in more frequently and to more places. This means more touchpoints to view lab results, message doctors, or download data – effectively increasing utilization of digital access rights granted under the Cures Act.

Moreover, a trusted digital identity can enable new access models: for example, a patient could verify their identity once and then use an app to **pull data from multiple providers without having to separately establish credentials with each** (kind of a "single sign-on" across organizations). This streamlines patient-directed exchange. It also could facilitate **TEFCA's Individual Access**: if QHINs accept a strong federated identity for patients, the patient could query multiple networks with one login rather than setting up accounts at each hospital network.

From a caregiver perspective, if widely adopted, a digital identity credential could incorporate delegation features – e.g., Login.gov is working on allowing one account to manage benefits for family – which could similarly let a caregiver with one login toggle between profiles of loved ones (with permissions). That dramatically simplifies how caregivers manage information for elders or children, improving effective access.

In summary, **broad use of CSPs basically removes friction**: fewer passwords, higher trust, and broader interoperability means patients access their health info more easily and widely.

Roles of CMS/Payers, Providers, and App Developers in Driving Adoption

- **CMS/Payers:** CMS can lead by example – integrate Login.gov (or similar) into Medicare and Medicaid systems. If Medicare beneficiaries can log into Medicare.gov or Blue Button using Login.gov, millions will get exposure to it. CMS could mandate or strongly encourage Medicare Advantage and Medicaid plans to offer federated login options on their member portals as part of interoperability compliance. Payers also manage large enrollee bases and can run outreach (mailers, emails) explaining the availability of a single sign-on for health needs. CMS can also certify or vet certain CSPs for healthcare (ensuring they meet HIPAA/business associate standards), giving providers confidence to use them.
- **Providers:** Providers (community-based PCPs, hospitals, clinics) are the touchpoint with patients – they should offer federated login on their patient portals. This requires technical integration (often with EHR vendors). Providers can advocate to their EHR suppliers to implement standards like **OpenID Connect** to accept third-party identity tokens. Additionally, providers should educate patients at registration: e.g., “You can use your existing Login.gov account to access our portal – no need to remember a new password.” Front desks and patient liaisons can help tech-challenged patients set it up. Providers have a role in explaining that this method is secure and approved. If large health systems start adopting common IDs, it sets a precedent for others.
- **App Developers:** Health app developers (such as personal health record apps or third-party Blue Button apps) should build in support for federated identity login. Many apps currently force a new account creation – instead, they could allow sign-in with Login.gov or other CSP. This not only helps users but also improves trust (users might trust an app more if they don’t have to give it a new password but use a known secure login). Developers can also make use of the strong identity to link data from multiple sources reliably. Essentially, they should embrace standards and SDKs provided by CSPs to make the user experience smooth.

Collaboration is key: CMS might convene a summit with EHR vendors, health systems, major payers, identity providers and community-based organizations (CBOs) like SOMOS to roadmap a nationwide adoption strategy

How Can CMS Encourage Patients to Get Digital Identity Credentials?

- **Integrate credentials into popular patient journeys:** For example, during Medicare enrollment at 65, CMS could introduce Login.gov: “Create your secure Medicare online account through Login.gov”. If right at the start beneficiaries get one, they’ll continue using it. Similarly, link it to things patients *want*: e.g., “Sign up for Login.gov to easily view your Medicare Summary Notices and claims online instead of waiting for mail.” For Medicaid, states with identity management could align with a federal or common ID – CMS could incentivize states via funding to use federated ID for Medicaid members. *Organizations like SOMOS, which serve large Medicaid populations, could pilot integration of these IDs during eligibility screening or onboarding processes.*
- **Incentivize usage through convenience/features:** Highlight what a patient can do with the credential that they otherwise couldn’t. Perhaps launch a feature that requires a higher-level credential – for instance, a new Blue Button feature that allows sharing data

with family or advanced analytics, available only if you use a verified identity (for security). This carrot motivates signup.

- **Educational Campaigns:** Use multiple channels (mail, email, in-office posters) to demystify digital IDs. Provide step-by-step guides. *Community health organizations like SOMOS can play a key role* — community health workers in our network could help patients sign up if they know it’s beneficial – CMS could provide funding for on-site “digital identity signup days” at clinics or senior centers.
 - **Leverage Trusted Brands:** Some patients might respond more if their provider or plan recommends it versus a government message. CMS could encourage or even require plans and providers to include information about these credentials in communications. For instance, a doctor’s office could say “We now offer sign-in via Login.gov, here’s how to link your account.” Seeing a familiar provider endorse it can alleviate patient concerns. *This is especially powerful in trusted regional systems like SOMOS that have deep ties to community care.*
 - **Address Privacy upfront:** CMS should also communicate strong privacy protections – e.g., that Login.gov does not share personal data with agencies without consent, etc., to build trust among skeptical groups.
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Conclusion and Call to Action

We believe **widespread digital identity credential use could be transformative** for patient access and interoperability. The challenges are real – particularly user-friendliness and trust – but with CMS leadership and a coordinated effort by payers, providers, and app makers, these can be overcome. We strongly support CMS’s efforts to encourage a single, secure digital identity for patients as it will reduce the “login burden” and thereby open the doors for patients to fully utilize the digital health tools available to them. SOMOS stands ready to support this vision by piloting digital ID adoption strategies in community-based settings.

Providers

The following section relates to use cases and workflows that involve providers.

Digital Health Apps

PR-1 through PR-4

PR-1. Encouraging Providers to Adopt Digital Health Products

Question: “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? a. What are the current obstacles? b. What information should providers share with patients when using digital products in the provision of their care? c. What responsibilities do providers have when recommending use of a digital product by a patient?”

SOMOS Perspective

Providers are key gatekeepers for digital health adoption. To encourage more providers – especially those primary care independent physicians integral to the most venerable communities – to embrace **approved digital health apps and tools** for patients, CMS and its partners can take several of the following actions.

Encouragement Mechanisms

- **Integration into Payment Models:** CMS can incorporate use of digital health tools into value-based payment incentives. For example, in MIPS or Alternative Payment Models, create improvement activities or quality measures related to digital health usage (e.g., percentage of diabetic patients using a remote monitoring app or patient portal engagement rates). If providers know they’ll get credit or even reimbursement for time spent on digital health (like billing for reviewing remote data), they are more likely to invest effort. CMS has started with things like reimbursing remote patient monitoring and telehealth – continuing to expand coverage for digital services (and making them permanent, including rural telehealth flexibilities) lowers financial barriers.
- **Curated “App Formularies” and Endorsement:** Many providers, especially those in smaller practices, are overwhelmed by the myriad of apps and worried about recommending something unreliable. CMS, possibly with ONC and FDA, could maintain a list of **vett ed/approved digital health products** (for various categories: chronic disease self-management apps, mental health apps, etc.). Knowing an app is “CMS-endorsed for Medicare beneficiaries” or listed in an ONC gallery gives providers confidence to recommend it. Partners like professional associations can also disseminate which products meet standards for privacy, effectiveness, etc. Essentially, we need an “app formulary” analogous to a drug formulary, to simplify provider choices.
- **Education and Training:** Many clinicians simply aren’t trained in how to integrate digital tools into practice. CMS could fund or support training programs and toolkits – especially aimed at rural providers who might have less access to internal IT support. For example, a series of webinars or case studies showing how a small practice used a blood pressure monitoring app to improve hypertension control, step-by-step. Peer ambassadors (respected physicians who champion digital tools) can be very persuasive. Through regional extension centers or QIN-QIOs, CMS can push educational outreach that frames digital tools as enhancements, not burdens.

Current Obstacles

- *Workflow Integration:* Providers fear that adopting an app will create more work (like another interface to check, more messages from patients to respond to). If the tools are not integrated with the EHR or daily routine, they may disrupt more than help initially.
- *Financial and Time Costs:* Many digital products require upfront costs or staff time to onboard patients, which are not directly reimbursed in fee-for-service. Particularly in rural or under-resourced settings, they may lack broadband or IT support for these tools.
- *Awareness and Evidence:* Some providers simply aren't aware of which products exist or are proven. Skepticism remains about the clinical value of certain apps ("is this just a gimmick?"). They need evidence of improved outcomes or efficiency to be convinced.
- *Liability and Privacy Concerns:* Providers worry – if I recommend an app and something goes wrong (data breach, patient misinterprets info), am I liable? Or if the app generates alerts, am I obligated to act on them 24/7? This uncertainty can deter recommendations.

CMS and partners can address these obstacles by: ensuring reimbursement pathways (as noted), promoting integration standards (like making sure certified EHRs support SMART apps, so providers can use apps within their workflow), funding demonstration projects in rural areas that provide technical assistance (showing that even with limited resources, telehealth and remote monitoring can be implemented with success).

SOMOS Commitment: We acknowledge these real-world challenges and is directly addressing them through practical, provider-centric strategies. To reduce workflow disruption, our **MediFlow platform is built with future EHR integration in mind**, using SMART on FHIR standards to embed tools within existing clinical systems rather than requiring separate logins or platforms. Recognizing the burden of onboarding and digital inequity, SOMOS is deploying **bilingual digital navigators and technical support staff** in under-resourced clinics to assist with patient education, connectivity barriers, and staff training—particularly in areas with limited broadband access. We are also partnering with academic institutions and payers to generate evidence on clinical and operational outcomes, ensuring providers see value in the tools we introduce. To address liability concerns, all recommended apps undergo security and clinical vetting, and our protocols clearly define provider responsibilities, reducing ambiguity around alert response. By combining integration, education, evidence, and safeguards, SOMOS aims to build trust and usability around digital health adoption in safety-net settings.

Information to Share with Patients

When providers do use digital products in care, they should set proper expectations with patients. Providers should inform patients about:

- *Purpose and Benefits:* Explain why the digital tool is being recommended – e.g., “This glucose monitoring app will help you and me track your sugars between visits so we can adjust meds faster and hopefully keep you out of the hospital.”

- *Privacy and Security:* Reassure patients that the product is approved and secure (assuming it is), describe what data it will collect and who will have access. Patients should know if data goes to their clinician, to the app company, etc. For example, “This app will send me your daily blood pressure readings. The data is transmitted securely and will become part of your medical record.”
- *Usage Instructions:* Providers should ensure patients know how to use the product – e.g., how often to input data or what to do if they get certain readings. Also, any costs – “This is provided free as part of your care” or “the device is covered by Medicare.”
- *Limits and Contact Protocol:* Important to clarify what to do with the data and when to call. For instance, “If your symptoms worsen, don’t wait for the app, call us or seek care. The app is an adjunct, not an emergency service.” If the app provides education or advice, the provider might tell patients to discuss questions arising from it at their next visit or via portal message.

Essentially, informed consent for digital involvement: patients should understand the tool and their responsibilities (like adherence to using it) and what the provider will (or won’t) do with it.

SOMOS Commitment: We ensure that every digital health deployment – whether through MediFlow or partner-supported tools – is paired with clear, culturally sensitive patient education to foster trust, transparency, and proper use. Our providers and digital navigators are trained to set clear expectations with patients by explaining the purpose and benefits of each tool in plain language, often in both English and Spanish (e.g., “*This screening tool helps us understand what social services you may qualify for so we can navigate you to the resources you deserve!*”). We emphasize **data privacy and security**, assuring patients that their information is securely transmitted and only accessible to authorized clinical teams. Patients receive **step-by-step usage instructions**, including how often to enter data, who to contact with questions, and any costs involved—most tools we use are provided at no cost as part of care. Finally, we **communicate limits and responsibilities**, making it clear that apps are supportive tools, not substitutes for urgent care, and guide patients on when and how to reach their provider directly. This approach promotes informed digital consent and empowers patients to engage confidently in their own care.

Provider Responsibilities

When a provider recommends or prescribes a digital product, their responsibilities likely include:

- *Due Diligence:* They should vet the product for safety, efficacy, and appropriateness for that patient. This is why having CMS-endorsed lists helps. But ultimately, like prescribing a drug, the provider should ensure the app is suitable (e.g., a patient with low tech literacy might need extra support or a different approach).
- *Monitoring and Follow-up:* If the provider has told the patient they will monitor data, they need a workflow to actually do so. For example, if a provider says “I’ll keep an eye on your blood pressure readings via the app,” they must either personally or via team look at those readings and have a plan for out-of-range values. Setting thresholds and

having maybe a nurse or automated system flag issues is crucial – otherwise data could slip through the cracks.

- *Maintaining Privacy & Data Integration:* Providers must handle any data from the app as part of the patient’s protected health info – e.g., incorporate it into the medical record if used for decision-making, or at least document relevant findings. They should also ensure that any data sharing from their side (like sending patient info to the app) is compliant.
- *Education and Support:* The provider (or their staff) should support the patient in using the product, at least at the start. That might involve demonstrating it, troubleshooting early on, or coordinating with tech support from the vendor. Particularly for older or rural patients who might find technology challenging, a provider’s office might need to go the extra mile initially (like a nurse calling to ensure the device is working, etc.).
- *Ethical Use:* The provider should remain vigilant that the tool continues to benefit the patient, not cause harm or confusion. If an app isn’t helping or the patient is anxious because of constant data, the provider might modify or stop its use. They also should avoid any conflict of interest (e.g., if the provider has financial ties to a product, they should disclose that to the patient).

By clarifying these responsibilities, CMS can also create guidance or even policy. For example, CMS could incorporate expectations into Conditions of Participation or quality programs that if providers engage patients with digital tools, they ensure safe and effective use (just as with any treatment).

SOMOS Commitment: We integrate provider responsibility into every phase of digital tool deployment to ensure safety, equity, and accountability in patient care. Before recommending any digital health solution through our MediFlow platform or care programs, providers are supported with **clinical and technical vetting protocols** to assess the tool’s appropriateness for each patient’s literacy, access, and health status. We implement structured monitoring workflows—including automated flagging and delegated follow-up by care coordinators or nurses—to ensure promised oversight is delivered. All relevant data collected via digital tools is treated as **protected health information (PHI)**, and SOMOS ensures its proper integration into the medical record when used to guide clinical decisions. To bridge digital literacy gaps, particularly among older adults or those in underserved communities, SOMOS deploys **digital navigators and bilingual care teams** who offer one-on-one setup support and ongoing patient education. Additionally, we maintain **strict ethical safeguards**, including full disclosure of any vendor relationships and regular reviews to assess whether a tool is genuinely benefiting patient outcomes. This commitment ensures SOMOS-aligned providers uphold the same clinical responsibility for digital tools as they do for traditional interventions.

Rural Consideration

For those in rural communities, digital tools can be lifelines (telehealth bridging distance, etc.) but they face connectivity issues and resource constraints. CMS might specifically provide grants or infrastructure support (broadband expansions, telehealth resource centers) targeted at rural

practices to adopt these technologies. Also, highlight success stories of rural clinics using telehealth or remote monitoring to manage chronic disease—peer inspiration matters.

In conclusion, CMS and partners can encourage digital health adoption by aligning incentives, reducing barriers (financial, knowledge, liability), and providing a safety net of reliable information and tools for providers to use. When providers feel confident and see that using these products will help their patients and not punish them with unreimbursed work, they will become strong advocates of digital health in practice.

PR-2. Obstacles to Innovative Physician Workflow Applications

Question: “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?”

SOMOS Perspective

There are numerous promising digital applications to improve physician workflows – from AI-assisted documentation to automated quality measure reporting – but several **obstacles hinder their development and uptake**. There are several key obstacles and mitigation strategies we will cover.

1. Lack of Interoperability and Data Standards

Innovative apps (say, an app for automatic quality reporting or clinical documentation) need to plug into the EHR and access data easily. Many EHR systems historically had limited or proprietary APIs, making third-party integration hard. This stifles independent app developers and frustrates deployment because each app might need custom integration per EHR vendor. *Mitigation:* Enforcement of open standards (like FHIR APIs and SMART on FHIR launch capabilities) by ONC’s certification is key. CMS and ONC can further require that EHRs not only have basic APIs, but also allow embedded apps in workflows (like launching within the EHR with single sign-on). The 21st Century Cures Act’s API requirements are a step – further steps (as per TD-10) to ensure “no special effort” to access all EHR data via API will let developers build robust tools that are EHR-agnostic. Additionally, continued refinement of data standards (USCDI expansion to cover more data elements relevant to quality and billing) will give these apps the data needed to function fully.

2. Financial and Incentive Misalignment

Developing an innovative workflow app requires investment, but often physicians or small clinics aren’t willing to pay directly for an unproven tool, and the benefits (time saved, fewer errors) don’t always translate into immediate revenue under fee-for-service. There’s also the “who pays?” problem – if an app streamlines quality reporting (benefiting providers and payers), providers might expect payers or CMS to subsidize it. *Mitigation:* CMS can provide incentive funding or create **innovation challenge programs** that fund pilot deployments of workflow apps (similar to innovation grants). If an app clearly reduces burden, CMS might incorporate it into its programs (e.g., promoting a documentation assist tool that helps with Medicare coding accuracy by endorsing or subsidizing it). Another approach is adjusting payment to reward efficiency – e.g., if documentation time goes down, physicians can see more patients or spend more time per patient (improving quality), but those gains are intangible in FFS. However, in value-based care, efficiency translates to cost savings or better outcomes which are rewarded. Thus, expanding value-based models inherently makes investments in workflow innovation more attractive. CMS

could also allow new billing codes for use of certain technologies (like they did for telehealth). For instance, if an AI tool drafts a clinical note, perhaps a code to reimburse the oversight time can be considered – this might be tricky, but conceptually tying some payment to tech use can nudge adoption.

3. Physician Adoption and Change Management

Even a great app faces **cultural resistance**. Physicians are overloaded and many are wary of new tools that might disrupt their routine or require learning. Some see these apps as “yet another thing” on top of the EHR. *Mitigation:* Emphasize **usability and training**. Apps must be designed with clinician input to seamlessly fit their workflow. Real-world pilot data showing time saved or improved satisfaction will help convince peers. Also, involve clinicians as champions: those who find success with the tool should share their stories (in webinars, at conferences). For example, if an AI documentation tool cut Dr. X’s charting time by 30%, let Dr. X present that result. To lower risk of disruption, implement in phases – perhaps start with optional use and gradually integrate as comfort grows.

4. Regulatory Uncertainty and Liability

Some innovative tools (particularly AI in documentation or decision support) face unclear regulatory environments. Physicians worry: if I use an AI to draft a note and it’s wrong, am I liable for any errors? Or if an algorithm for billing has a glitch, will an auditor accuse me of upcoding? This uncertainty makes practices hesitant to trust new tech fully. *Mitigation:* CMS can offer **clear guidance or safe harbors**. For instance, clarify that using an AI-assisted coding tool is acceptable and won’t be penalized if done in good faith and with oversight. ONC could provide guidance on how FDA’s stance on clinical decision support applies (some apps might be considered medical devices if they guide care). If certain innovative tools prove safe/effective, CMS/ONC can publicly endorse them, alleviating fear. Also, insurance carriers may need to adapt liability coverage (maybe malpractice insurers offer coverage that includes AI usage, once it’s proven to reduce errors, ironically it might lower liability risk).

5. IT Infrastructure in Smaller Practices

Many innovative solutions might require modern IT infrastructure (reliable internet, updated hardware, possibly cloud services). Small or rural providers may lack this, making deployment difficult. *Mitigation:* Support these practices through grant funding or shared services. For example, a regional health information exchange could host a quality reporting app on behalf of many small clinics, so each doesn’t need to implement it individually. CMS could collaborate with HRSA or FCC to improve broadband and IT support in underserved areas to create a foundation where digital tools can run.

6. Vendor Lock and Business Practices

Sometimes EHR vendors see third-party apps as competitors to their own modules (e.g., an EHR might have its own billing add-on and not be keen on an outside billing app integrating). They may erect subtle barriers like high fees for integration or not prioritizing external app support.

Mitigation: Enforce anti-information blocking provisions with regard to **Business-to-Business (B2B) integration** too. The info blocking rules allow fees only if reasonable – ONC/CMS should scrutinize if EHRs charge exorbitant interface fees for innovative workflow tools; such practices should be discouraged. Also, foster an ecosystem via programs like an **app certification or marketplace**: if EHR vendors have app stores (some do, like Epic’s “App Orchard”), ensure fairness so that innovative small developer apps can get in without onerous terms.

Recommendation to CMS

To unlock the full potential of innovative physician workflow applications, we recommend that CMS establish a **federally supported, standards-based integration framework** that enforces interoperability requirements across EHR vendors while considering funding regional deployment hubs to assist under-resourced providers with implementation. Specifically, CMS should condition continued certification and incentive eligibility on EHR vendors supporting SMART on FHIR launch, bidirectional APIs, and fair access for third-party apps—reducing vendor lock and custom integration burdens. In parallel, CMS should consider creating a **Digital Workflow Innovation Fund** to support safety-net clinics, ACOs, and small practices in piloting workflow-enhancing tools (e.g., AI-assisted documentation, automated quality extraction) with technical assistance. This should be accompanied by billing code adjustments or shared-savings incentives to reward providers who adopt tools that improve efficiency and data quality. Additionally, CMS should publish **safe harbor guidance** clarifying provider liability boundaries when using AI-supported tools, reducing hesitation around novel technologies. By aligning infrastructure, financing, and liability clarity, CMS can accelerate physician workflow innovation while safeguarding equity for small and community-based providers—many of whom serve the most complex and underserved populations.

Conclusion and Call to Action

In summary, **obstacles revolve around technical integration, financial incentives, user acceptance, and policy clarity**. By tackling each – standardizing integration, aligning incentives to reward efficiency (so good apps are worth it), educating and building trust, and smoothing regulatory wrinkles – CMS and broader industry can unlock a wave of innovation in physician workflows. As a network that has deployed tools like our QR+ for quality and CareFlow for admin tasks, we’ve seen that once initial barriers are overcome, clinicians quickly appreciate the value (e.g., less manual work on reports). Ultimately, we recommend CMS continue pushing on all these fronts to create an environment where innovators can thrive and providers can easily adopt the best new solutions.

PR-3. Making All EHR Data Accessible – Importance and Challenges

Question: “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. b. Impact on patient care quality. c. Technical barriers to full data accessibility. d. Cost or privacy implications of making all data formats interoperable. e. Priority level compared to other interoperability needs.”

SOMOS Perspective

Complete data accessibility – including unstructured content – is important to achieve a fully interoperable and effective health system, but it comes with significant challenges. We will address each par.

Challenges in Accessing Different Data Formats

EHRs contain structured data (diagnosis codes, lab results, medications), semi-structured (forms, some notes), and unstructured data (free-text notes, scanned PDFs, images). Accessing each poses unique challenges:

- *Structured data:* These are easier to exchange via standards (like FHIR for meds, labs). The challenge is ensuring semantic consistency – e.g., one system’s coding vs another. But by and large, structured fields are already the focus of interoperability (USCDI defines many of these).
 - *Free text notes:* These often contain crucial nuances (impressions, rationale) but are not standardized. Exchange typically involves sending the whole text (like a C-CDA narrative). Challenges: volume (notes can be lengthy), relevance (difficult for receiving systems to parse meaning out), and potential sensitivity (notes may include info patient might not want disclosed, e.g., mental health observations).
 - *Scanned documents/faxes:* These are essentially images or PDFs. The challenge is they’re not computable – a receiving system or clinician has to read them like a paper chart. They can be exchanged (as attachments or binary data via HL7), but the info inside isn’t discrete. So if a scanned consult note has a diagnosis, it won’t automatically update the problem list on import. Also, large scans are heavy to store and transfer, and quality can be poor (illegible handwriting).
 - *Images (radiology, etc.):* These require special handling (DICOM standards, large file sizes) and aren’t usually included in typical EHR data exchanges except by reference or patient-mediated retrieval.
-

Impact on Patient Care Quality

If certain data formats aren't accessible, it can compromise care:

- *Missing context:* For quality and safety, having **all relevant info** is crucial. For instance, free text may mention a patient's care preferences or nuanced history that doesn't fit in structured fields. If that isn't exchanged (or found by the next provider), care could suffer – e.g., duplication of tests, misdiagnosis.
- *Care delays:* If scanned documents (like an outside hospital discharge summary) aren't easily accessible, a provider might wait or treat with incomplete info.
- *Competition and patient choice:* If not all data flows, patients might feel locked into one provider/hospital (because “the new doctor won't have my full records if I switch”). That inertia hurts competition and continuity. Conversely, when all data travels, patients can move and still receive high-quality care because new providers have the complete picture.

Our clinicians often have to manually chase unstructured data (like calling to get that cath lab report that was faxed as an image). Making that available seamlessly would improve efficiency and reduce error (how many times key details in a scanned doc are overlooked because the system didn't highlight them?).

However, there's a diminishing return: not every scrap of data is equally critical. Some old scanned records may be rarely needed. But lacking a needed piece even rarely can be catastrophic (e.g., allergies noted only in an old scanned letter – if missed, could cause a reaction).

Technical Barriers to Full Accessibility

- *Natural Language Processing (NLP):* To truly integrate free text, one might apply NLP to extract structured info. While NLP has improved (especially with modern language models), it's not perfect. Technical barrier: building and implementing NLP at scale across healthcare systems, and ensuring it's accurate (NLP might misinterpret sarcasm or context in notes). Also, processing burden – analyzing thousands of notes quickly is computationally heavy.
- *OCR for scanned docs:* Converting scans to text via Optical Character Recognition. Accuracy issues (handwriting recognition is still very hard). Without reliable OCR, scanned docs remain pictures that can't be searched or analyzed easily.
- *Standardization of metadata:* Even if we exchange a PDF, systems need to know what it is (lab report? specialist letter?). There's limited metadata standards for unstructured content beyond maybe a filename or description field. Lack of uniform metadata makes managing and finding unstructured data difficult.
- *Integration to workflows:* Suppose we succeed in extracting all info; presenting it meaningfully is a challenge. Clinicians don't want to scroll through dozens of irrelevant documents to find one line. Technical challenge is how to filter and highlight pertinent info from the trove of exchanged data.

- *System performance and storage:* Exchanging heavy data (imaging, long notes) can strain systems. Many HIE interfaces time-out if data payload is too large. Upgrading infrastructure or using cloud solutions costs money (see part d).

Cost or Privacy Implications

- *Cost:* Storing and processing all data formats costs more (in storage, compute, developer time to enable exchange). Is it worth exchanging every 30-page scanned pre-2000 chart? Possibly not. HIEs might charge more if they have to shuttle large images or incorporate complex NLP.
- *Privacy:* Some data in unstructured fields might be especially sensitive (mental health notes, family secrets mentioned). When everything is accessible, controlling *appropriate* access is a concern. For example, currently psychotherapy notes are usually excluded from exchange by law unless specifically authorized. If we say "all data accessible," we need safeguards to still honor such privacy rules and patient preferences. Another issue: if we OCR all documents, now sensitive info previously buried in an image becomes searchable text – which could make it more easily discoverable (good for care, but potentially riskier for privacy if breaches happen).
- *Consent management:* Patients might be comfortable sharing basic records but not certain sensitive free-text entries. We would need more granular consent mechanisms if all data flows – which is complex to implement (few systems have fine-grained consent beyond all or nothing).
- *Security:* The more data we exchange, the bigger target for hackers. Systems must ensure high security for these larger volumes of data. Also, any automated processing (like NLP in cloud) must secure PHI properly. All that is doable, but adds overhead and cost.

Priority Level vs Other Interoperability Needs

- It is certainly important in the **long-term vision** of a learning health system that no important data is siloed. However, in the near term, there might be higher priority items: for example, ensuring all structured *critical* data elements (like meds, allergies, labs) are reliably exchanged and used. Many places still struggle with that basic level – that likely ranks higher priority to fix first.
- That said, some unstructured data exchange is already happening (via clinical document exchange like CDA). So it's not completely absent, it's just not integrated. The question is whether we invest a lot now to improve unstructured data interoperability or focus on things like patient matching, provider directories, standardizing social determinants data (which are structured albeit new).
- We would rank making key unstructured content accessible as moderately high priority – for example, exchanging at least the narrative from discharge summaries, consults, etc., which we often do via CCDAs. But turning every free text into coded data is lower priority given current resource constraints and other pressing issues (like closing

interoperability gaps in behavioral health or post-acute sectors, which might yield bigger improvements in care).

- In context, **priority trade-off**: It might be more urgent to ensure interoperability of, say, **price and claims data** (to empower patients in cost decisions, which is currently lacking) or to implement national identity solutions (which enable all exchange generally) than to invest huge efforts in parsing every old note.
 - But from a provider perspective, certain unstructured data (like outside notes) are frequently needed, so improving access to those is quite important for daily workflow.
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Recommendation to CMS

We believe **progressively expanding interoperability to more data types is important**.

Initially, focus on high-yield items: for example, ensure that when exchanging a summary, it includes as much of the clinically relevant narrative as possible. Over time, adopt technologies like NLP to allow queries into those narratives (e.g., “find last ejection fraction in cardiology notes”). Already, some HIEs and EHRs have simple keyword search across notes – rudimentary but useful.

We consider making all data available as an ideal end goal, but with pragmatic phasing. We wouldn’t delay current interoperability efforts to solve unstructured data overnight, but we would invest in research and pilot projects now (like ONC LEAP in AI for NLP, etc.) so that in a few years, we can integrate more of this. In terms of priority, **structured data interoperability remains top priority**, but unstructured data interoperability is the next frontier to truly complete the picture.

Conclusion and Call to Action

In summary, **very valuable but challenging** describes it well. It should not be ignored (because crucial info often lies in unstructured text), but we must tackle it carefully with advancements in tech and policy to mitigate costs and privacy issues.

PR-4. Access to Administrative Workflows via Third-Party Products

Question: “What changes or improvements to standards or policies might be needed for patients’ third-party digital products to have access to administrative workflows, such as auto-populating intake forms, viewing provider information and schedules, and making and modifying an appointment?”

SOMOS Perspective: Enabling third-party apps to integrate with **administrative workflows** can greatly streamline patient experience – imagine an app that automatically fills out your registration forms or lets you schedule across different clinics easily. Currently, these tasks are often siloed in provider systems. To open them up, we provide insight into several standards/policy improvements that are needed.

1. Adopt and Extend Scheduling APIs (FHIR Appointment)

We need a standardized API for querying provider schedules and booking/cancelling appointments. HL7 FHIR has an Appointment resource and some workflow around it, but not all EHRs implement robust scheduling APIs. *Policy:* ONC could include appointment scheduling interoperability as a certification criterion in the future (so EHRs must allow third-party apps to at least retrieve available slots and request bookings). *Standards:* We might need to refine standards to account for the complexities (multiple slot types, new patient vs existing, referral requirements). Initiatives like the Argonaut Project have worked on scheduling – this needs to be accelerated to production use.

2. Provider Information and Directories

Third-party apps need reliable provider directory info: practice locations, specialties, contact, and accepting new patients indicator, etc. FHIR has a Provider Directory specification (endpoint, organization, practitioner resources). *Policy:* CMS’s work on a national provider directory (as discussed in TD-5 and VB-15) is crucial here. If policy requires health plans to publish up-to-date directories via API (which CMS already proposed for payer interoperability), third-party apps can leverage that to show patients what providers are available and link to scheduling. *Improvements:* Standardize fields like office hours, languages spoken – so apps can present useful filters.

3. Form Auto-Population and Patient Data Reuse

It's frustrating for patients to fill the same forms repeatedly (intake, insurance, history). If third-party apps have patient-entered data or data from health records, they should be able to populate provider forms. This requires *standardizing common form data*. For example, perhaps use FHIR Questionnaire or some template for intake forms (with fields like name, DOB, insurance ID, current meds, allergies – many of which the app could pull from Blue Button or EHR with consent). *Policy:* ONC/CMS could push for providers to accept electronic submission of intake

info. Today, even if a patient has an app with all their data, they often have to transcribe it onto paper or a web form because the provider system isn't set up to receive it electronically. Encouraging use of standards like FHIR Questionnaire Response to intake data (maybe as part of Meaningful Use/Promoting Interoperability measures) could drive this. *Privacy/Security Policy:* Ensure that if patients send their data ahead via an app, HIPAA Business Associate considerations are clear (the app likely acting as patient's agent, not requiring BAA with provider – guidance from OCR on this would help provider comfort).

4. API Access to Administrative Systems

Many administrative functions reside in practice management systems (scheduling, insurance eligibility, billing). To integrate these with apps, those systems need APIs or integration points. Some standards exist (like HL7 FHIR for scheduling, and the Da Vinci Project has implementation guides for things like coverage eligibility). We need broader adoption. *Policy:* CMS could require that certified EHRs include certain practice management API capabilities too – historically certification focused on clinical, but now admin integration should be considered. Also, CMS could coordinate with payers to ensure eligibility APIs (there is the X12 EDI standard now, but a FHIR Eligibility resource is emerging). If apps can automatically verify a patient's insurance and fill that in forms, it's a big win.

5. Empower Patient Identity (Login simplification)

For third-party apps to interact with provider systems (like to book an appointment or send forms), we need to authenticate the patient to the provider's system. Today, each provider portal separate login is a barrier (a third-party app can't easily mimic a user to do scheduling behind the scenes unless using screen-scraping, which is fragile and discouraged). *Improvements:* Implement universal patient identity solutions (as in PC-14) so third-party apps can present a token proving "this is Jane Doe and here's her insurance/member ID," which provider systems trust. This might involve federated ID (Login.gov) and tying to provider portals, as discussed before. *Policy:* Encourage providers to accept external identity assertions for at least certain functions, or use standards like SMART on FHIR's App Launch outside the EHR where a patient app can connect to a provider FHIR API with scheduling scope.

6. Consent and Workflows for Proxy Use

If a caregiver is using an app to arrange care for someone, ensure standards support that (maybe out of scope here, but likely needed so an app can indicate it's acting on behalf of a patient, which might require a permission mechanism in the provider system).

7. Regulatory clarity on obligations

Some providers worry that if an app books an appointment, is the provider obligated to treat if something was mis-scheduled? Or if an app sends in an intake form, is it official? We need trust frameworks and maybe policy safe harbors: *Policy idea:* CMS or ONC could create guidelines around third-party scheduling – e.g., if an app books an appt through an API, it should be treated

same as if patient called in, and likewise patient has obligations (cancel if not needed, etc.). Not so much regulation as clear best practice and liability distribution.

8. Data Minimization and Privacy

If apps will auto-fill forms, ideally they only share needed info. Standard forms can allow pick-and-choose. Policies should encourage that providers *request only what's necessary* and that apps only send data with patient consent. This is more an implementation principle than a new law, given HIPAA allows broad sharing for treatment, but in spirit of privacy, consider e.g. not every specialist needs the full social history from 10 years ago unless relevant.

Recommendation to CMS

We recommend that CMS and ONC expand certification criteria to include **administrative interoperability standards**—specifically around scheduling, intake data exchange, and provider directory access—so third-party digital tools can integrate seamlessly with clinical and practice management systems. We urge the formal adoption and enforcement of FHIR Appointment APIs, FHIR Questionnaire/Questionnaire Response, and standardized provider directory fields (e.g., office hours, new patient status, languages spoken) to ensure consistent app usability across provider systems. To encourage uptake, CMS should establish pilot programs and liability-safe harbors that clarify expectations when patients or caregivers book, cancel, or submit intake data through third-party tools—helping providers trust and accept these interactions as legitimate. Additionally, CMS should promote **federated patient identity frameworks** (e.g., Login.gov, SMART App Launch with external tokens) to simplify access across provider networks, and support proxy workflows to reflect real-world caregiving. Ultimately, by embedding administrative interoperability into certification and quality program incentives, CMS can catalyze the consumer-grade, frictionless experience patients expect—without placing disproportionate burden on small or community-based providers.

Conclusion and Call to Action

To open up admin workflows to patient apps, we need **open APIs for scheduling and intake**, robust **provider directories**, standardized data schemas for forms, and an identity/trust fabric that lets apps act as patient agents securely. Many of these fall under the umbrella of interoperability that hasn't been as emphasized as clinical data exchange – it's time to bring them to the forefront. CMS can push vendors and providers by including these in future interoperability mandates or pilot programs.

By implementing these improvements, we foresee a future where a patient's app can, for example, find Dr. Jones in-network, see she has an opening next Tuesday at 3pm, book it, fill in all the registration paperwork from the patient's stored profile, and even share the patient's medication list with Dr. Jones ahead of time – all seamlessly. That would drastically improve patient experience and reduce administrative burden on provider staff (fewer phone calls, less manual data entry), fulfilling the promise of interoperability on the ground level.

Data Exchange

PR-5 through PR-8

PR-5. FHIR APIs and Capabilities Used by Providers

Question: “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. d. Provider Access API. e. Payer-to-Payer API. f. Prior Authorization API. g. Bulk FHIR—Do you support Group ID-based access filtering for population-specific queries? h. SMART on FHIR—Do you support both EHR-launched and standalone app access? What does the process for application deployment entail? i. CDS Hooks (for clinical decision support integrations).”

SOMOS Perspective

As a value-based care organization working with multiple providers and health IT systems, we have been progressively adopting various FHIR-based APIs and capabilities. Below we describe our current utilization of each and relevant details.

Patient Access API

Supported via intermediary. Many of our providers use EHRs (e.g., eClinicalWorks, MDLand) that offer a Patient Access API as mandated by ONC/Cures (enabling patients to use third-party apps to access their records). While our provider organizations themselves don’t run the API servers (their EHR vendors do), we encourage patients to use apps that connect.

- **Use case:** Some of our Medicare patients use Blue Button-enabled apps to pull their CMS claims; similarly, some use Apple Health or other tools to aggregate their clinical data via the EHR’s FHIR API (e.g., downloading their lab results or visit notes onto their phone).
 - **Transaction model:** These are typically *RESTful FHIR R4 APIs* requiring the patient to authenticate (using OAuth) and then the app queries individual resources (like Observation, Encounter, etc.).
 - **Individual vs Bulk:** Patient Access APIs are by design individual – one patient’s data at a time. We use no bulk in this context.
 - **Constraints:** One constraint we’ve seen is that not all data elements are exposed yet (some EHR APIs don’t include images or certain note types). Another is that app adoption by patients is still modest – many patients stick to portals. We’ve found the OAuth workflow can be confusing for less tech-savvy patients (like they have to understand what it means to allow an app to access their data). But technically, our systems support it and we have integrated with apps like OneRecord during pilots.
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Standardized API for Patient and Population Services

This phrase likely refers to the **g(10) FHIR API** that ONC requires (which covers both single patient and group export). In our environment, through our EHR partners, we do have this. For example, eClinicalWorks rolled out a FHIR Bulk Data export in compliance.

- **Use case:** We have utilized this for *population data pulls* – e.g., extracting a roster’s worth of clinical data to feed into our analytics (MediFlow risk stratification tool).
- **Transaction model:** Bulk FHIR uses an asynchronous REST pattern (we request a Group export via FHIR, the server prepares data and gives us a link to download NDJSON files).
- **Individual vs Bulk:** This API covers both – individual patient data (which overlaps with the Patient Access API above, but for provider use or authorized entity use) and bulk (the population export). We primarily use bulk for care management and quality improvement tasks (with appropriate data use agreements in place, since we act as a Business Associate to providers in our network to aggregate their data).
- **Constraints:** Bulk exports are still new – one constraint we hit is filtering by group (we needed to define a Group of patients in the EHR to export just our ACO patients’ data). Not all EHRs have a user-friendly way to define a dynamic group; in some cases we needed vendor support to set up an attribution list. Another constraint is data volume/time – initial bulk export of entire EHR can be huge and take many hours. We mitigated by doing incremental exports (using parameters for since-date). Also, some data types in bulk NDJSON weren’t needed (like Audit events, we skip those to reduce size). We handle output via an intermediary data pipeline (the raw NDJSON into our SQL warehouse, then into MediFlow). Overall, we do support standardized FHIR APIs at both patient and population level via our systems.

Provider Directory API

Internally, we maintain a directory of our provider network, but using FHIR provider directory API is something we’ve started to explore rather than fully implemented. *Direct support:* Our system does not yet expose a FHIR directory endpoint for others, but we do consume directories from payers and HIEs. For example, one of our partners is a health plan that offers a FHIR endpoint for their provider directory (per CMS requirement). We have experimented with pulling that to reconcile our provider list with theirs (ensuring consistency of practice addresses, etc.).

- **Use case:** Ensuring our referral management app (CareFlow) has up-to-date info on specialists and service providers, and enabling our care coordinators to quickly find in-network options for patients.
- **Transaction model:** Simple REST queries on endpoints like /Practitioner or /Organization with search parameters (name, specialty, etc.).
- **Constraints:** Many directory APIs are read-only and often not complete with all details (for example, some don’t list whether a provider is taking new patients, or their digital contact info). Also, linking a FHIR directory entry to a real person in our network can be tricky due to naming differences. We see promise as CMS’s centralized directory efforts progress. We have not yet implemented a directory API on behalf of our providers for

public use, as that requires aggregation of all our independent practice data – currently, that’s a manual process, but we foresee possibly exposing one in future as part of transparency or compliance.

Provider Access API

This might refer to APIs like CMS’s **Data at Point of Care (DPC)** or payer-to-provider APIs (like a provider querying a payer for data, which is an upcoming requirement). As a provider org, we have engaged in CMS’s DPC pilot: that allows our participating providers to retrieve Medicare FFS claims data for their patients.

- **Use case:** Our care managers query DPC API for a newly attributed Medicare patient to get historical claims (which supplements gaps in EHR data).
- **Transaction model:** DPC is FHIR-based – we register our application, get patient consent (via attribution), then can GET claims and other data by FHIR resources (CarrierClaims, etc.). It’s individual/bulk hybrid – we can bulk fetch a roster. We do this via an intermediary tool that CMS provided.
- **Constraints:** We needed to map that claims data into our system – not trivial, but doable. Another provider access concept is querying state immunization registries or other networks – often that’s via specific APIs (HL7 VXU/QBP). Not exactly FHIR yet in many states, but moving there. Also, as providers, we utilize an intermediary (our HIE) to access outside records – that’s more QHIN/TEFCA query model rather than FHIR at present. But we are keen on future FHIR provider-to-provider queries.

Payer-to-Payer API

For continuity of care when patients switch plans, this is envisioned in CMS rules (though enforcement was delayed). As a provider org, we aren’t directly involved in payer-to-payer, but as an ACO we care that our patients’ data follows them. We have not directly used any FHIR API for payer-to-payer, since it’s mainly between insurers. However, we benefit when a new plan a patient joins has the old plan’s data. In one instance, a patient’s Medicare Advantage plan change triggered a request of prior data through an intermediary HIE – but not via FHIR API, more via direct agreement.

The future FHIR standard (perhaps PDex – the Da Vinci Payer Data Exchange) is known to us but not something we implement as providers. We do encourage payers we work with to be ready – e.g., we asked our partner Medicaid plan if they will share historical data if a patient joins another plan we manage. So far, limited support (because rule not fully enforced yet). In summary, **no direct use yet** by our system, waiting on industry adoption.

Prior Authorization API

This is a big pain point area. We are in early pilots with an insurer for electronic prior auth using HL7 FHIR (the Da Vinci CRD/DTR/PAS specifications). One of our large hospital partners implemented an EHR-integrated prior auth where, for certain procedures, the EHR triggers a CRD (Coverage Requirements Discovery) query to the payer to see if prior auth is needed and then uses DTR (Documentation Templates and Rules) to gather necessary info and PAS (Prior Auth Submission) to send it in FHIR format.

- **Use case:** speeding up prior auth for advanced imaging.
- **Transaction model:** It's interactive – our provider's EHR (Epic at hospital side) calls the payer's FHIR endpoint with patient, plan info, and service, gets a response about need and documentation, then eventually posts a FHIR bundle representing the prior auth request and gets back an auth ID.
- **Individual vs Bulk:** Always individual (one auth at a time).
- **Constraints:** This was limited to certain services and one payer. Smaller clinics in our network not on Epic can't do this yet because their EHRs don't support those FHIR workflows out of the box. Many payers don't have a FHIR prior auth endpoint yet (though CMS proposed requiring it for Medicare Advantage soon). So, while we see huge promise, our current usage is limited to a test program. Another constraint is aligning coding – sometimes the codes we use vs what payer expects differ, causing hiccups. We had to do mapping. But initial results: a couple of days saved in getting auth vs faxing.

Bulk FHIR (Group ID filtering)

As touched in (b), yes, we support bulk FHIR and specifically we use group-based filtering (i.e., we define a Group of patients such as all patients in our ACO or all patients in Dr. X's panel, then we request bulk data just for that group). Our eCW EHR's bulk export supports a group filter – we supply a list of patient IDs (or an EHR-defined group ID).

- **Use case:** Efficient extraction for those specific populations rather than entire database.
- **Transaction** as described earlier, asynchronous.
- **Constraints:** Setting up the group requires we know the patient IDs in that EHR – we often match via MRN lists from the EHR. Also, some EHRs have a limit of how many patients can be in a group for export or require segmenting if too large. We overcame by doing separate exports for each practice, for example. But group filtering is crucial for us to avoid pulling unrelated records. We also implemented our own mapping of payer IDs to EHR IDs to maintain the group membership up to date.

SMART on FHIR (EHR launch vs standalone)

We have at least one **SMART on FHIR application** in use: our SOMOS QR+ quality dashboard. Currently, it is implemented as a **standalone web app** that uses FHIR to pull data

from EHRs (with appropriate authorization). But we are working on an EHR-launched version for MDLand EHR – so a provider logged in MDLand can click a button and it opens QR+ for that patient context (launch-in-context).

- **Use cases:** When providers want to see care gaps while charting, or to submit supplemental data to payers. We found that if they have to log in separately (standalone), usage is lower; if launched from EHR (SSO, patient already selected), it's much more user-friendly.
- **Process for deployment:** We had to register our SMART app with each EHR vendor to get a client ID and allow it. For eCW, an intermediary was needed since eCW's FHIR support is evolving. For MDLand, we had direct cooperation to integrate it.
- **Constraints:** Each EHR's launch and authentication flow has subtle differences, and we had to host our app and ensure compliance with OAuth scopes. Also, not all EHRs support full WRITE scopes – our app mainly reads data, but if we wanted to write back a note or flag a gap as addressed, some APIs didn't allow that easily. Additionally, deploying at scale means ensuring our app meets all vendor security and compatibility tests – a smaller developer may struggle with that overhead. On the plus side, once up, it's powerful: e.g., a provider can open QR+ and see pre-fetched quality info (via FHIR bulk we loaded) and then click to write a result back (like an immunization record) to the EHR via FHIR if needed. We see a future where more of our tools, or third-party ones, run seamlessly inside EHRs – thanks to SMART.

CDS Hooks

We have not fully implemented custom CDS Hooks, but we are exploring it with one hospital partner. The idea is to have a hook that triggers when a diabetic patient hasn't had an eye exam in a year – then call our service which returns a card suggesting “Patient due for eye exam, click here to refer to ophthalmologist.” This is in concept phase.

- **Use case potential:** Real-time decision support and care gap closure suggestions integrated in clinician workflow. Some EHRs (like Epic) allow custom CDS Hooks, others not yet. We do utilize some *built-in* CDS features of EHRs, but those aren't standardized across systems.
- **Constraints:** Implementing CDS Hooks requires the EHR to expose certain hook points and allow external services, which not all do. Also, our service needs to be very fast (<1 second) to return advice so as not to slow the workflow. We also must ensure recommendations are evidence-based and not too intrusive (to avoid alert fatigue). So we're cautiously testing in a small environment before broad rollout.

Conclusion and Call to Action

We are embracing FHIR APIs across various dimensions – mostly reading data for patient care and quality, starting to for scheduling and prior auth. We find **FHIR and SMART enable integration** that previously required manual work or clunky HL7 V2 interfaces. Our usage is partial but growing: Patient Access (through patients), Bulk data (for population analytics), some directory consumption, DPC provider access, early prior auth, some SMART apps, planning CDS Hooks. The main constraints are uneven adoption by vendors/payers and the need to build new workflows around them. Yet, the direction is clear and very promising for improved care coordination and reduced burden in our organization.

PR-6. Is TEFCA Helping Provider Access to Info?

Question: *“Is TEFCA currently helping to advance provider access to health information? a. Please provide specific examples. b. What changes would you suggest? c. What other options are available outside of TEFCA? d. Are there redundant standards, protocols or channels or both that could be consolidated?”*

SOMOS Perspective

At this moment (2025), TEFCA’s impact on provider access is minimal – largely because TEFCA is just beginning operationally. Most provider data exchange is still via existing networks (HIEs, Direct messaging, vendor networks like Carequality). We expect TEFCA to help in the near future, but "currently," it's more potential than reality.

Examples of TEFCA Advancing Provider Access (Real-World)

Since formal QHIN connectivity is just starting, we have limited direct examples. However, one early positive is that some large networks designated as QHINs (e.g., CommonWell, eHealth Exchange) have begun aligning their policies under TEFCA, which in theory will expand reach. For instance, if a provider in our network uses CommonWell, historically they might not reach another provider on eHealth Exchange; but as those become QHINs with mutual exchange via TEFCA, that provider should soon be able to pull records from a broader set of sources through their normal EHR query. That hasn't widely manifested yet, but in pilot tests we've seen glimpses – e.g., a hospital IT department participated in a TEFCA interoperability exercise and successfully retrieved patient info from a health system in another region that previously wasn't reachable. It's a small-scale example, but it shows TEFCA's promise of bridging networks.

Another anecdotal example: One of our providers was part of a trial where their EHR vendor connected to a TEFCA QHIN test environment – they were excited that in the future this single connection could replace multiple separate HIE connections. It hasn't improved day-to-day practice yet, but it has streamlined their backend onboarding to exchange networks (one legal agreement vs many).

Suggestions for Changes to TEFCA to Better Help Providers

- **Expand Reach & Participant Diversity:** Encourage more regional and specialty HIEs, and small provider groups to connect via Participant/Participant Members. Right now, TEFCA is very top-level (QHINs are big players). To truly help providers, especially smaller ones, TEFCA needs to **trickle down**. CMS could provide incentives or requirements for, say, **community-based healthcare systems, like SOMOS** with an extensive list of primary care providers, critical access hospitals or rural clinics to connect to a TEFCA QHIN (perhaps via their EHR vendor or state HIE). Also, ensure that **behavioral health and long-term care** providers are included – often they are left

out of exchange. TEFCA should explicitly fold in those sectors to help providers get a fuller picture.

- **Improve Use Case Support:** Initially TEFCA is focused on treatment and individual access. Providers might also need data for quality measurement or population health. TEFCA could expand to support **population-level queries** (with appropriate permission) or specific use cases like notifications. For instance, TEFCA could incorporate a national patient event notification service so that if a patient is seen anywhere in the network, their primary provider can be notified – similar to how we intend to incorporate MediFlow into our Medicaid population. Right now, TEFCA’s message delivery could be leveraged but isn’t explicitly tailored to that. We suggest adding implementation guides under TEFCA for such use cases.
- **Simplify Workflow Integration:** The current exchange frameworks often require separate portals or query interfaces. TEFCA’s benefit will be best realized when these queries are **embedded in EHR workflow** (like a clinician hitting their "query external data" button and TEFCA brings in all outside info). We suggest ongoing work with EHR vendors to ensure TEFCA connectivity is behind the scenes and seamless to providers. If any policy impediments exist (like needing multiple credentials or patient consent issues at query time), address those – e.g., create standard patient consent language that providers can use to cover TEFCA queries in their intake forms, so it’s not a barrier each time.
- **Educate & Support Implementation:** Many providers haven’t even heard of TEFCA. CMS and ONC should push educational outreach illustrating how TEFCA will help them, to build buy-in. Also, provide implementation support – perhaps through ONC’s Regional Extension Centers revived for interoperability – to help smaller orgs connect via TEFCA-enabled networks.

SOMOS Commitment

We are committed to advancing TEFCA’s vision by serving as a bridge between community-based providers and large-scale health data networks. We are actively working to **onboard small primary care practices, FQHCs, behavioral health providers, and long-term care partners** into TEFCA-aligned data exchange through our existing relationships with EHR vendors and state HIE infrastructure. Our goal is to ensure that providers in underserved neighborhoods—who often lack direct connections to QHINs—can still **send and receive critical health data across systems seamlessly**. Through our MediFlow platform, we are also preparing to support population-level use cases, such as real-time event notifications and screening integration, that TEFCA should expand to include. Recognizing the importance of workflow efficiency, SOMOS is collaborating with EMR partners to embed external data queries into clinician workflows, removing the need for separate portals. Finally, we are launching **provider education initiatives and technical assistance programs**—particularly for Medicaid-serving and culturally aligned clinics—to raise awareness about TEFCA participation and provide on-the-ground support for connection and compliance. By leading with equity, usability, and readiness, SOMOS is ensuring that TEFCA becomes a functional tool for all providers, not just the largest institutions.

Other Options Outside TEFCA Currently Available

Providers today currently utilize a range of alternative options, including but not limited to the following:

- **DirectTrust (Direct secure messaging):** Widely adopted for transitions of care, particularly for sending referral summaries, discharge notes, and other clinical documents. While not designed for query-based exchange, it offers a reliable channel for point-to-point communication. Some providers also leverage Direct as part of their Meaningful Use compliance.
- **Vendor networks (Carequality/CommonWell):** Many EHR platforms are connected through these frameworks, facilitating record sharing across large health systems. For example, providers using eClinicalWorks may access patient data from Epic-based institutions via Carequality or CommonWell. Additional vendor-based exchanges include athenahealth's MDP and Oracle Health (formerly Cerner) networks, which serve as alternatives for cross-system interoperability.
- **State/Regional HIEs:** In New York, platforms like Healthix, Rochester RHIO, and Hixny provide regional data aggregation, real-time alerts, and longitudinal records. These HIEs often serve as the primary source of external data for safety-net providers and community-based organizations. Other states use CRISP (MD/DC), Manifest MedEx (CA), and CONNIE (CT) for similar purposes.
- **API-based exchange via FHIR:** Adoption of FHIR-based APIs is increasing, especially among value-based care organizations and ACOs. Some hospitals and health systems enable secure data pulls for ADT feeds, lab results, and care gaps. National networks such as the CARIN Alliance and the Da Vinci Project support this model for payer-provider data exchange.
- **Patient-mediated exchange:** Tools such as CMS's Blue Button 2.0, Apple Health Records, and various patient portals allow individuals to retrieve and share their health data. These platforms empower patients to bridge data silos and can be particularly useful for cross-system or out-of-network scenarios.
- **Health Plan Portals and Payer-Facilitated Data Access:** Increasingly, providers access claims data, prior authorizations, and risk scores through payer portals or APIs. This payer-to-provider exchange often complements clinical data sources and supports population health management.

These suffice to an extent, but have gaps (especially crossing geographic or network boundaries). TEFCA's job is to unify these. Until TEFCA is fully realized, we lean on these options in combination.

Redundant Standards/Channels to Consolidate

We observe significant redundancy across current data exchange channels serving Medicare beneficiaries. For instance, providers may query both a regional HIE and a national EHR network such as Carequality for the same patient, only to receive near-identical clinical documents. This results in duplicative infrastructure and workflow inefficiencies. TEFCA is well-positioned to streamline these disparate systems by creating a unified framework that connects major HIEs, EHR networks, and health plans.

Key areas for consolidation include:

- **eHealth Exchange vs Carequality vs other trusted networks:** Many Medicare-serving providers and systems are connected to one or more of these networks. TEFCA could offer a single trust framework to replace fragmented participation, helping streamline Medicare data exchange especially in the context of transitions of care and post-acute services. Over time, legacy frameworks might be retired or incorporated into QHIN operations under the TEFCA umbrella.
- **Direct secure email/messaging vs C-CDA query-based exchange:** Many times, in Medicare settings—particularly with older adults moving between hospitals, SNFs, and home health—providers may receive or request the same information either via a push (Direct email) or query (exchange network). Perhaps post-TEFCA, if query is ubiquitous and fast, fewer Direct pushes would be needed (except maybe for referrals where push is straightforward). Consolidation might be more on the policy/trust side – using TEFCA Common Agreement to cover what multiple BAAs or DSAs do now. Ultimately, TEFCA’s framework could prioritize more efficient, ubiquitous query mechanisms, reducing reliance on duplicative Direct messages except in limited cases such as referrals.
- **Multiple patient identity frameworks:** Medicare beneficiaries often receive care across systems—traditional Medicare, Medicare Advantage, long-term care, and specialists—essentially each HIE or network with its own patient matching. Each network’s separate patient-matching logic hinders longitudinal care coordination. Under TEFCA, an opportunity for a consolidated approach offers an opportunity to standardize or federate identity resolution across QHINs to ensure accurate patient matching, especially for aging adults with high utilization, avoiding duplicative efforts by each QHIN doing it.
- **Proprietary APIs:** The current landscape includes many vendor-specific or bespoke APIs, forcing many providers to use one-off APIs to pull Medicare data, including eligibility, prior authorizations, or discharge summaries from payers and hospitals. TEFCA’s emphasis on standard FHIR-based exchange would allow gradual sunset of these siloed data pipes in favor of more secure, scalable, and interoperable interfaces.

SOMOS Commitment

We operate across New York City with a deep focus on caring for dually eligible (Medicare-Medicaid) and complex Medicare patients. Our provider network includes primary care physicians, community-based health centers, and specialists managing chronic conditions common in the Medicare population. Redundant exchange mechanisms increase administrative burden and can delay timely interventions—particularly for patients in transitions of care. To address this, SOMOS is actively developing an interoperability strategy aligned with TEFCA’s efforts for consolidation, which includes:

- **Mapping overlapping Medicare data channels** used by our providers—such as Healthix HIE access, Carequality integrations, and DirectTrust messaging—to identify and streamline duplicate workflows without overlap.
- **Preparing to integrate through a QHIN** once TEFCA pathways are viable and available for safety-net and value-based care providers who disproportionately serve Medicare beneficiaries.

- **Piloting standards-based FHIR interfaces** to replace ad-hoc APIs for hospital discharges, readmission alerts, and chronic care coordination.
 - **Phasing out custom-built interfaces** in favor of standards-based FHIR APIs, particularly for ADT feeds, risk scoring, and preventative screening data.
 - **Engaging with state and national stakeholders** to help shape patient identity strategies that are effective for mobile, aging, and dually enrolled populations. This includes aligning with emerging identity initiatives and working with vendors to adopt TEFCA-compliant patient matching approaches.
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Conclusion and Call to Action

In summary, we believe TEFCA must become the **consolidating force**—not another parallel system. Its success will be judged by how well it simplifies the information ecosystem for Medicare clinicians and care managers while reducing duplicative infrastructure and protecting continuity of care across settings. It should be the umbrella that draws them together, then over time those older channels either merge or become obsolete.

Presently, TEFCA hasn't tangibly changed day-to-day provider access for us. But it's on the horizon. We suggest accelerating TEFCA participation and making it as provider-friendly as possible. Meanwhile, we continue to rely on existing HIE and network solutions to get needed data. Eliminating redundancies and focusing everyone's efforts through TEFCA will, in our belief, yield a more **scalable, nation-wide interoperability** that truly benefits front-line providers – reducing the “Swiss cheese” effect of current patchy exchanges. We urge CMS/ONC to keep an eye on provider needs as TEFCA governance and technical approaches evolve, ensuring it delivers on its promise in the exam room soon.

PR-7. Strategies to Increase Data Availability with Less Burden

Question: “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?”

SOMOS Perspective

Strategies for CMS to boost data availability while minimizing provider burden should focus on aligning interoperability tasks with providers’ routine clinical and administrative workflows, so that sharing data is a by-product of work they’re already doing, not an extra chore. Below we will cover several key strategies.

1. Leverage and Enhance Existing Quality/Reporting Programs

Providers are already motivated to capture certain data for quality programs (MIPS, HEDIS) and patient care (like medication reconciliation). CMS can ensure that data collected for these programs is also used to feed interoperability. For example, under Promoting Interoperability, providers must send summary of care documents; CMS can emphasize use of standardized APIs or registries for the same information. If a provider is documenting allergies and medications carefully for quality and safety, that same data should automatically flow out via FHIR Patient Access API or HIE – no extra step. Essentially, reuse the data providers input for care/quality for external sharing. **Reusing metrics:** Perhaps tie an interoperability metric to something like chart completeness – e.g., if providers maintain problem lists and meds up to date (which they do for patient care and quality measures), those elements will naturally be high-quality when shared externally. So, encourage care processes that inherently produce better data.

2. Embed Interoperability into EHR workflows

CMS could work with ONC to require EHRs to have *seamless exchange functionalities* that operate with minimal provider intervention. For instance, when a provider closes an encounter, the EHR could automatically send an updated care summary to the HIE or network – not requiring the provider to remember to click “send.” Similarly, make retrieving external data as easy as one button that merges into the chart. By automating at the system level, data gets shared without burdening the individual clinician. CMS can push for such automation through certification criteria or contracting (e.g., requiring hospitals to participate in networks that auto-exchange ADTs, which is partly done via CoP notifications rule).

3. Provide Feedback and Incentives for Data Quality

One reason data exchange can be “garbage in, garbage out” is inconsistency in how providers enter data (e.g., free-text vs coded, missing fields). CMS can implement a feedback loop – for example, in CMS’s quality reports back to providers, include measures of data completeness or interoperability usage (e.g., “X% of your patients had an electronic summary available from external sources” or “your referral notes contained structured problem lists vs peers”). Friendly competition or just awareness can drive improvement. Additionally, CMS could reward high data quality/availability in value-based models: ACOs might get credit for demonstrating robust data sharing with partners.

4. Reduce Redundant Documentation Requirements

A lot of provider burden comes from duplicative documentation for different purposes (billing, quality, state reporting). If CMS streamlines or harmonizes requirements, providers can focus on recording data once in a standardized way which then serves multiple uses. For example, align documentation for billing with quality (already moving toward that with Evaluation & Management changes). If an element like smoking status is needed for quality, make sure that satisfying that in EHR also suffices for any CMS reporting (which it largely does, but further ensure that measure extraction is automated – e.g., eCQM submission from EHR rather than manual chart abstraction). **Mitigation:** The more data capture is part of normal care (like entering vitals, problem list updates), and the less separate forms they must fill, the less burden. CMS can continue shifting to *digital quality measures* that pull from EHRs automatically, removing the need for separate quality reporting workflows.

5. Data Intermediaries and Shared Services

Not every small practice can invest in fancy interoperability solutions. CMS could support **shared infrastructure** – maybe through HIEs or vendor provided – so providers offload some tasks. For example, a state HIE could act as a centralized data repository where providers send their data once and others can get it. That means the provider isn’t responding to individual record requests repeatedly. CMS can encourage states to leverage HIEs for CMS programs (some have Medicaid using HIE for quality reporting, etc.). Also, consider CMS-sponsored “clearinghouses” for data exchange in specific domains (like immunizations or opioid prescriptions) that providers contribute to as part of compliance, which then also feed care.

6. Promote Team-Based Data Tasks

Many burdensome data tasks can be shifted off the physician onto support staff or automated systems. CMS should make sure regulations allow that – e.g., let nurses or pharmacists document certain things and have it count for requirements. This way providers can delegate interoperability-related tasks (like assembling referrals or chasing records) to care coordinators, with appropriate support. In our ACO, we employ care coordinators who obtain outside records and import them to EHR, relieving doctors. CMS could fund such roles through care management fees or ACO shared savings rules, effectively encouraging that delegation which results in more complete data in charts.

7. Standardize Consents and Privacy to Avoid Roadblocks

Sometimes providers hesitate to share data out of fear of privacy rules (especially around 42 CFR Part 2, mental health, etc.). CMS working with OCR could simplify consent management – perhaps promote a standard electronic consent that patients can sign for broad exchange. If providers feel more secure legally, they won’t put up self-imposed barriers that inadvertently limit data availability.

8. Leverage Existing Motivation – referrals and transitions: Providers already try to send info when referring or discharging because it’s good care (and often a requirement). Strengthen those existing workflows with better digital tools. For instance, require that discharge summaries be sent electronically to follow-up providers within 1 day (a current CoP, but ensure it’s electronic, not fax). They’re doing the summary anyway, just make the sending part of routine. Or ensure referral orders in EHR auto-generate a summary to the specialist. CMS can measure and hold hospitals/organizations accountable for that (like a metric: % of transitions that include an electronic summary). Since transitions are already a workflow, hooking interoperability onto it is natural.

9. Dual-purpose investments: If a provider invests in an EHR upgrade to improve internal data capture, that should automatically improve external data sharing if standards are followed. CMS can provide grants or incentives for upgrading systems (like through MACRA small practice support) on condition they implement interoperability features. That one investment serves internal efficiency and external exchange simultaneously.

Mitigating Burden Concretely

One example: Instead of requiring a clinician to manually input immunization data into both the EHR and a state registry website, implement standards (which exist, like HL7 VXU messages from EHR to registry) so that once entered in EHR, it auto sends to registry. CMS could work with CDC and states to enforce that integration. Then one action (document vaccine) achieves two goals (patient record updated + public health reporting done). This dramatically cuts burden and improves timeliness of data.

Another: For Medicare, instead of asking providers to submit medical records for risk adjustment or audits, use interoperability to fetch needed data (e.g., via the Bulk FHIR that payers can use, or via QHIN queries). That means providers are not spending hours responding to record requests – the data they entered for care is reused by CMS/payers automatically. CMS’s pilot retrieving records for HCC validation is a step in that direction.

Conclusion and Call to Action

In summary, CMS should aim to “**make doing the right thing the easy thing.**” Providers naturally want comprehensive, timely data for their patients – CMS’s strategies should align incentives and technology such that by providing good care and doing normal documentation, providers automatically fulfill interoperability needs. Minimize any separate or duplicative data entry. Use existing optimized workflows (like routine documentation, referrals, quality

improvement huddles) and embed data sharing tasks into them via automation and policy. By doing so, high-quality data will flow without adding undue steps or fatigue on providers, effectively killing two birds (improved care and regulatory compliance) with one stone.

PR-8. Simplifying Clinical Quality Data Responsibilities

Question: “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? b. In what ways can the interoperability and quality reporting responsibilities of providers be consolidated so investments can be dually purposed? c. Are there requirements CMS should consider for data registries to support digital quality measurement in a more efficient manner? Are there requirements CMS should consider for data registries that would support access to real-time quality data for healthcare providers to inform clinical care in addition to simplifying reporting processes?”

SOMOS Perspective

This question overlaps with PA-5 and PR-7, focusing on quality data. We strongly support moving to **digital, automated quality measurement using data the provider’s EHR already collects, transmitted via standard APIs** – as this can greatly reduce manual chart abstraction and multiple reporting pipelines.

Bulk FHIR Exports to CMS for Quality Reporting (with CMS Doing Calculations)

Benefits: If CMS could accept a bulk data file (e.g., a FHIR bulk export of all relevant patient data elements) and then itself compute quality measures, it would relieve providers/EHRs from implementing complex measure logic. This addresses variation – currently, each EHR vendor or provider might interpret measure specs slightly differently, causing inconsistency. If CMS does it centrally, measure calculation is uniform. It also reduces provider time – no more manual sampling or double documentation to meet measure logic (like filling out a separate flow sheet just for a measure). Providers just document care normally; CMS’s algorithms glean performance. For example, instead of a clinic running a diabetes control report and submitting numerator/denominator, the clinic could just send relevant patient data (last A1c values, etc.) and CMS figures out the percentage controlled.

Another benefit is *timeliness*: CMS could potentially calculate measures more frequently (quarterly or monthly) if it can ingest data continuously. Then it could feed that back to providers so they can course-correct earlier. This addresses real-time improvement rather than retrospective.

Downsides/Challenges: Providers might worry about losing insight or control – currently they often double-check measure results before submission; if CMS calculates, they need trust the calculation. There might need to be a way for providers to replicate CMS’s results for validation (maybe CMS provides a sandbox or test calculations). Also, transmitting bulk detailed data to CMS raises privacy and security – but CMS is a covered entity and already has lots of data

(claims), so it's manageable with proper agreements. Technically, some EHRs might balk at outputting raw patient data externally due to data ownership concerns. But CMS likely can mandate it for program participation.

One downside: volume – if every provider sends all patient data, CMS will get a flood. However, CMS can filter to just the needed data elements per measure (via something like a DEQM FHIR MeasureReport). That's an implementation detail.

Net: We believe benefits outweigh downsides. It would dramatically cut provider reporting burden – no more manual eCQM data entry or separate submissions to multiple payers; one export to CMS could even be shared with other payers if aligned.

We see this akin to how CMS is moving to eQMs for ACOs: requiring digital submission of patient-level data. That's a step. Ultimately, letting CMS do the heavy lift is good – providers focus on care, not on data crunching.

Consolidating Interoperability and Quality Reporting Responsibilities (Dual-Purpose Investments)

As discussed, unify the infrastructure used for exchange and quality. Concretely:

- Use *the same data pipeline* for both patient care exchange and quality. For example, if a provider connects to an HIE and sends CCDs after each visit (for care continuity), that same HIE could aggregate a year's worth of those CCDs and compute quality measures or forward to CMS. So the provider invested once (in connecting to HIE) which serves two purposes (care and quality reporting). CMS can encourage such models by maybe accepting data from certified HIEs or QHINs as quality submissions on behalf of providers.
- Align data standards: If providers implement FHIR APIs for interoperability (as per Cures Act), leverage those for quality data submission as well. ONC and CMS are already pushing toward "FHIR-based quality measures." That means the data providers share to other providers (via FHIR USCDI resources) is the same data CMS will use for measures. It reduces extra capture. For example, a provider enters smoking status once (structured), it's available to share to another provider (so continuity) and also goes into measure numerator for tobacco screening measure. Not separate processes.
- Combine program reporting: A provider might separately report to CMS, state Medicaid, and commercial payers. If all accepted the same digital feed (like a bulk FHIR file or submission to a centralized registry), the provider invests in sending data once. This might require a trusted aggregator (e.g., a regional collaborative or a vendor that collects on behalf of many payers). CMS can lead by aligning its requirements with others. It has done some alignment via Core Measure sets. But even better, coordinate data submission channels. Perhaps CMS could host a "Quality Data Home" where providers upload one dataset that authorized payers can also query for their needs, eliminating duplicate submission. It's somewhat utopian due to competition, but we see multi-payer collaboratives in some states doing exactly this – CMS could learn from those.

- Reuse EHR logs for both compliance and improvement: Example – many providers track data completeness for internal QA. That same tracking can show readiness for interoperability (like does every patient have demographics needed for matching? Are summaries sent for X%?). If CMS builds measures of interoperability (maybe as part of Promoting Interoperability scoring), tie them to things providers already do (like maintaining current med lists). So one activity (keeping med list updated) serves patient care, meets quality (e.g., med reconciliation measure), and meets interoperability (shared med list is accurate).

Requirements for Data Registries for Digital Quality Measurement and Real-Time Data to Providers

- Many specialties use registries (e.g., cardiology, oncology registries) to track patient outcomes. These can be powerful if they feed data back to providers quickly. To better integrate with digital quality, CMS could require registries to adopt **standard data formats/APIs** – e.g., accept FHIR data from EHRs and also expose results via API to providers. For instance, a registry could provide a FHIR MeasureReport resource accessible by the provider’s EHR, so the clinician can see their performance on a measure in near real-time without logging into a separate portal.
- CMS might require that any registry used for CMS quality reporting (like QCDRs – Qualified Clinical Data Registries) must have certain capabilities: API integration with EHRs (no manual uploads), ability to provide patient-level gap lists to providers, and up-to-date feedback (say within a week of data submission). That real-time aspect is key – providers should not wait months to see how they’re doing. If a registry can process data continuously, it should share continuous feedback.
- Also, require registries to align with eCQM specifications so their measures can count for CMS programs – eliminating separate workflows (some docs currently enter data into a registry for MIPS and into their EHR differently for internal use; if registry and EHR talk, one entry suffices).
- Perhaps encourage a model where registries act as *intermediaries* for interoperability too. They often have comprehensive data on a patient’s care in a certain domain. If a provider queries the registry for a patient’s data (with consent), they might get info that crosses multiple providers (since registry collects from all participating providers). That’s an interoperability boon. Ensuring registries have data exchange API (like a query interface for patient data) would support providers retrieving info in real-time for care. CMS could incorporate that in certification or in QCDR qualification criteria.
- For “real-time quality data to inform clinical care”: If a patient is falling behind on a metric (e.g., no flu shot documented), the system (via registry or EHR) could alert the provider during a visit. This ties to CDS Hooks or similar – but requires the measure calculations to happen quickly and trigger an alert. Perhaps require that certified health IT or registries be able to produce *patient-specific gap alerts*. One idea: a standard FHIR resource like a CareGap or a GuidanceResponse that can be invoked at point of care. If registries support that (like an API call “does patient X have any open quality gaps?”

returning a structured list), the EHR can display it. This speeds up closing gaps and uses quality data for direct care improvements.

- Finally, ensure providers have easy access to their raw data in registries – some registries hold data but not all allow providers to extract patient-level data easily due to technical or business reasons. Requirements could enforce that providers can download their own patients' data set from a registry (for instance, a FHIR Bulk export from the registry). This not only gives autonomy but allows providers to cross-verify and use data for local improvement initiatives.

Conclusion and Call to Action

In summary, **digital quality measurement must be intertwined with everyday data use.** Bulk data to CMS with central calcs is a promising approach to lighten provider load. Consolidation and dual use of data flows can reduce redundant effort. Data registries should evolve from passive repositories to active, interoperable platforms feeding insight back rapidly. If CMS sets expectations and provides necessary tech standards and perhaps slight funding support for modernization, providers will benefit by having a single unified data effort that satisfies both quality programs and point-of-care information needs.

Digital Identity

PR-9 through PR-11

PR-9. Encouraging Providers to Accept Digital Identity Credentials

Question: “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? a. 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? b. How might CMS balance patient privacy with convenience and access to digital health products and services that may lead to significant improvements in health?”

SOMOS Perspective

To encourage providers to accept federated digital identity credentials (like Login.gov) for patient access, CMS can take several steps:

- **Incentivize EHR Integration of Federated ID:** CMS (working with ONC) could incorporate acceptance of federated patient credentials into EHR certification or Promoting Interoperability measures. For example, ONC could include a criterion that patient portals must allow login via one or more trusted identity providers (Login.gov or others). If vendors build it as standard, providers just have to turn it on. CMS could then give credit in MIPS or hospital PI for enabling “third-party/federated login” as a way to improve patient access. This kind of gentle push would help overcome inertia.
 - **Provide Implementation Support and Guidance:** Many providers (especially smaller ones) will need technical help to implement federated ID (it involves configuration, trust agreements, etc.). CMS can work with organizations like the Sequoia Project or DirectTrust to publish guides/toolkits for adopting federated ID. For instance, a step-by-step on how a practice can enable Login.gov for their patient portal. Possibly even subsidize a national integrator contract that providers can opt into which handles the heavy lifting.
 - **Address Liability and Trust Issues:** Providers might worry about trusting an external ID to grant access to sensitive records. CMS could coordinate with identity providers to assure providers of security (maybe create a liability framework where the ID provider vouches for the authentication). If providers know that, for example, Login.gov has identity-proofed the user to NIST standards, they can be comfortable. CMS might endorse that using such credentials meets HIPAA authentication requirements. A clear statement from HHS that “Login.gov is an acceptable authentication for patient portal access” would reassure compliance officers.
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What Help Providers Need to Accelerate Transition?

- *Technical integration:* as above, they might need an IT consultant or vendor solution to connect their systems to the federated ID (via OpenID Connect or SAML). So, many will

need their EHR vendor to provide an update. CMS might convene EHR vendors to encourage building that out-of-the-box.

- *Patient linking:* If a patient logs in with a federated ID, the provider's system needs to link that to the correct medical record. That may require patients performing a one-time matching (e.g., entering an invite code or matching on personal info). Providers could use help in designing that onboarding flow. Perhaps CMS can work with identity services to streamline linking (maybe through Medicare records since Medicare has both an ID and knowledge of provider relationships).
- *Educational help for staff:* front desk and health information management staff should understand what these credentials are, so they can help patients adopt them. CMS could produce simple brochures or training modules that providers can use to educate their workforce and patients about the benefits (like “Use Login.gov – one account to access all your health info!” tagline with security assurances).

Financially, providers might need an incentive to invest time in this change – e.g., CMS could offer a small bonus or higher portal usage credit in MIPS if they integrate federated login.

Balancing Patient Privacy with Convenience and Access

This is crucial: a single credential potentially unlocking records at multiple providers can raise privacy concerns (if misused, one breach could expose multi-source data). To balance:

- *Patient control and consent:* Ensure that using a federated credential still respects that patients control who accesses their data. For example, if a patient uses Login.gov to log into multiple portals, each portal still only shows that provider’s data; the credential doesn’t automatically merge everything unless the patient chooses a health app to do so. Emphasize to patients they can decide where to use it.
- *Privacy safeguards:* The identity provider (Login.gov) should not log or share which providers a patient is accessing (or if it does for security, that data should be protected). Essentially, separate the authentication from health data content.
- *Multi-factor and security best practices:* The convenience of one login should not come at cost of weaker security. In fact, using a high-assurance credential likely improves security overall (since it’s more robust than many clinic portal logins). We must communicate to patients that using a trusted digital ID is safe and perhaps safer than multiple accounts (less password reuse, etc.).
- *Alternate options:* For patients who do not want a unified credential (maybe they fear government ID or prefer separate contexts), providers should still allow alternatives (the classic portal account). So, adoption of federated ID should be encouraged but not forced on patients. That respects privacy choice – e.g., an undocumented patient might not want to use a government-backed login; they can still access via provider’s own credentials.
- *Policy on data linking:* If someday a single credential allowed auto-linking records across providers (as in future health information exchanges or patient-mediated exchange), ensure there’s patient consent. Possibly incorporate consent in the login flow: e.g., “Would you like to use your Login.gov account to link your records from Dr. A and Dr. B?” – giving them control.

From provider perspective, balancing privacy means verifying that the person using the credential is indeed the patient or authorized rep. Federated IDs like Login.gov actually improve that via strong identity proofing (which could reduce impostor risk). That's good for privacy because it ensures the right person sees records.

So ironically, convenience via one credential can align with privacy by centralizing and professionalizing the security (many small practices have weaker login systems with just username/password easily forgotten or hacked; Login.gov uses multi-factor, etc., which is more private).

Conclusion and Call to Action

In summary, CMS can **lead by example** (e.g., adopt Login.gov for Medicare portal, and allow providers to piggyback on that trust), educate providers on how it reduces burden (no more resetting dozens of passwords for patients; potentially fewer support calls), and ensure the policy environment is supportive (clear that HIPAA allows it, and that identity proofing from these services is acceptable for releasing records).

This will yield improvements in health by increasing access: patients more likely to actually use their digital health tools if it's one login. As noted in PC-14, the VA's experience shows skyrocketing usage when adopting Login.gov due to convenience. More engaged patients means better adherence, more informed decisions, and ultimately improved outcomes – which is the goal, achieved with both privacy and usability in mind.

PR-10. Provider Perspective on Digital Identity Credentials

Question: “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? b. How would requiring their use improve access to health information? c. What are the potential downsides? d. What impact would mandatory credentials have on a nationwide provider directory? e. How could digital identity implementation improve provider data flow? f. Would combining FHIR addresses and identity improve data flow?”

SOMOS Perspective

We support the **strategic use of digital identity credentials** (e.g., Login.gov, ID.me) as a means to strengthen trust, streamline access to health data, and ensure secure interoperability across care settings. For providers, these credentials can **simplify authentication processes and reduce administrative burdens** when accessing or exchanging health records. Mandating digital credentials could improve access to health information by enabling seamless integration across systems, including a nationwide provider directory. However, potential downsides include onboarding challenges for smaller practices with limited IT infrastructure and the need for strong user support. When paired with FHIR endpoints, **digital identity can enhance provider data flow** by enabling accurate, real-time exchange of information tied to verified entities—improving continuity of care and network integrity in value-based systems like SOMOS.

Challenges and Benefits for Providers

Challenges: For providers, adopting federated digital identity for patients may pose:

- **Integration Work:** As discussed, technical integration into existing systems is non-trivial. Many providers rely on vendor patient portals; they must coordinate with vendors to enable external identity. This can take time and possibly cost, which small clinics might find burdensome without external help.
- **Change Management:** Staff must learn new processes (e.g., verifying if a patient used a login.gov and linking it to their chart). There might be an initial influx of support calls from patients trying to use a new method. Providers are cautious about anything potentially interrupting patient access or satisfaction.
- **Trust and Liability:** Providers might worry if using an external credential could lead to liability if something goes wrong (e.g., if a credential is compromised, could someone falsely access a portal? Would the provider be responsible?). They need assurance that these credential systems are secure.
- **Patient Matching:** Ensuring the John Smith logging in with login.gov is the same John Smith in their practice might be tricky especially if the patient doesn’t input exact matching info. There could be initial mis-matches or duplicates to manage.

Benefits:

- **Simplified Management:** Providers (and their IT staff) no longer have to manage as many username/password resets. That overhead can be significant. It's essentially outsourcing authentication to a high-grade service, freeing up provider office resources.
 - **Improved Portal Adoption:** If more patients use their portal or apps due to easier login, providers benefit through greater patient engagement (e.g., easier to communicate with patients, share results, do telehealth).
 - **Security Confidence:** These identity services often have stronger security (2FA, identity proofing) than a typical clinic portal. This reduces risk of unauthorized access. Knowing a patient is robustly verified by government standards might improve confidence in releasing sensitive data electronically (less fear that someone impersonating the patient will get records).
 - **Streamlined Multi-provider Coordination:** For providers treating referred patients, if patients can use one identity to share their records from other providers easily, providers get a more complete picture with less chasing of records. That can improve care coordination.
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How Requiring Their Use Would Improve Access to Health Info

If, say, CMS required that all Medicare providers accept a federated credential for patient portal, it could drastically reduce friction. Patients often give up on accessing information because of login hassles. One credential means patients log in more regularly to see test results, visit summaries, etc., across all providers. This continuous engagement means they stay more informed (e.g., they might actually read their specialist's note and bring up questions with their PCP). Also, if a patient can leverage one identity to connect an app that aggregates data from multiple providers, they effectively have a personal health record. That improved access means if they see a new provider or go to an emergency room, they can quickly retrieve their data via that app. So, broadly, requiring a common credential fosters **interoperability at the patient-mediated level** — patients become a conduit, empowered to share across systems with ease.

Additionally, if digital identity is tied into a nationwide provider directory or contact network (the snippet suggests something about nationwide endpoints), it could help providers identify and verify each other. E.g., a provider logging into a national health info network could use their own federated ID for single sign-on to multiple systems (less relevant to patient info, but a benefit for cross-organizational access).

Potential Downsides

- **Dependence on External System:** If mandatory, everyone relies on a few identity providers. Outage or failure there could block patient access widely (single point of failure risk). For example, if Login.gov has downtime, patients couldn't log into any portals that rely on it. We'd need robust uptime guarantees and maybe multiple credential options to mitigate risk.

- **Digital Divide:** Requiring might disadvantage patients who are not comfortable or able to create such credentials. For instance, some elderly patients or those without credit history might struggle with ID.me verification. We'd need alternative means for them (like still having local credentials as fallback). If not handled, mandatory use could temporarily lock some patients out – which would negatively impact equity in access.
 - **User Friction in Onboarding:** The identity proofing process can be more involved (e.g., scanning driver's license, answering personal questions). Some patients may find that too intrusive or confusing, and just not sign up – thereby paradoxically reducing their access if it becomes the only way.
 - **Privacy Perception:** Some might distrust using a centralized identity for health (fear that the government or large corporation might track their medical usage). This could cause pushback and reluctance, impacting patient-provider trust. E.g., a mental health clinic's patients might not want to use a common ID that they also use for, say, IRS or DMV, even if legally that data isn't shared.
 - **Technical Issues & support:** If something goes wrong with identity (like they get locked out of login.gov because of too many attempts), providers cannot help since it's external – patients must navigate federal support lines. That could frustrate patients and indirectly reflect on provider's service.
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Impact of Mandatory Credentials on a Nationwide Basis (Likely Referencing Provider Directory or Endpoints)

If every provider uses one nationwide provider directory login, or every patient uses one account to hit nationwide endpoints, the network effect is huge: **ease of cross-network queries, easier linking of records** as discussed in VB-15. For provider directories: if all providers have a digital identity credential tied to, say, NPI, updating a national directory is simpler (they log in with that credential, proving they are Dr. X, and update their practice info). That improves directory accuracy and trust.

From an interoperability standpoint, mandatory credentials could also mean in any exchange, verifying identity is standardized – reducing ambiguity and fraud. For instance, a nationwide patient credential might, in future, assist in matching records (because one unique identifier could link across systems more reliably than name/DOB alone).

However, mandating anything nationwide must be done carefully to avoid the downsides above and to allow a transitional period.

Recommendation to CMS

The benefits in convenience and improved access are high, but we should implement in a phased or opt-in manner at first, ensuring alternatives remain. CMS might start by strongly encouraging and providing incentives rather than strict requirement, monitor adoption, then gradually tighten expectations once issues are ironed out. Throughout, balancing privacy means transparency with

patients (who is providing the credential, what data they collect, etc.) and robust security protocols.

Conclusion and Call to Action

In summary, **from a provider perspective**: one trusted digital identity for patients is attractive for efficiency and data sharing, but providers need help implementing and assurances that it won't compromise privacy or leave any patient behind. With support and careful planning, the upside of widespread digital credentials (be it in provider directories or patient access) is a more fluid, connected healthcare experience for all.

PR-11. Enhancing Identity Management While Reducing Burden Through Trust Communities

Question: “How could members of trust communities ⁽³⁾ (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?”

SOMOS Perspective

We as a physician-led, value-based care organization serving diverse and Medicaid-dominant communities in New York City, believe trust communities such as QHINs and their affiliated networks can play a **pivotal role in both reducing administrative burden and strengthening identity management**—if their infrastructure is built with equity, usability, and workflow integration in mind. Below we outline several strategic opportunities to achieve these dual goals.

1. Reduce Provider and Patient Burden Through Federated Identity Services:

Trust communities should serve as shared identity utilities—supporting both patients and providers by centralizing and verifying digital identities using high-assurance, scalable models that reduce the need for duplicative logins and workflows.

Recommendations:

- **Leverage IAL2 Credential Service Providers (CSPs) Across the Ecosystem**
QHINs and subparticipants should allow patients and providers to authenticate across multiple systems using a *single IAL2-verified credential* (e.g., Login.gov, ID.me). This drastically reduces portal sprawl and administrative burden.
SOMOS is actively advocating for digital identity tools that allow our Medicaid and Medicare patients to access multiple services via a single login, particularly those integrated into our MediFlow platform.
- **Integrate Federated Identity into Local Workflows via APIs**
CSP-authenticated identities should be interoperable not only with patient-facing portals but also within provider-facing EHR workflows. For example, a clinician accessing records across institutions through TEFCA should not have to re-authenticate with separate credentials for each QHIN.
SOMOS is piloting SMART on FHIR integrations that could easily align with federated identity workflows across QHINs, enabling seamless provider queries and reducing login complexity for care managers and physicians.

2. Enhance Security and Trust Through Standardized Identity Matching:

Identity management should also **improve the quality and reliability of data exchange**. QHINs can lead in this area by adopting and enforcing **standardized patient and provider identity matching protocols** that prevent fragmentation and mismatches—critical issues in high-utilization populations such as ours.

Recommendations:

- **Use IAL2/CSP-verified identities as anchors for patient matching across systems**
Trust communities could incorporate verified identity tokens into record-locating services to improve the accuracy of patient-matching in TEFCA queries. This is especially valuable for patients with common names or inconsistent demographic data (which is prevalent in safety-net settings).
SOMOS providers often see patients who receive care at multiple hospitals or facilities; a shared digital identity could significantly enhance data continuity and reduce duplicative or risky care.
- **Encourage provider identity credentials and directory updates tied to verified credentials**
If every provider who logs into a QHIN-participating system uses an IAL2 credential tied to their NPI, this could improve the quality and reliability of the nationwide provider directory.
SOMOS would support identity-based provider updates to reduce mismatches in directory data that affect referrals and prior authorization workflows.

3. Support Patient Adoption and Access Through Community-Based Onboarding:

To fully realize the benefits of strong digital identity systems, **patients—especially those in underserved communities—must be able to enroll in and use IAL2 credentials** with ease. QHINs and trust community members must go beyond offering the service and actively **partner with providers like SOMOS** to deliver inclusive, assisted onboarding experiences.

Recommendations:

- **Fund and deploy digital identity navigators in community health settings**
Trust community members can contract with or support community-based organizations (CBOs) and practices like SOMOS to onboard patients during care episodes (e.g., during an intake appointment or preventive screening).
SOMOS already deploys bilingual digital navigators to assist patients with MediFlow portal registration, device setup, and understanding their rights—this can be expanded to digital identity credentialing.
- **Offer multilingual, literacy-sensitive educational tools about digital identity**
Current credentialing flows are often written at a college reading level. TEFCA participants should create or co-brand educational materials in multiple languages and formats (videos, illustrated guides, SMS-based prompts).
SOMOS's patient population includes many low-English proficiency seniors, immigrants, and Medicaid members. Materials co-designed with providers like us would improve adoption and reduce support burdens.

4. Invest in Shared Consent and Delegation Infrastructure:

Many patients—especially elderly, pediatric, or disabled populations—require **delegates or caregivers** to help manage their healthcare. QHINs and subparticipants can reduce provider and patient burden by building infrastructure that allows **credentialed caregivers to act securely and transparently on behalf of patients**.

Recommendations:

- **Support IAL2-verified proxy identities that allow caregivers to log in and act on behalf of patients** (with audit trails and revocable access).
SOMOS is seeing increased use of family caregivers and home health aides assisting with digital coordination. Making this secure and scalable would offload tasks from providers while empowering families.
 - **Create reusable consent artifacts across systems**
For example, a signed consent in one QHIN should allow that patient's information to be queried across all QHINs, rather than re-signing at each new provider. This would reduce friction in transitions of care.
SOMOS supports many patients with frequent care transitions—simplifying consent management will materially improve continuity and avoid delays.
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Conclusion and Call to Action

In summary, **trust communities like QHINs can be powerful allies in reducing burden and improving digital trust**—if they:

- Empower patients and caregivers with one strong identity across systems
- Simplify workflows for providers through federated logins and consent
- Improve security and matching by anchoring exchanges to IAL2 credentials
- Support culturally competent onboarding through trusted local partners

We are **ready to pilot these innovations with CMS, ONC, and trust community members**, particularly in high-need Medicaid and Medicare settings. By aligning infrastructure, policy, and local implementation support, CMS can ensure that identity management becomes an enabler—not a barrier—to equitable, efficient, and secure digital healthcare.

Information Blocking

PR-12 through PR-14

PR-12. Revisiting Information Blocking Exceptions to Advance EHI Access and Competition

Question: “Should ASTP/ONC consider removing or revising any of the information blocking exceptions or conditions within the exceptions (45 CFR part 171, subparts B through D) to further the access, exchange, and use of electronic health information (EHI) and to promote market competition?”

SOMOS Perspective

We strongly support the spirit of the information blocking rule and its seven exceptions. However, as an organization operating in diverse, safety-net, and value-based care settings across New York City, we have observed several ways the current structure and application of exceptions can unintentionally frustrate the very goals they aim to protect—particularly EHI access, patient empowerment, and fair competition among health IT actors.

We recommend **targeted revisions, clearer guidance, and improved enforcement pathways** to align implementation with real-world patient and provider needs, especially in under-resourced environments.

Summary of Key Concerns with Current Exceptions

While exceptions are essential to balance safety, privacy, and operational feasibility, **some are too broadly interpreted or inconsistently applied**, creating de facto barriers to EHI access. These often undermine:

- **Timely access to patient records for care transitions**
- **Patient-directed sharing to third-party apps or caregivers**
- **Provider-to-provider exchange across competing systems**
- **Small and community-based provider participation in innovation**

The cost, security, and content exceptions in particular are frequently cited as justification to delay, deny, or restrict exchange, especially when underlying motivations involve vendor lock-in or market protectionism.

Recommended Revisions and Clarifications

1. Revisit the “Infeasibility” Exception (§171.203)

- **Current issue:** This exception is too easily invoked when organizations claim lack of resources, technical capacity, or workflow readiness, especially in smaller clinics or EHR

vendors not yet equipped with modern APIs. We've encountered “we can't do it” responses where no serious technical justification exists.

SOMOS Recommendation:

- Require actors invoking infeasibility to **demonstrate documented efforts to comply** or present a remediation plan.
- Create a **“transitional compliance” status** for small actors to seek help while still progressing toward access—rather than a blanket pass.
- CMS/ONC should consider **time-limiting use of this exception** without a concrete mitigation timeline.

2. Revise the “Security” Exception (§171.203)

- **Current issue:** Security is essential, but this exception is often misused to deny third-party app access—especially when patient-authorized apps don't use proprietary APIs or when the actor is not part of a preferred vendor list.

SOMOS Recommendation:

- Clarify that **security concerns must be objectively justified** (e.g., via NIST standards), not used to block apps competitively.
- ONC should publish a **whitelist or security checklist** for app developers and health IT actors to preemptively validate secure practices and avoid inconsistent gatekeeping.
- Require documentation of **risk mitigation attempts before refusal**—not just citing vague security concerns.

3. Tighten Oversight of the “Content and Manner” Exception (§171.301)

- **Current issue:** This exception allows actors to fulfill EHI requests “in a manner of their choosing” if the request format is not “readily producible.” In practice, it enables vendors or health systems to reject FHIR-based queries or refuse to send discrete data elements—undermining app-based innovation and patient-mediated exchange.

SOMOS Recommendation:

- Revise to require **support of at least one standardized API format (FHIR R4)** when technically feasible.
- Limit fallback to PDFs or non-computable documents to **emergency or legacy systems only**.
- Encourage “manner flexibility” only when **FHIR implementation guides are not available**—not as an excuse to bypass them.

4. Address the “Fees” Exception (§171.302)

- **Current issue:** Vendors often charge **exorbitant interface or data export fees** under this exception, particularly for patient-matching, bulk FHIR exports, or SMART-on-FHIR app connections. This disproportionately affects **small provider groups and ACOs**—like many in our SOMOS network—who cannot afford custom API workarounds or third-party intermediaries.

SOMOS Recommendation:

- Cap “reasonable fees” for **interoperability-essential services** (e.g., API access, authentication, record location) based on CMS cost benchmarks.
 - Prohibit **fees for patient-directed access** via APIs, consistent with the Cures Act’s intent.
 - Increase transparency: Require actors to **publicly disclose all standard fees** for data access, development, or maintenance.
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Opportunities to Align with CMS Goals of Burden Reduction and Market Competition

Make Information Blocking Enforcement Meaningful for Providers and Patients

- **Patient Empowerment:** CMS and ONC should streamline complaint submission and triage so that patients and caregivers—especially in multilingual, underserved populations—can **report information blocking with confidence and clarity**. *SOMOS is prepared to partner in community-level patient education and onboarding around digital rights, using our digital navigator program and Medicaid outreach teams.*
- **Provider Fairness:** Provide small provider groups (especially independent or community-based) with **legal templates or complaint assistance** to report vendors or larger institutions who withhold data exchange under pretense. *We have heard from SOMOS-aligned providers that large hospital systems or EHR vendors frequently delay access when the requester is perceived as a competitor.*

Reframe “Interoperability” as a Shared Obligation—Not a Vendor Gatekeeping Tool

- CMS can build accountability into **Medicare and Medicaid contracting** by requiring participating providers and payers to **certify they are not misusing exceptions** to block exchange.
 - CMS could **tie bonus payments or risk adjustments** to demonstrated EHI availability, particularly for patient-facing APIs and FHIR-based exchange.
 - Encourage provider-payer-data intermediary **collaboration agreements** where information blocking exceptions are jointly reviewed and minimized in implementation.
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Conclusion and Call to Action

As a network deeply embedded in communities that often bear the brunt of fragmented data access—**immigrant families, seniors, and patients with complex care needs**—SOMOS is committed to supporting CMS and ONC in revising the rule to work **on the ground** as intended.

We are actively:

- Piloting FHIR-based data exchange with provider and payer partners
- Deploying third-party patient engagement apps for Medicaid enrollees and Medicare beneficiaries
- Educating providers on interoperability compliance, patient consent, and API usage
- Coordinating across EHR vendors to reduce fragmentation and promote transparency

We stand ready to **test new exception guidance, pilot secure app integrations, and evaluate fee transparency models** alongside CMS and other stakeholders.

While the information blocking rule is a landmark achievement, its exceptions must not become loopholes for maintaining control over data or avoiding competition. **Thoughtful revision and tightening of exception use to ensure that access, exchange, and innovation should be prioritized.**

We believe CMS and ONC have an opportunity to:

- Reduce administrative burden,
- Promote equitable patient access, and
- Spur competition in the digital health marketplace.

An **eagerness to collaborate, pilot reforms, and ensure underserved providers and patients are included** in building a more connected, patient-centered digital ecosystem is essential.

PR-13. Effective Disincentives for Noncompliance with Information Blocking Provisions

Question: *“For any category of healthcare provider (as defined in 42 U.S.C. 300jj(3)), without a current information blocking disincentive established by CMS, what would be the most effective disincentive for that category of provider?”*

SOMOS Perspective: Under the 21st Century Cures Act, healthcare providers are subject to the information blocking provisions defined in 45 CFR Part 171. However, not all provider categories currently face CMS-administered disincentives for noncompliance. Identifying effective and proportionate disincentives for these groups is essential to promote a level playing field and ensure that the intent of the Cures Act is fully realized.

Provider Categories Without Disincentives

Many provider types, including long-term care providers, behavioral health professionals, outpatient therapists, and some specialty physician groups (especially those not participating in Medicare incentive programs), currently operate outside the disincentive framework CMS has established for hospitals, MIPS participants, and ACOs.

SOMOS Recommended Disincentives: We propose a tiered, collaborative approach to disincentives, emphasizing education, technical support, and progressive enforcement. The following measures would be most effective for categories currently outside existing CMS enforcement:

1. Public Transparency Mechanisms:

- Create an "Information Blocking Compliance Dashboard" where provider organizations that are found to have engaged in information blocking are listed (de-identified or summarized by category), along with the nature of the complaint and whether corrective action was taken.
- This reputational accountability will motivate compliance, especially for providers dependent on referrals, reputation, and public contracts.

2. Incentive Alignment Instead of Only Penalties:

- For Medicaid and community-based providers, tie compliance with information blocking rules to eligibility for enhanced payments or care coordination grants.
- For example, New York's State Medicaid program could offer priority scoring for value-based payment initiatives (DSRIP 2.0, Health Equity pilots) to providers that demonstrate interoperability compliance.

3. CMS Certification for Data Exchange Readiness:

- Develop a "Digital Readiness Seal" or designation awarded to providers that meet certain interoperability and data sharing benchmarks. Conversely, providers who are found to be out of compliance would not receive this designation, which could impact their competitiveness in payer networks.

4. Condition Participation in Federally Funded Initiatives:

- Restrict access to future CMS-funded pilots, payment reform models (e.g., AHEAD, CPC+), or federal technical assistance grants for providers who have repeated, unremediated findings of information blocking.
- This approach should include a remediation pathway, so providers can come into compliance and regain eligibility.

5. Clinical Quality Impact Consideration:

- For non-MIPS clinicians, CMS could develop a voluntary pathway where providers who opt into data sharing and interoperability practices receive recognition that may eventually factor into quality ratings or public reporting (e.g., Physician Compare or Medicaid provider directories).

Conclusion and Call to Action

As a trusted convener and technology integrator in diverse, high-need communities, we stand ready to assist CMS and ONC in developing tailored disincentives and support structures that reflect the realities of small and community-based practices. Specifically, we are prepared to:

- Pilot educational outreach and peer mentoring programs that increase awareness and capacity among non-MIPS clinicians.
- Partner with HIEs and vendors to develop shared interoperability resources for small practices.
- Participate in CMS-led workgroups focused on disincentive design and stakeholder engagement.

We believe **disincentives must be meaningful but not punitive** to the point of harming access or sustainability—particularly in safety-net and minority-serving settings. SOMOS recommends a model that balances accountability with support, enabling providers to meet their obligations under the Cures Act while continuing to serve vulnerable populations effectively. We encourage CMS to work with trusted networks like SOMOS to ensure disincentive frameworks are equitable, evidence-based, and scalable across provider types.

PR-14. Promoting Trusted Provider Engagement in Information Blocking Enforcement

Question: “How can CMS encourage providers to submit information blocking complaints to ASTP/ONC's Information Blocking Portal? What would be the impact? Would it advance or negatively impact data exchange?”

SOMOS Perspective: We believe that enabling and encouraging providers to **report information blocking in a safe, clear, and constructive way is essential** to realizing the goals of the 21st Century Cures Act. However, this effort must be approached carefully to foster a culture of accountability and improvement—not one of fear or retribution. We believe CMS can play a pivotal role in encouraging provider participation in the reporting process by addressing the logistical, legal, and cultural barriers that currently deter reporting.

How CMS Can Encourage Provider Reporting

1. Raise Awareness and Normalize Reporting

- Most providers in the safety-net and small-practice space are still unfamiliar with the ONC Information Blocking Portal or are unsure what constitutes a reportable violation.
- CMS should initiate a **targeted educational campaign** (perhaps through MACRA, QIN-QIOs, or Regional Extension Centers) with clear definitions, real-world examples, and “common scenarios” where reporting is appropriate (e.g., EHR vendor refusing to enable API access for data sharing).
- SOMOS would gladly collaborate with CMS to **develop multilingual and culturally relevant materials** to educate our network of providers on their rights and obligations under information blocking rules.

2. Simplify and Streamline the Reporting Process

- Current reporting tools are not well-tailored to time-constrained or less tech-savvy providers.
- CMS could work with ONC to develop a **"Provider Quick Report" form**—a simplified digital form that allows providers to flag suspected information blocking with minimal legal or technical jargon.
- Optionally, allow **anonymous reporting with documentation**, or **delegate reporting rights** to an administrative staff member or ACO representative.
- SOMOS recommends piloting an **EHR-integrated reporting shortcut** (e.g., within provider portals or dashboards) to flag when a vendor action or denial may warrant reporting.

3. Offer Protections and Incentives

- Many providers—especially small practices and those working with powerful vendors—fear retaliation or regulatory consequences for reporting.
- CMS could offer a **“no retaliation” policy** with whistleblower-style protections for providers who report in good faith.

- Additionally, CMS could provide **incentive scoring credit** under Promoting Interoperability or MIPS Improvement Activities for reporting verified incidents or participating in an ONC follow-up.
 - SOMOS proposes that CMS establish a “**trusted reporter pathway**” where networks like SOMOS can assist providers in preparing and submitting validated complaints, ensuring accuracy and relieving individual burden.
4. **Provide Feedback and Follow-Up**
- Providers are more likely to engage if they feel heard. Currently, many complaints seem to enter a “black hole” with no update or resolution feedback.
 - CMS and ONC should provide **transparent follow-up mechanisms**, such as confirmation receipts, status updates, or anonymized enforcement summaries that show action is being taken.
 - SOMOS recommends a **public dashboard** (respecting confidentiality) showing trends in information blocking complaints by type or vendor category, which can motivate change and give providers a sense of collective impact.
-

Anticipated Impact on Data Exchange

Advancing Interoperability:

- **Yes**, increasing provider complaints can improve data exchange by shedding light on systemic or recurring patterns of resistance to lawful data sharing.
- Providers often face obstacles from EHR vendors, health systems, or intermediary networks that go unreported. Enabling more reporting will help ONC target enforcement and remove these barriers.
- When entities know they may be reported, it **creates a culture of compliance** and improves vendor responsiveness.

Potential Risks to Manage:

- There is a small risk of **over-reporting** or “defensive reporting” where providers file complaints unnecessarily or to preempt scrutiny.
 - CMS should mitigate this by clearly defining **reportable behaviors** vs. non-reportable ones (e.g., a technical delay vs. intentional blocking).
 - To avoid a chilling effect on collaboration, CMS and ONC should frame reporting not as punitive, but as a **shared quality improvement tool**—especially in initial years.
-

Conclusion and Call to Action

We stand ready to partner with CMS and ONC in:

- Developing culturally competent educational outreach for safety-net and independent providers.
- Facilitating provider complaint support as a **trusted reporting intermediary**.
- Participating in pilot programs to test simplified reporting workflows.
- Sharing provider pain points and real-world examples to inform CMS's future policy refinements.

We see information blocking enforcement not as a threat but as a **necessary step toward equity in data access**—especially for Medicaid and dually eligible patients who often fall through the cracks of fragmented systems.

We believe, **encouraging provider reporting is a low-cost, high-impact strategy** to identify and remove obstacles to data sharing. CMS can build trust and momentum by simplifying the process, educating providers, ensuring protections, and demonstrating that reporting leads to real improvements. With strategic collaboration, especially through trusted networks like SOMOS, provider engagement in reporting can accelerate the national interoperability agenda without burdening the front line.

Payers

This section is intended for all stakeholders to provide input on questions as they relate to use cases and workflows that involve payers.

PA-1 through PA-7

PA-1. TEFCA – Payer Perspective on Limitations

Question: “What policy or technical limitations do you see in TEFCA? What changes would you suggest to address those limitations? To what degree do you expect these limitations to hinder participation in TEFCA?”

SOMOS Perspective

From a payer (and value-based organization) standpoint, **TEFCA’s promise of nationwide interoperability** is exciting, but we observe several limitations that could affect payer participation and overall effectiveness. Our suggestions aim to ensure TEFCA is attractive and useful to payers such as Medicaid managed care plans, Medicare Advantage organizations, and ACOs acting in a quasi-payer role for population health.

Key Limitations and Suggested Changes

1. Limited Data Domains (Claims integration)

TEFCA is primarily designed around clinical data exchange among health care providers (e.g., treatment information). Payers, however, rely heavily on **claims and administrative data** which currently are outside TEFCA’s scope. A limitation is that TEFCA networks may not carry claims data or adjudication info that payers have; nor do they explicitly handle financial data or some payer-specific data (like risk scores, authorizations). *Suggestion:* Expand TEFCA or parallel frameworks to include **claims data sharing** or at least align TEFCA with CMS’s payer-to-payer data exchange mandates. Perhaps incorporate a standard method for payers to query clinical data *and* attach relevant claims context (e.g., link an encounter’s clinical and billing info). Alternatively, ensure TEFCA QHINs can onboard payer organizations as full participants, not just providers, enabling payers to both contribute data (e.g., medication fill history from claims) and retrieve clinical data for care management.

- *Regional payers like SOMOS, which manage large Medicaid populations in underserved areas, could serve as early pilots for aligning claims with clinical data to enhance care coordination.*

2. Uncertain ROI and Cost for Payers

Joining a QHIN or connecting through one will carry costs (integration, membership fees, transaction costs). Payers will weigh those against the benefits. Right now, the value proposition is a bit indirect: TEFCA might help payers obtain clinical data for coordination or risk adjustment more easily, but many payers already have some pathways (HIE agreements, vendor solutions). If TEFCA is too complex or expensive, payers may hesitate. *Suggestion:* **Incentivize payer participation** via policy – e.g., CMS could recognize TEFCA participation as meeting certain network adequacy or care coordination requirements, or even factor it into quality ratings/star ratings for MA plans (rewarding those who proactively exchange data). Also,

consider funding support: in initial years, perhaps subsidize smaller payers' connection costs to not only rely on the big nationwide payers to join.

- *Community-oriented organizations like SOMOS would benefit from such support and could model how regional payers can succeed within the TEFCA framework.*

3. Policy Limitation – Consent & Privacy Alignment

Payers face strict privacy regulations (HIPAA, 42 CFR Part 2 for certain substance use info, etc.). TEFCA's common agreement tries to streamline consent for treatment uses, but payers accessing data may be for care coordination or operations which might have different consent considerations. There's a risk that inconsistent interpretation of allowable uses could deter payer use. *Suggestion:* Clarify in TEFCA policy and guidance how payers can use TEFCA data within HIPAA bounds (likely as covered entities for health care operations including care management, quality improvement – which should be permissible). Possibly codify that queries by payers for coordination under ACOs or value-based contracts are considered health care operations or treatment proxy, to reduce legal uncertainty. This clarity will reduce fear of compliance issues.

- *Input from mission-driven payers like SOMOS, who already navigate sensitive community-based consent processes, could help shape more inclusive, culturally-competent and realistic privacy frameworks.*

4. Technical Complexity & Readiness: Some payer IT systems are not as up-to-date with FHIR/modern APIs; TEFCA's initial implementation relies on IHE profiles (e.g., XCA) moving to FHIR in the future. Payers might find technical integration challenging if they mostly process batch claims and use older tech. *Suggestion:* Provide a **testing sandbox and phased onboarding** for payers, maybe through CMS. For example, incorporate TEFCA exchange tests in the CMS Data at Point of Care pilot or other CMS programs. Allow payers to start with read-only query participation (pulling data) then later contributing. Provide technical assistance funded by CMS for smaller/regional plans to develop connectors.

- *Regional payers such as SOMOS, with proven experience deploying EMR integration across fragmented care settings, could be early adopters and testbeds for TEFCA onboarding programs.*

5. Provider Directory / Endpoint Discovery Issues

For payers to use TEFCA effectively, they need to query data on their members from many providers across networks. TEFCA QHINs need robust directories to know which QHIN/participant holds data for which patients or providers. If this isn't well-formed, payers might struggle to find data, reducing usefulness. *Suggestion:* Accelerate work on a **nationwide FHIR endpoint directory** (as also referenced in VB-15) which includes provider-to-QHIN mappings. This would help payers route queries more efficiently ("Which QHIN has Dr. Smith's records for patient X?"). Additionally, ensure TEFCA's "record location" services work for payer use cases—so payers don't have to shotgun queries everywhere.

- *Organizations like SOMOS, which operate across numerous community clinics, could help test and refine these discovery tools to ensure they work for high-churn Medicaid populations.*

6. Liability and Data Governance

Payers worry: if we rely on TEFCA data for making decisions (care coordination, utilization management), how do we ensure its quality and completeness? If something is missing or erroneous, who is accountable? *Suggestion:* Develop clear **data governance and accountability frameworks** within TEFCA, possibly an extension to the Common Agreement that outlines recourse if data is incomplete or participant fails to share. Knowing there's an enforceable trust will encourage participation.

Hindrance to Participation

These limitations, if not addressed, could significantly slow payer uptake. Payers are pragmatic: if TEFCA doesn't readily solve a problem or introduces risk/cost, they will stick to known methods (like direct contracting with HIEs or EHR vendor networks). For example, if a regional Medicaid plan finds that none of the local hospitals are yet in a QHIN, they won't join just for theoretical future benefit. Similarly, if privacy concerns aren't ironed out, legal departments may advise against participation or only partial use.

We expect larger national payers might join early (especially if CMS nudges via Medicare Advantage policy), but smaller payers and Medicaid plans might hang back unless they see clear support and incentives. That could lead to an uneven network effect, hindering TEFCA's goal of broad connectivity. SOMOS, with its on-the-ground experience and cross-provider integration efforts in diverse communities, exemplifies the kind of stakeholder that can help bridge this gap and ensure TEFCA works for both large and small systems alike.

Recommendations to CMS

CMS should view payers as crucial nodes in TEFCA and tailor the framework to their needs. This includes possibly **broadening the data scope** (to incorporate claims or at least use TEFCA to link clinical to claims data), **subsidizing or incentivizing participation**, aligning **consent/privacy frameworks**, and ensuring the technology and directories meet payer requirements. By proactively addressing these limitations, CMS can prevent them from becoming barriers. This will make payers enthusiastic participants rather than reluctant ones – which in turn will accelerate nationwide interoperability.

Conclusion and Call to Action

If done right, TEFCA could become the backbone not just for provider exchange, but for **payer-provider data collaboration**, which is essential in value-based care. Organizations like SOMOS

are ready to contribute their practical insights and operational expertise to make this a success. We believe these changes will improve TEFCA's adoption and effectiveness, rather than fundamentally altering its mission. The limitations are not insurmountable, but ignoring them could indeed hinder participation, so we commend CMS for seeking input and we urge implementation of these suggestions.

PA-2. Accelerating Payer APIs for Patients

Question: *“How can CMS encourage payers to accelerate the implementation and utilization of APIs for patients, providers, and other payers, similar to the Blue Button 2.0 and Data at the Point of Care APIs released by CMS?”*

SOMOS Perspective: Under CMS’s Interoperability and Patient Access Rule, payers (Medicare Advantage, Medicaid plans, etc.) are already required to implement Patient Access APIs (FHIR-based) that allow members to retrieve claims and other data. However, **implementation quality and utilization vary greatly**. We will discuss several steps we believe, CMS can take to **encourage faster and more effective deployment and uptake** of these APIs.

1. Stronger Oversight and Transparency:

CMS should monitor payers’ API implementations more closely and make results public. For instance, require payers to report metrics like API uptime, number of third-party apps connected, and number of member data requests fulfilled. Publishing a “report card” could create a competitive environment – no plan wants to be seen as lagging on digital empowerment. If some plans have near-zero usage, CMS might audit whether their API is properly functional and promoted. Essentially, enforce not just that an API exists, but that it’s usable (no egregious latency or data omissions).

2. Clarify and Expand Data Requirements

Some payers met the bare minimum (e.g., only providing claims and a few clinical fields). CMS could encourage expansion of data available via APIs – such as including **claims from longer historical periods**, making **explanation of benefits (EOB) details** available, including more frequent updates (daily rather than monthly), and perhaps incorporating clinical data they might have (like lab values from wellness programs or supplemental data). By signaling that future rulemaking may require more data types (e.g., prior auth decisions, provider networks, formulary data in standardized form) in the Patient API, CMS nudges payers to invest now in robust systems.

3. Incentivize Utilization through Member Engagement Programs

CMS can permit or encourage payers to integrate API usage into their member engagement or rewards programs. For example, some plans reward members for completing certain healthy activities; similarly, they could reward members for using a third-party app that pulls their data (the reward is for “taking charge of your health information”). CMS could explicitly allow such incentive under wellness program guidelines. Additionally, CMS could highlight best practices: one plan might send its members a mailer saying “Connect your health data to manage your care – here’s how,” while another did nothing. Showcasing how engagement increased in the proactive plan can motivate others.

4. Encourage Payer-Provider Collaboration via APIs

Many payers invest in portals or data sharing for providers (to close gaps in care, etc.). CMS could encourage payers to use those same APIs to share data with providers or with ACOs, not only with patients. For instance, a patient's app could allow them to send their claims history to their doctor. If payers see the APIs as a tool to reduce their reporting burden to providers (e.g., instead of separate quality reports, just let providers pull needed data via API with patient consent), they may invest more in accelerating and enhancing them. CMS might integrate this concept into value-based care program requirements – e.g., encourage MA plans to use the Patient Access API to supply data to ACOs or providers managing the patient's care (with permission), which ultimately benefits the patient through better-coordinated care.

5. Technical Assistance and Standardization

Smaller Medicaid MCOs or regional insurers might lag due to technical capability. CMS can fund technical assistance or provide a **“plug-and-play” solution** – maybe partner with a vendor to offer a secure, compliant API hosting service that smaller plans can use. Also, continuing to advance the HL7 FHIR standards (like member matching, consent frameworks) will reduce friction. CMS could host sandbox events or hackathons linking payers and app developers to accelerate learning and solve issues.

6. Promote App Ecosystem

One reason utilization is low is lack of consumer-friendly apps that use these APIs. CMS can stimulate the **app ecosystem** by publicizing the opportunity (perhaps an “App Gallery” on the CMS site listing applications that connect to Medicare/Medicaid plan APIs, akin to an app store). CMS did something similar with Blue Button by listing connected apps. If members know “there's an app for that” (for medication management, or organizing their records), they are more likely to use the API via that app. CMS might also include patient API capabilities in plan marketing guidelines – e.g., allow plans to advertise their digital integration as a feature.

7. Potential Policy Levers

Eventually, CMS could tie a portion of plan Star Ratings or accreditation to digital access performance. For instance, add a measure for “Provider and Enrollee Access to Health Information” – capturing whether a plan's API and interoperability offerings are robust (this might include how many members actually use it or member satisfaction with digital access). Knowing that these aspects affect competitive ratings or bonus payments will certainly get payer leadership attention and speed up improvements.

Encouragement vs. Enforcement

We recognize that CMS has already mandated these APIs; the challenge is now encouraging **utilization and quality**. A combination of gentle pressure (reporting and transparency) and support (technical guidance, sharing best practices) is ideal initially. If progress stalls, CMS

could escalate to stronger measures such as incorporating requirements into contracts or new rules.

In practice, when payers implement great APIs, we as a value-based care org see benefits too: our patients can bring us their claims data or we can help them use apps to track utilization (e.g., to prevent duplicative tests). So accelerating payer APIs has broad positive ripple effects.

Recommendation to CMS

CMS should **make it easy and rewarding for payers to do the right thing** (implement high-quality patient APIs) and make it uncomfortable to do the bare minimum. By shining a light on performance and championing the value (better member engagement, possibly reduced admin costs in long run due to self-service), CMS will accelerate both implementation and *actual use*. This ultimately empowers patients – the true goal of these interoperability efforts.

Conclusion and Call to Action

We are actively aligning our infrastructure and strategy with CMS’s vision for interoperability and patient access. As a value-based care network deeply rooted in Medicaid/Medicare and underserved communities, we recognize the transformative potential of payer APIs in empowering patients and improving care coordination. In support of this initiative, SOMOS is implementing the following efforts:

- **API-Integrated Patient Tools:** We are developing patient-facing applications that will integrate with Medicaid/Medicare plan APIs to allow beneficiaries to view their claims, utilization patterns, and medication history. These tools will be embedded into our digital health platform and accessible through MediFlow – our mobile-first screening and care navigation system.
- **Provider-Payer Data Sharing Pilots:** In partnership with selected Medicaid MCOs, SOMOS intends to launch pilot programs allowing providers within our network to access real-time patient data through API integration (with patient consent). This will reduce duplicative services, streamline care coordination, and enhance value-based performance.
- **Community-Based Digital Literacy Campaigns:** Recognizing that uptake of API-connected apps can be hindered by digital barriers, SOMOS is launching localized engagement campaigns to educate patients – especially older adults and limited English speakers – on how to safely use mobile health apps to manage their information. Bilingual digital navigators will be deployed through our care coordination teams to facilitate onboarding.
- **Vendor Partnerships for Small Plan Enablement:** To support our smaller payer partners who lack internal API capability, SOMOS is brokering discussions with trusted technology vendors to offer shared or white-labeled API platforms. This coalition approach will ensure more uniform digital capabilities across our regional partners.

- **Data-Driven Incentive Design:** SOMOS is exploring collaborations with Medicaid/Medicare plans to reward patients for engaging with digital tools connected via APIs – such as completing wellness assessments, submitting SDOH data, or tracking their prescriptions. These incentives may be funded through supplemental benefits or wellness budgets and aim to foster active digital participation.

Through these initiatives, SOMOS is not only promoting the spirit of the Patient Access API rule but also operationalizing it in the communities that often face the greatest barriers to digital inclusion. We welcome continued CMS support and look forward to contributing to scalable models that demonstrate how payer APIs can truly advance equity, engagement, and efficiency in care delivery.

PA-3. Payers Accepting Digital Identity Credentials

Question: *“How can CMS encourage payers to accept digital identity credentials (for example, CLEAR, ID.me, Login.gov) from patients and their partners instead of proprietary logins?”*

SOMOS Perspective: Payers – like health plans’ member portals – often use their own username/password systems. Transitioning to accept trusted **federated digital identities** could greatly streamline patient access (see PC-14). Below we offer some guidance for CMS to encourage this shift through a mix of **policy signals, technical enablement, and incentives**.

1. Incorporate Federated ID into CMS Regulations/Guidance:

CMS could update relevant regulations (for Medicare Advantage organizations, Medicaid IT guidance, etc.) to explicitly encourage or require offering federated login options. For example, in future rulemaking, CMS might state: “MA plans should support federated identity solutions that meet NIST IAL2/AAL2 as an option for member portal authentication.” This sets the expectation that proprietary logins are not the only way. Even without an immediate mandate, CMS’s endorsement in sub-regulatory guidance or letters to plans would carry weight.

2. Lead by Example – Integration with Federal Services

If CMS integrates Login.gov for Medicare (as discussed earlier), that immediately sets a precedent. Then CMS can say to payers, “You can federate with Medicare’s Login.gov too.” For instance, an MA plan could allow members to sign in with their Medicare credentials. CMS could facilitate that by providing a trust framework or API. If Medicaid states adopt something like Login.gov or state-level equivalents, CMS should share those success stories.

3. Certification or Standards for Identity

CMS, possibly via ONC, could establish an ***“Interoperable Identity” certification or guideline for payers. That is, define what it means to accept external credentials securely – leveraging standards like OpenID Connect. If CMS developed a standard profile (say, a FHIR-based or OIDC profile) for how payers should implement federated identity, it reduces technical ambiguity. Plans would have a blueprint to follow, making it easier to adopt. Additionally, CMS could partner with GSA (which runs Login.gov) to make integration easier or perhaps free of charge for healthcare payers.

4. Highlight Benefits & Provide ROI Data

Many payers might be hesitant due to perceived security risk or cost. CMS can gather evidence from early adopters to assuage this. For example, the Veterans Affairs Login.gov integration results show huge uptake and user satisfaction, which are transferrable lessons. If a large plan tried it and saw reduction in password reset calls and higher portal use, share that data. CMS could even pilot a program with a few volunteer plans to implement Login.gov integration and

measure outcomes (we suspect positive outcomes like increased portal traffic and fewer credential issues).

5. Tie to Interoperability and Burden Reduction Goals

CMS might include adoption of federated identity as part of the broader interoperability scorecard for payers. Under the theme of reducing burden, using a common identity reduces burden on patients who currently manage multiple logins. CMS can frame it as part of member experience improvement (which often is measured via CAHPS in Star Ratings, for example). Potentially, a plan that adopts easy login might see better member satisfaction scores – CMS can make that connection in communications.

6. Collaborate with State Medicaid Agencies

Many Medicaid beneficiaries have difficulty with portals. If CMS encourages state Medicaid systems to accept, say, Login.gov or state-level IDs, and then push those down to managed care plans, that will help. Possibly include it as an enhanced matching fund condition for state IT upgrades (“if you integrate a federated ID solution, we’ll support with 90% federal match for the development”).

7. Ensure Partner Access via Identity Proofing

The question mentions patients “and their partners” – presumably caregivers or authorized reps. Encouraging payers to accept federated IDs also means addressing how proxies might use them. CMS can encourage payers to implement standardized delegation: e.g., Login.gov is planning features for one account to manage others. CMS can push that pipeline, so payers can confidently allow a caregiver with the patient’s permission to log in via a credential.

8. Security and Privacy Guidance

CMS should also reassure plans that accepting these credentials is secure and compliant. Some plan CIOs might worry about HIPAA if an external identity provider is involved. Clear guidance on how using a NIST 800-63-3 IAL2 credential is actually an **enhancement** (since identity proofing is stronger than many plan’s own methods) would help. Perhaps ONC’s Security Risk Assessment tool could add a module about federated identity to help plans assess it properly.

Real-world Impact

If payers accept federated IDs, patients will have a smoother experience accessing their claims, checking benefits, and linking their health data to apps. It also indirectly promotes data exchange, because a common identity can link records across payers and providers. We’ve seen in our community that when processes are simplified, utilization goes up. For example, New York Medicaid’s online enrollment integrated with a state ID proofing saw more take-up than previous separate accounts.

Potential Hurdle

Some payers might resist due to branding – they like having members use the plan’s app or portal exclusively. CMS can address that by showing that federated login doesn’t remove the portal’s branding or relationship; it’s just a door key that happens to be universal. Also, plans might worry about losing control over the login process. CMS’s encouragement might need to include demonstrating that these identity services have robust support and uptime (perhaps include SLAs or liability coverage by identity providers so plans feel assured).

Conclusion and Call to Action

We are actively advancing digital access for **Medicare beneficiaries** by deploying solutions that reduce friction in identity verification and improve navigation of health services. Recognizing that **older adults often face barriers to accessing online portals** due to complex login processes, SOMOS has been piloting approaches that align with CMS’s vision for **federated identity acceptance**:

- **Federated Credentialing Pilots with Community-Based Navigation:** SOMOS is exploring partnerships with trusted digital identity providers like Login.gov and ID.me to allow beneficiaries in its network to authenticate once and access multiple services – including Medicare Advantage plan portals, care coordination platforms, and social care tools. By **integrating identity credentialing into community health worker** and patient navigator workflows, SOMOS is **reducing access disparities** for limited-English proficient, low-tech literacy, and immigrant Medicare populations.
- **Single Sign-On (SSO) Infrastructure for Medicare Services:** In collaboration with its EMR and digital health vendors (e.g., MDLand and eClinicalWorks), SOMOS is building infrastructure that supports **SSO integration** with CMS-trusted credentials, allowing patients to use a **universal login** to access health records, care plans, telehealth, and transportation benefits.
- **Focus on Medicare Dual-Eligibles and Underserved Seniors:** SOMOS’s work in the Medicare space focuses on **dual-eligible beneficiaries (Medicare + Medicaid)**, many of whom encounter complex access systems across payers and social programs. Through its innovation arm, SOMOS is working to **streamline digital access** by:
 - Embedding credentialing into **mobile social care navigation apps**.
 - Supporting **tablet and phone-based onboarding** using existing federal digital ID tools.
 - Training provider offices and care coordinators on using federated login systems for patient

In summary, CMS can encourage payers by **setting expectations, reducing technical barriers, aligning incentives, and collaborating on security**. As a result, patients (and caregivers) will be able to access multiple systems with one login, fulfilling the vision of interoperability not just at the data level but at the user experience level. SOMOS supports this strongly, as it will help many of our patients who struggle with multiple accounts today.

PA-4. Nationwide FHIR Endpoint Directory – Value to Payers

Question: *“What would be the value to payers of a nationwide provider directory that included FHIR endpoints and used digital identity credentials?”*

SOMOS Perspective: A nationwide provider directory of FHIR endpoints (essentially a comprehensive address book of healthcare organizations’ API endpoints, possibly with associated digital identity info) would be highly valuable to payers (and other stakeholders). From a payer perspective, we see several concrete benefits.

1. Facilitating Data Exchange for Care Coordination

Payers (and organizations like ACOs) frequently need to send or retrieve clinical data to coordinate care for their members. For example, our ACO’s partnered health plan may want to notify all of a patient’s providers after a hospital discharge. A provider directory with FHIR endpoints allows the plan’s system to quickly lookup “Dr. Smith – endpoint URL X” and push a care notification or retrieve recent clinical data. Without a directory, the plan often resorts to manual lookup or phone calls to find where to send info. A unified directory **saves time and ensures the data reaches the right place electronically.**

2. Streamlining Quality Reporting and Risk Adjustment

Payers have to gather data from many providers for HEDIS quality measures or risk adjustment audits. A national FHIR endpoint directory helps the plan identify which providers’ EHRs can be queried directly. For instance, if a plan knows provider A has a FHIR bulk data endpoint at a known URL, it can programmatically pull needed data (with proper authorization) for quality measurement. This reduces reliance on fax or custom portal logins. It makes these processes more efficient and less costly – a significant value considering the scale at which payers operate these programs.

3. Improving Provider Directories & Network Transparency

Payers maintain their own provider directories for members (to find in-network doctors). A nationwide directory could feed into that, ensuring more up-to-date and standardized information (addresses, specialties, etc.). Including FHIR endpoints in that directory is forward-looking: as patient apps become more prevalent, a member could find a provider in their network and immediately know that provider supports FHIR API – potentially allowing the member’s apps to connect for things like appointment scheduling or retrieving records. This level of transparency becomes a competitive advantage for plans that help members digitally connect to providers.

4. Using Digital Identity for Trust

If the directory “used digital identity credentials,” presumably it means each provider listing is associated with a verified identity or is accessible through a trust framework (e.g., providers

authenticate to update their entry with a trusted credential). For payers, this **increases confidence** in the directory data. They can trust that endpoint information is maintained by the actual organization (reducing risk of sending data to wrong/unverified endpoints). It could also support **secure authentication**: e.g., the directory might list not just the URL but the public key or requirements for connecting (maybe tied to a provider's identity credential). This helps payers automate secure connections (like knowing which certificate to use when connecting to a provider's API).

5. Efficiency in Prior Authorization and Referrals

As healthcare moves toward automated **prior authorization (PA) APIs**, a payer will need to query providers' systems for clinical documentation or send authorization decisions. The nationwide directory would let a payer quickly find the provider's FHIR prior-auth endpoint and exchange data. This could cut days off the PA process. Similarly for referrals or notifications – e.g., when a plan's case manager wants to notify a primary care doctor about a patient's ER visit, the directory tells them how to send that alert directly into the PCP's EHR (if the EHR has a FHIR endpoint or uses a HIN – the directory would specify those).

6. Reduction of Administrative Overhead

Payers spend substantial resources maintaining contact lists for providers – for sending care gap reports, etc. A centralized directory maintained at a national level (perhaps by an entity like ONC or a consortium) means each plan doesn't have to do it from scratch. It reduces duplicative efforts. Plans could rely on a consistently formatted data source for provider contacts and tech endpoints, freeing staff from constant data cleaning.

7. Data Source for Analytics

A national provider directory can help payers map provider networks, referrals, and connectivity. If enriched with endpoints, payers could see how “plugged in” certain providers are (e.g., those with robust endpoints might be easier to integrate with in value-based contracts). It might influence network development – perhaps a plan favors contracting with providers who are digitally enabled (because they can exchange data easily). This indirectly spurs competition where providers see value in being on the directory with a functional endpoint.

Key Data Elements Needed (Asked in VB-15, but Relevant Here)

For payers to maximize value, the directory should include at minimum: Provider name and identifiers (NPI, organization ID), practice locations, contact info, **FHIR API endpoint URL(s)** for different purposes (patient access, provider access, bulk data, etc.), technical details like supported versions, and possibly **public certificates or trust framework info** (so a payer knows how to authenticate its API calls to that endpoint). Tying in digital identity, perhaps each provider entry is linked to a digital certificate or key that confirms their identity – making connections more secure (like a directory integrated with an identity federation, so you know the

endpoint belongs to who it says it does).

Recommendation to CMS

CMS can accelerate this by continuing efforts like the National Provider Plan and Provider Enumeration System (NPES) API enhancements to include endpoint information, or by building on TECCA's directory work. Perhaps CMS could require that providers participating in Medicare (or any CMS programs) list and maintain their digital contact information in a national directory – analogous to how they must update NPI data. This would rapidly populate the directory, benefiting payers.

Conclusion and Call to Action

We recognize the immense value that a nationwide FHIR endpoint directory with digital identity credentials presents—not only for payers, but also for community-based providers, accountable care organizations (ACOs), and Medicaid/Medicare members. As an organization uniquely positioned at the intersection of care delivery and care coordination, SOMOS commits to the following:

- **Standardizing Endpoint Publication for Our Network:** SOMOS has already begun working with our EMR partners (including MDLand and eClinicalWorks) to ensure that every community provider and specialist in our network has a registered and maintained FHIR API endpoint discoverable through national registries such as NPES or TECCA-compatible directories.
- **Credentialing Digital Identity Across Our Network:** We will pilot a digital identity credentialing program across a subset of SOMOS-participating providers, ensuring their endpoints can be authenticated through secure trust frameworks. This enhances not only endpoint discoverability, but also safe data transmission for referrals, transitions of care, and risk adjustment.
- **Public-Private Collaboration with Payers:** As a convener between our providers and Medicaid managed care plans, SOMOS will collaborate with health plans to map FHIR endpoint utility and to facilitate bulk data access for HEDIS, prior authorization, and care gap closure workflows. We will also incorporate payer-requested directory features (such as endpoint metadata or certificate references) in provider onboarding documentation.
- **Advancing Directory-Based Automation:** Through our MediFlow platform, SOMOS is exploring integrations with national endpoint directories to automate referral notifications, post-discharge follow-up alerts, and care coordination APIs. MediFlow will support smart routing of communications based on verified directory data, replacing outdated manual outreach.
- **Equity-Focused Digital Enablement:** Recognizing that many community-based providers lack the technical support to configure or maintain endpoint infrastructure, SOMOS will deploy technical assistance resources to uplift digital readiness, especially in underserved boroughs of New York City. This ensures our providers are not left out of the evolving national digital health infrastructure.

- **Advocacy and Leadership:** SOMOS supports CMS efforts to expand and mandate digital contact and endpoint registration as part of participation in Medicare and Medicaid programs. We are committed to working with ONC, NPPES, and QHIN entities to ensure that the directory reflects the diversity of care settings, including small practices and safety-net providers who are often excluded.

We believe **value to payers is substantial:** a nationwide FHIR endpoint directory with integrated digital identity would act as critical infrastructure for interoperability. It would reduce the current “friction cost” of finding and trusting connections, thereby enabling faster data exchange, better care coordination, and administrative simplification. Our organization, bridging payer and provider roles, strongly supports establishing such a directory as a foundation for the digital health ecosystem.

PA-5. Payers Helping Simplify Providers' Quality Data Tasks

Question: “What are ways payers can help with simplifying clinical quality data responsibilities of providers? a. How interested are payers and providers in EHR technology advances that enable bulk extraction of clinical quality data from EHRs to payers to allow them to do the calculations instead of the provider-side technology? b. In what ways can the interoperability and quality reporting responsibilities of providers to both CMS and other payers be consolidated so investments can be dually purposed? Are there technologies payers might leverage that would support access to real time quality data for healthcare providers to inform clinical care in addition to simplifying reporting processes?”

SOMOS Perspective

Providers today shoulder a heavy burden collecting and reporting quality data to multiple payers and CMS, often duplicating effort. As a value-based organization, we work closely with both providers and payers, so we see the inefficiencies firsthand. We believe **Payers can play a pivotal role in relieving that burden** through several of the following approaches.

1. Bulk Data Extraction & Payer-Side Calculation

There is indeed significant interest and value in having EHRs enable **bulk extraction of clinical quality data** (e.g., via FHIR Bulk Data APIs) so payers can retrieve the raw data and calculate quality measures themselves. Many measures (HEDIS, Stars, ACO metrics) require the same clinical inputs that providers have in their EHR (e.g., HbA1c lab results, blood pressure readings, cancer screening dates). If payers can pull those directly, providers wouldn't have to manually chart review and report those measures.

- Payers (especially large ones or CMS itself) have robust analytic infrastructure that can handle the calculation. For example, instead of each practice running a diabetes control report, the payer could gather each patient's latest A1c from the EHRs and compute the metric. This approach also ensures consistency in measurement across providers.
- **Provider perspective:** They generally welcome offloading calculation as long as data accuracy is maintained and they get timely feedback. The benefit is they can spend more time on patient care rather than generating reports. In our ACO, we've seen enthusiasm when we, acting like a payer proxy, aggregate their data and send them back their performance – it saves them work.

To implement this, EHRs must support exporting relevant data fields at patient population level. Many now can (thanks to ONC certification requirements like the g(10) FHIR API). Payers will need a means to identify the patients (e.g., a roster) and a secure method to query EHRs. CMS can encourage this by endorsing standards like **FHIR Bulk Data with Group ID** for payer-provider data exchange, which could allow a payer to say “give me all XYZ data for my enrolled members in your practice.” Payers leveraging this should do so in a collaborative spirit – e.g.,

informing providers how the data will be used, and possibly even providing credit/incentives if the provider simply documents well and lets the payer handle the rest.

SOMOS Commitment

We are actively piloting bulk data exchange strategies with aligned payers and provider networks to streamline quality reporting and reduce clinical administrative burden. Leveraging our MediFlow platform and close integration with EHR partners like MDLand and eClinicalWorks, we are creating FHIR-enabled workflows that allow for population-level extraction of clinical quality inputs—such as HbA1c values, screening dates, and vitals—based on attributed member rosters. Our role as both a value-based convener and data steward enables us to act as a trusted intermediary: aggregating patient-level data on behalf of payers and returning timely, standardized performance feedback to providers. This not only reduces duplicative reporting but also builds transparency and alignment across payer and provider quality goals.

2. Consolidation of Responsibilities & Dual-Purposing Investments

One of the biggest frustrations for providers is different payers asking for slightly different cuts of data or using different quality measures. A single clinic might report one diabetes measure to CMS, another variant to a commercial plan, etc., despite them measuring similar concepts. Payers can alleviate this by **aligning quality measures and reporting formats** as much as possible.

- **Measure Alignment:** Through initiatives like the Core Quality Measures Collaborative, many payers have agreed on common measure sets. Payers should continue this trend, minimizing custom measures. If CMS can streamline its measures with those used in commercial value-based contracts, a provider's one set of data collection can satisfy all. For example, if every payer uses the same specs for blood pressure control, the practice just focuses on recording BP properly; the data serve multiple masters.
- **Single Submission, Multi-Use:** Payers and CMS could coordinate so that providers submit data once, and it's shared (with permission) among payers. One idea is a **"clinical data repository"** approach: a provider exports their clinical quality dataset to a trusted intermediary or repository (perhaps a CMS or HIE-run system) and then CMS and other payers pull from that instead of each asking directly. This way a provider invests in one good data export system, and multiple payers leverage it. An example: CMS's DEQP (Digital Quality Measurement) strategy could produce a centralized submission channel that others could also accept results from.
- **EHR and Health IT Investment Reuse:** Payers often invest in provider-facing tools (like payer-provided dashboards or nurses to help close gaps). Those should be built on standards so outputs can go back into EHRs or other payers' systems. If a payer funds an alert system for gaps, ensure it writes back data to the EHR that can then be used for any program. CMS could encourage multi-payer collaboratives in local regions to jointly fund a single care gap closure platform rather than each deploying separate ones.

SOMOS Commitment

We are actively working to reduce data fragmentation and reporting fatigue by advocating for aligned quality measures across Medicaid, Medicare, and commercial plans within our provider network. Through our role in regional value-based care collaboratives and technical partnerships, we are advancing a **“single submission, multi-use”** model—building standardized clinical data extracts from EHR systems that can be shared securely with multiple payers via trusted intermediaries. Additionally, SOMOS encourages joint payer-provider investment in shared tools—such as gap-closing alerts and dashboards—ensuring outputs are interoperable and write directly into EHRs for cross-program use. This strategic alignment empowers practices to focus on care delivery rather than duplicative reporting.

3. Real-time Quality Data for Providers – Technologies Payers Can Leverage

Payers have claims and sometimes pharmacy data that providers lack in real time. They could use **APIs, notification services, or portals integrated with EHRs** to push insights to providers that help during patient care. For example:

- **Event Notifications:** A CMS Condition of Participation now requires hospitals to send ADT notifications. Payers can similarly leverage HIEs or direct feeds to notify providers when their patient has an ER visit or a care gap arises (like “no mammogram on record and patient just turned 50”). Real-time alerts help providers take action.
- **Dashboards and Embedded Tools:** Some payers provide web portals listing care gaps, but a better approach is integration. Technologies like SMART on FHIR apps or CDS Hooks can allow a payer’s quality insights to appear in the provider’s EHR workflow. For instance, when a doctor opens a patient chart, a CDS Hook could query the payer’s database for any open gaps or recent claims events and display “Your patient saw a cardiologist last week, note to follow up on X.”
- **Data Feeds for Registries:** Payers could send monthly or even more frequent data dumps of key metrics or patient lists to clinics. We partner with plans that provide monthly lists of our patients who are non-compliant with meds or overdue for screenings. Automating this via APIs (so it’s near real-time) would be even better. Technology like FHIR Subscription could allow a payer to “subscribe” a provider to relevant data changes (e.g., if a member hasn’t filled their statin in 90 days, trigger a notice to the provider’s system).

SOMOS Commitment

We are leveraging its unique position across both payer and provider domains to close the real-time data gap by integrating payer-derived quality insights directly into provider workflows. Through collaborations with Medicaid MCOs and regional HIEs, SOMOS is implementing real-time **care gap notifications** via our SOMOS QR+ platform, ensuring providers receive timely updates such as ED visits, hospital discharges, or overdue screenings. We are exploring **SMART on FHIR and CDS Hooks** integrations that embed payer-sourced insights—like medication non-adherence or recent specialist visits—into the EHR at the point of care. Additionally, we are exploring **FHIR Subscription-based APIs** to deliver dynamic registries and actionable alerts,

moving beyond monthly care gap lists toward near real-time support. This approach empowers community providers with up-to-date data that drives proactive, high-quality care.

The key is that these technologies should not just create an additional portal; they should **feed into providers' existing systems** to truly reduce burden. Payers might leverage tools like our SOMOS QR+ (quality dashboard) by plugging their data into it rather than making providers log into the plan's system.

Consolidation Example

In New York, under DSRIP, multiple payers and Medicaid came together to unify performance metrics for providers. The state created a centralized analytics platform where clinical and claims data merged. Providers benefitted because they looked at one platform for all metrics. This model could be replicated – CMS could convene multi-payer data aggregation at regional or ACO levels so providers see one combined view.

Conclusion and Call to Action

In conclusion, **payers can simplify providers' quality data tasks by doing more heavy lifting** on their side (calculations), aligning and combining reporting requests, and leveraging modern APIs to integrate real-time insights back to providers. This two-way data exchange approach (providers give raw data; payers give back intelligence) transforms quality measurement from a retrospective paperwork exercise into a more automated, proactive process that ultimately improves patient care. We strongly support CMS fostering these approaches, as we have seen in our network that when providers are freed from duplicative reporting, they can focus on closing gaps and innovating in care delivery.

PA-7. Encouraging Payers to Report Information Blocking

Question: “How can CMS encourage payers to submit information blocking complaints to ASTP/ONC's Information Blocking Portal? What would be the impact? Would it advance or negatively impact data exchange?”

SOMOS Perspective

Payers, like providers and patients, sometimes encounter **information blocking** by providers or health IT developers – for instance, a hospital refusing to share discharge data needed for care management, or an EHR vendor charging unreasonable fees for data integration. Encouraging payers to report these practices can help enforce interoperability rules.

How to Encourage Payer Reporting

- **Clarify that Payers Can and Should Report:** CMS and ONC should explicitly communicate that health plans and other payers are welcome to file information blocking complaints. Some payers might not realize the portal is open to them (the term “information blocking” often conjures provider context). Clear guidance via HPMS memos (for MA plans) or Medicaid director letters can state: “If you as a payer experience providers or IT developers impeding necessary data exchange, you should report it.”
 - **Assure Non-Penalization:** Payers might worry about souring relationships with providers if they complain. CMS could allow anonymized or confidential complaints (ONC likely already treats them carefully). Emphasize that the target is pattern or policy-level blocking, not minor disputes, and that ONC will handle it systematically. If payers trust the process, they’ll be more willing to come forward.
 - **Incorporate into Oversight:** CMS could integrate a question in program audits or network management: e.g., asking MA plans “Have you encountered refusal by any providers to share required data (like risk adjustment or supplemental data)? Did you report it?” This signals that CMS expects them to be proactive allies in enforcement. Similarly, for Medicaid, tie it into MCO contract expectations that they must attempt to obtain data and report obstacles.
 - **Highlight Success Stories:** If a payer reports a blocking issue and it gets resolved (for example, an HIE starts cooperating or a provider starts sending ADT feeds after ONC engagement), publicize that success (without naming parties, perhaps). Knowing that reporting leads to action will motivate payers to invest the time.
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Impact of Increased Payer Reporting

- **Advancing Data Exchange:** Payers have a broad view of the ecosystem. If they report blocking, it likely targets high-impact areas – e.g., a major hospital system not

participating in data exchange, or a vendor's policy affecting many. Addressing these via enforcement or policy clarifications would have **system-wide benefits**, thereby advancing exchange. For instance, if multiple plans report that Hospital X won't share data unless paid extra, ONC/OIG can intervene and set a precedent that such behavior is not allowed. The result: not only that hospital, but others too will open up, improving data flow for all stakeholders.

- **Deterrence:** The possibility of payers reporting adds another layer of accountability for providers and IT vendors. Many providers care about their payer relationships (contracts, network status). If they know plans might escalate non-cooperation to regulators, they'll likely improve compliance to avoid that conflict. Thus, payer reporting encourages *self-correction* in the ecosystem – which is a positive for interoperability.
- **Risk of Adversarial Dynamics:** One potential downside is it could strain payer-provider relationships in the short term if not handled diplomatically. A provider might resent a plan “tattling” on them to ONC. To mitigate, CMS should encourage payers to first attempt resolution collaboratively before official complaints. The complaint portal can be a last resort. Ideally, just the knowledge that payers *could* report will push providers to solve it bilaterally (“no one wants a federal complaint on record”).
- **Focus on Genuine Blocking vs Technical Issues:** Payers need to be educated on what constitutes information blocking under the rules (which focus on unreasonable practices). If payers flood ONC with issues that are actually due to technical limitations or misunderstanding (not deliberate blocking), it could cause noise and tension. So, guidance to payers should include examples: e.g., yes report a provider who refuses to sign a data use agreement for no reason; but don't report a provider whose EHR hasn't built a feature yet – instead, work with them or their vendor on timeline. This discrimination ensures that increased reporting truly tackles blocking and doesn't just reflect general interoperability frustrations.

Conclusion and Call to Action

If done properly, increasing payer engagement in policing information blocking will **advance data exchange**. Payers bring resources and oversight that complement ONC's efforts. As a value-based entity, we work with payers to get data; when we hit roadblocks (like a hospital charging us exorbitantly for data access), having the payer weight behind a complaint can trigger change. We have seen payers use contractual levers to demand data sharing (e.g., requiring providers to connect to HIEs), which is somewhat parallel to reporting blocking. Making blocking an enforceable regulatory issue ups the stakes.

We believe that **CMS can and should empower payers to be active participants** in identifying and eliminating information blocking. We anticipate that while a few feathers may be ruffled, overall, it will accelerate the culture shift towards open data. Over time, routine payer reporting won't be needed because actors will get the message that hoarding data is not acceptable (they'll face pressure from both patients and payers). That will create a more seamless data environment which benefits everyone, especially patients.

Technology Vendors, Data Providers & Networks

Due to time constraints and the desire to provide thoughtful, evidence-based responses, we were unable to submit a comprehensive reply to this particular section within the current RFI timeline. We appreciate the importance of this issue and would welcome the opportunity to engage further on this topic through future comment periods or collaborative dialogue.

Value-Based Care Organizations (VCOs)

The following section relates to use cases and workflows that involve value-based care organizations.

Digital Health Adoption

VB-1 through VB-4

VB-1. Incentives and Barriers for Digital Health in APMs

Question: *“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?”*

SOMOS Perspective

We as a physician-led ACO serving over two million Medicaid and Medicare beneficiaries across New York City, has built its value-based care strategy on a foundation of culturally competent, community-based primary care. Many of our attributed beneficiaries are from linguistically diverse, low-income populations with complex medical and social needs. We believe digital health management and care navigation tools can play a pivotal role in improving outcomes, reducing disparities, and driving cost savings—if deployed with equity, usability, and engagement in mind.

Recommended Incentives to Encourage Digital Health Adoption in APMs

1. Enhanced Shared Savings for Digital Engagement Metrics

CMS should incorporate digital engagement performance into MSSP quality metrics and shared savings formulas. ACOs demonstrating patient uptake of digital tools—e.g., care navigation platforms, virtual visits, asynchronous chats, or social needs screeners—should be rewarded with higher savings rates or bonus points in quality scoring.

2. Upfront Investment through Implementation Funding

Safety-net ACOs often lack the capital to procure interoperable platforms, remote monitoring technologies, and multilingual user interfaces. CMS should provide one-time grants, infrastructure payments, or innovation funding through CMMI or MSSP tracks to support these high-need ACOs in adopting scalable digital tools.

3. Bundled Reimbursement for Digital Care Coordination Activities

CMS should develop or expand HCPCS/CPT codes to support digital modes of care delivery—particularly within Chronic Care Management (CCM), Transitional Care Management (TCM), and Principal Care Management (PCM). These bundles should include:

- Asynchronous messaging and mobile check-ins
- App-based care navigation
- Remote physiological monitoring (RPM) and remote therapeutic monitoring (RTM)

4. Risk-Stratified Payment Adjustments for High-Need Populations

ACOs serving digital health-disadvantaged populations—such as seniors, those with limited English proficiency, or patients with low digital literacy—should receive supplemental payments

or risk adjustment bonuses to offset the greater resource intensity required to onboard and support these patients.

5. Recognition and Incentives for Digital Equity Initiatives

ACOs implementing programs that advance digital equity—such as broadband access partnerships, smart device distribution, culturally adapted mobile app development, or multilingual patient education campaigns—should receive recognition through MSSP scoring or eligibility for enhanced payment models.

6. Performance Feedback and Learning Networks

CMS should provide regular feedback to ACOs on digital engagement metrics (e.g., patient portal use, telehealth retention, device adherence), alongside access to national learning collaboratives that disseminate best practices in digital care delivery and equity.

Barriers Preventing Broader Digital Health Adoption in ACOs

1. Infrastructure Gaps and the Digital Divide

Many SOMOS patients face structural barriers such as lack of broadband, smart devices, or private digital environments. These limitations are acute in low-income households, particularly among seniors and non-English speakers.

2. Lack of Integration into Clinical Workflows

Digital tools that are not seamlessly embedded into EHRs and care team workflows increase clinician burden. This fragmentation creates workflow friction, reduces provider buy-in, and threatens long-term sustainability.

3. Interoperability Challenges and Vendor Lock-In

Many digital health products fail to meet interoperability standards or impose high costs for data integration. As a result, ACOs face data silos and duplicative documentation, impeding effective care coordination.

4. Cultural and Linguistic Mismatch

Off-the-shelf digital tools are often developed without regard for the cultural and linguistic needs of minority populations. SOMOS has had to invest heavily in customizing mobile interfaces and patient education materials to support Spanish-speaking, Haitian Creole, and Chinese-speaking patients.

5. Low Patient Trust and Digital Literacy

Digital adoption is limited by fear, misinformation, and lack of trust. Patients require culturally competent onboarding, one-on-one coaching, and hands-on support to develop digital self-efficacy and maintain engagement.

Conclusion and Call to Action

CMS has a significant opportunity to accelerate equitable digital health adoption by embedding targeted incentives within MSSP and other APM frameworks. By supporting infrastructure, advancing culturally tailored tools, rewarding digital engagement, and enabling performance

feedback, CMS can ensure that all beneficiaries—not just the digitally fluent—benefit from modern care navigation and engagement technologies.

SOMOS is prepared to serve as a model ACO for CMS in piloting and scaling digital health strategies in underserved, multilingual, and urban populations. We welcome the opportunity to collaborate on testing enhanced digital equity models that demonstrate meaningful improvements in quality, access, and patient experience.

VB-2. Integration of Key Themes and Technologies into APM Requirements

Question: *“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?”*

SOMOS Perspective

We believe to modernize APMs and achieve health equity, CMS must more intentionally embed emerging technologies and concepts—including AI, analytics, usability, and patient engagement—into program design and requirements.

Recommendations for Embedding Emerging Technologies into APM Requirements

1. Artificial Intelligence (AI) and Predictive Analytics

- **Enable Risk Prediction and Operational Efficiency:**
CMS should support ACOs using AI to stratify patients based on risk, predict avoidable hospitalizations, prioritize outreach, optimize care team allocation, and flag gaps in preventive care. SOMOS, for instance, deploys AI-driven models using claims, encounter, and social care data to trigger proactive outreach for high-risk patients.
- **Incentivize Ethical AI Use and Bias Mitigation:**
Require transparency in AI algorithms and mandate testing for algorithmic bias, especially related to race, ethnicity, language, and disability. ACOs using AI should document mitigation strategies and regularly audit outcomes by demographic subgroup.
- **Include AI Utilization in Reporting Requirements:**
CMS could establish optional fields or incentives in MSSP reporting to capture whether and how ACOs are using AI for quality improvement, patient targeting, and predictive modeling.

2. Population Health Analytics and Risk Stratification

- **Mandate Stratified Care Models in APMs:**
ACOs should be required to segment their patient panels by clinical risk, social drivers of health (SDoH), and care complexity. Each tier should have associated care interventions—ranging from preventive self-management tools to intensive care management.
- **Require Data-Driven Panel Management:**
CMS should require ACOs to document how they use population health analytics to guide resource allocation, monitor health equity metrics, and improve longitudinal

outcomes. Platforms that support stratification should be interoperable with EHRs and community-based data sources.

3. Care Coordination and Real-Time Event Notification

- **Mandate Participation in Health Information Exchange (HIE):**
All ACOs participating in MSSP or other APMs should be required to join regional HIEs or Qualified Health Information Networks (QHINs) under TEFCA. Real-time ADT (Admission, Discharge, Transfer) alerts and continuity of care documents should be integrated into care workflows.
- **Support Multi-Provider Care Plan Sharing:**
CMS should promote bi-directional care planning tools that allow primary care, specialists, hospitals, and community-based organizations to share and update care plans across episodes of care.

4. Usability, Accessibility, and Patient-Centered Design

- **Integrate Usability into Tool Certification:**
CMS should require that ACO-affiliated digital tools meet standards such as WCAG 2.1 (Web Content Accessibility Guidelines), provide language access for Limited English Proficient (LEP) patients, and incorporate usability testing with underserved populations.
- **Center Human-Centered Design in Digital Engagement Requirements:**
Encourage (or require) ACOs to involve patients—especially those from marginalized communities—in co-design and iterative testing of digital tools. This ensures tools align with cultural preferences, literacy levels, and trust factors.

5. Digital Quality Measurement and Patient-Generated Health Data

- **Advance eCQMs and Hybrid Reporting Models:**
ACOs should be permitted to submit quality data sourced from digital platforms, mobile apps, and remote monitoring tools—not just claims or EHRs. Examples include home BP cuffs, glucometers, and medication adherence trackers.
- **Incorporate PROMs and PREMs (Patient-Reported Measures):**
CMS should allow patient-reported outcome measures and experience measures to count toward APM quality scoring, especially when collected via digital channels or integrated apps.

6. Patient Engagement as a Core APM Metric

- **Establish Engagement Benchmarks:**
CMS should require ACOs to report and be benchmarked on patient engagement indicators, such as:
 - Digital check-in completion rates
 - Patient portal log-ins
 - Social needs screening rates
 - Secure message responsiveness

- Telehealth visit utilization by race/language
 - **Reward Sustained Engagement and Health Literacy Efforts:**
ACOs that implement multilingual education, health coaching apps, or community-based digital onboarding should receive performance credit or technical assistance under MSSP.
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Conclusion and Path Forward

CMS has a pivotal opportunity to integrate advanced technology, real-time data, and patient-centric design into the foundation of value-based care. By **requiring stratification, rewarding meaningful digital engagement, and promoting equity-focused usability standards**, APMs can shift from reactive care delivery to proactive, personalized population health.

SOMOS welcomes the opportunity to work with CMS to pilot and scale these approaches across Medicaid and Medicare populations. Our experience building AI-powered, multilingual, and equity-centered tools in partnership with safety-net providers makes us uniquely positioned to help operationalize the future of accountable, tech-enabled care.

VB-3. Essential Health IT Capabilities for Value-Based Care

Question: “What are essential health IT capabilities for value-based care arrangements? a. Examples (not comprehensive) may include: care planning, patient event notification, data extraction/normalization, quality performance measurement, access to claims data, attribution and patient ID matching, remote device interoperability, or other patient empowerment tools. b. What other health IT capabilities have proven valuable to succeeding in value-based care arrangements?”

SOMOS Perspective

With a mission rooted in health equity, SOMOS deploys customized, multilingual digital infrastructure to support care coordination, risk stratification, and social determinants of health (SDOH) management in a value-based care environment. Our experience across multiple EHRs (including MDLand and eClinicalWorks) and health information platforms has informed a nuanced understanding of the essential IT capabilities that drive value-based success.

Essential Health IT Capabilities for Value-Based Care Arrangements

1. Longitudinal, Shared Care Planning Tools

- **Capability:** Tools that enable multidisciplinary teams to collaborate on a single care plan accessible across settings (primary care, specialists, care managers) and viewable by patients/caregivers.
- **Value Impact:** Promotes care continuity, reduces duplication of services, and enhances patient activation.
- **SOMOS Example:** SOMOS has developed interoperable care plan dashboards accessible to physicians and care coordinators across platforms, with task-level tracking and patient progress metrics.

2. Real-Time Patient Event Notification (ADT Alerts)

- **Capability:** Integration of Admission, Discharge, and Transfer (ADT) feeds into clinical workflows to alert care teams when patients visit emergency rooms, are hospitalized, or are discharged.
- **Value Impact:** Enables timely post-acute outreach, reduces readmissions, and supports transitional care management (TCM) interventions.
- **SOMOS Example:** SOMOS integrates HIE-based ADT alerts directly into care coordinator workflows to trigger outreach within 24 hours of discharge.

3. Claims and Clinical Data Integration Across Systems

- **Capability:** Platforms capable of ingesting, de-duplicating, and harmonizing claims, labs, pharmacy, and unstructured clinical data (e.g., progress notes) from multiple sources.
- **Value Impact:** Enables holistic patient views, advanced analytics, and accurate quality reporting.
- **SOMOS Example:** SOMOS connects EHRs (MDLand and eCW) using a custom middleware layer to unify data for care teams, population health, and analytics.

4. Remote Device Interoperability

- **Capability:** Integration of home-based monitoring devices (e.g., glucometers, blood pressure monitors, weight scales) with clinical dashboards and EHRs.
- **Value Impact:** Facilitates chronic disease management, reduces preventable ED visits, and enhances self-monitoring.
- **SOMOS Example:** Devices are distributed to high-risk patients through community health workers; SOMOS ensures device data flows into care manager dashboards for review and intervention.

5. Multilingual, Mobile-First Patient Engagement Interfaces

- **Capability:** Mobile-responsive platforms that allow patients to book appointments, complete check-ins, receive reminders, and communicate securely with care teams—available in multiple languages and literacy levels.
- **Value Impact:** Improves appointment adherence, care plan compliance, and patient satisfaction, particularly in marginalized communities.
- **SOMOS Example:** SOMOS offers a text-based mobile platform, optimized for low-bandwidth environments, that supports Spanish, Chinese, and Haitian Creole.

6. SDOH Integration and Referral Management Platforms

- **Capability:** Tools that screen for food, housing, transportation, and financial insecurity; manage referrals to community-based organizations; and track outcomes.
- **Value Impact:** Enables upstream interventions, improves compliance, and closes equity gaps.
- **SOMOS Example:** SOMOS uses MediFlow to screen for social risks during telehealth intake, connect patients to resources, and document closure of referral loops.

Additional Health IT Capabilities Valuable for Value-Based Success

1. FHIR-Based API Integrations

- **Capability:** Fast Healthcare Interoperability Resources (FHIR) APIs that allow modular data exchange between EHRs, payer platforms, and third-party apps.

- **Value Impact:** Enhances data liquidity, reduces vendor lock-in, and enables real-time decision support.
- **SOMOS Use:** Enables extraction of data from multiple EHRs into population health and reporting tools.

2. Digital Identity and Authentication Tools

- **Capability:** Tools such as Login.gov, ID.me, or other federated identity systems that streamline patient access and protect privacy.
- **Value Impact:** Reduces onboarding friction, improves access, and ensures secure identity verification across care settings.

3. Natural Language Processing (NLP) for Clinical Summarization

- **Capability:** NLP engines that analyze free-text clinical notes to extract diagnoses, care gaps, and social risks.
- **Value Impact:** Increases coding accuracy, enhances quality metric capture, and identifies care needs not documented in structured fields.

4. Patient-Generated Health Data (PGHD) Frameworks

- **Capability:** Secure infrastructure for storing, validating, and incorporating patient-reported metrics, symptom logs, and wearable device data.
- **Value Impact:** Expands visibility into patient experience, supports personalized care plans, and contributes to digital quality measurement.

CMS Recommendation and Policy Implication

To enable equitable and high-performing value-based care, CMS should **formalize the adoption of a baseline set of essential IT capabilities**—such as shared care plans, real-time event notification, remote monitoring, and SDOH integration—within APM participation criteria. At the same time, **flexibility should be preserved for ACOs** to adopt emerging technologies like NLP and FHIR-based APIs as part of a continuous innovation cycle.

SOMOS recommends CMS:

- Provide technical assistance to support capability adoption in safety-net ACOs
- Expand incentives under MSSP and CMMI models tied to digital maturity
- Align ONC Health IT Certification Program criteria with the needs of community-based ACOs serving complex patients

SOMOS stands ready to support CMS in operationalizing these capabilities and advancing the future of equitable, data-driven accountable care.

VB-4. Essential Data Types for Value-Based Care

Question: “What are the essential data types needed for successful participation in value-based care arrangements?”

SOMOS Perspective

Operating under multiple value-based care contracts—including risk-bearing Medicaid ACO models—we rely on diverse, real-time data to enable effective care coordination, health equity analysis, and quality performance. Based on our experience, success in value-based arrangements requires timely access to a comprehensive, longitudinal, and interoperable dataset spanning both clinical and non-clinical domains.

Essential Data Types for Value-Based Care Participation

1. Medicare and Medicaid Claims Data

- **Data Elements:** Part A/B/D claims, encounter data, pharmacy fills, and durable medical equipment (DME) utilization
- **Use Case:** Supports risk adjustment, patient attribution, utilization review, chronic condition flagging, and benchmarking
- **SOMOS Practice:** Our population health platform relies on merged Medicaid claims and encounter data for risk stratification and resource targeting.

2. Clinical/EHR Data

- **Data Elements:** Diagnoses, problem lists, laboratory results, medications, vital signs, immunizations, imaging reports, and encounter summaries
- **Use Case:** Facilitates care gap closure, real-time care plan updates, medication reconciliation, and disease management
- **SOMOS Practice:** SOMOS aggregates clinical data across MDLand and eCW into a single analytic layer for care team access and quality reporting.

3 Patient-Generated Health Data (PGHD)

- **Data Elements:** Home blood pressure readings, glucose levels, symptom diaries, wearables data (e.g., activity, sleep)
- **Use Case:** Enables remote monitoring, personalized interventions, early warning alerts, and chronic condition self-management
- **SOMOS Practice:** We distribute and integrate RPM devices for hypertensive and diabetic patients, feeding results into care dashboards.

4. Social Determinants of Health (SDOH) Data

- **Data Elements:** Housing insecurity, food access, transportation needs, legal or safety concerns, utilities, caregiving status
- **Use Case:** Identifies upstream barriers to care, directs referrals to community-based organizations, and informs risk adjustment
- **SOMOS Practice:** Using Accountable Health Communities (AHC)-aligned screeners via MediFlow, SOMOS captures SDOH and automates resource referrals with closed-loop tracking.

5. Patient-Reported Outcomes and Experience Measures (PROMs/PREMs)

- **Data Elements:** Pain scores, functional status, mood/depression scales, satisfaction with care, perceived health improvements
- **Use Case:** Supplements clinical outcomes with patient perspective; informs quality measurement and shared decision-making
- **SOMOS Practice:** We incorporate PROMs into weight management and chronic care pathways, with results reviewed during care plan updates.

6. Demographic, Language, and Identity Matching Data

- **Data Elements:** Race, ethnicity, preferred language, gender identity, disability status, unique patient identifiers
- **Use Case:** Enables health equity tracking, performance stratification, language access accommodations, and accurate data matching across systems
- **SOMOS Practice:** Our demographic data is analyzed monthly to assess equity in outreach, outcomes, and digital tool utilization.

CMS Recommendation and Policy Implication

For APMs to be successful and equitable, access to high-quality, standardized, and interoperable data across the full continuum of care is critical. CMS can support this by:

- **Mandating minimum data availability standards** for participation in APMs
- **Incentivizing EHR vendors and HIEs** to make SDOH and PGHD data interoperable
- **Aligning ONC certification criteria** with requirements for capturing PROMs, identity data, and non-clinical inputs
- **Requiring demographic and social risk stratification** in quality reporting to ensure equitable performance and program integrity

SOMOS supports CMS in advancing data-driven value-based care and welcomes the opportunity to contribute to standards development and implementation pilots.

Compliance & Certification

VB-5 through VB-10

VB-5. Evaluation of ONC Certification Program Support for Value-Based Care

Question: *“In your experience, how do current certification criteria and standards incorporated into the ONC Health IT Certification Program support value-based care delivery?”*

SOMOS Perspective

Our value-based care model depends on timely access to structured and unstructured data, seamless interoperability across provider systems, and equity-aligned digital engagement. We work with ONC-certified health IT vendors, including MDLand and eClinicalWorks (eCW), to support our clinical and administrative infrastructure. Based on our experience, ONC’s certification program provides a helpful foundation for enabling value-based care—but significant gaps remain that limit its full potential for ACOs serving high-need populations.

How ONC Certification Criteria Support Value-Based Care

1. Foundational Interoperability and Data Access

- Certified EHRs support essential functions such as C-CDA (Consolidated Clinical Document Architecture) exchange, e-prescribing, immunization reporting, and lab result sharing.
- These capabilities form the backbone of care coordination and clinical quality reporting in APMs.

2. Support for Patient Access to Data

- Criteria enabling the use of APIs (e.g., SMART on FHIR) and patient-facing apps have allowed SOMOS to build mobile-first platforms that engage patients through portals, SMS messaging, and telehealth applications.
- This supports VBC goals such as shared decision-making and self-management.

3. Data Standardization

- Structured documentation of problems, medications, allergies, and lab results enables more accurate risk stratification and facilitates quality measurement across patient populations.

4. Clinical Decision Support (CDS)

- CDS functionalities in certified health IT systems aid physicians in adhering to preventive care and chronic disease guidelines, helping improve HEDIS and other quality metrics used in APM contracts.

Limitations in Current Certification Standards for VBC Enablement

- 1. Inadequate SDOH and Behavioral Health Data Support**
 - Most certified systems are not required to collect, store, or exchange standardized data on social determinants of health or behavioral health—key drivers of cost and utilization in value-based models.
 - SOMOS has had to implement custom tools (e.g., MediFlow) outside of certified EHR workflows to close this gap.
- 2. Limited Bi-Directional Data Exchange with Community Providers and CBOs**
 - Certification criteria focus heavily on intra-clinical data sharing. However, value-based care requires interoperable communication between ACOs and community-based organizations, such as food, housing, and legal service providers.
- 3. Usability and Language Access Gaps**
 - Certification focuses on technical criteria but does not meaningfully address usability across different patient populations, such as those with limited English proficiency or disabilities.
 - SOMOS frequently modifies or supplements certified tools to meet WCAG standards and linguistic access needs.
- 4. Lack of Standards for PGHD and Remote Monitoring Data**
 - While some systems can accept patient-generated health data (PGHD), there is no consistent certification requirement for remote device data integration or the clinical use of such information.
 - This limits integration of RPM and home-based care into value-based care workflows.

Recommendations to Improve ONC Certification Alignment with Value-Based Care

- **Expand Certification Criteria to Include SDOH Data Collection and Exchange:**
 - Require EHRs to support structured fields and vocabularies (e.g., LOINC, Gravity Project) for social needs screening and referral tracking.
- **Certify Capabilities for Interoperability with CBOs and Public Health Entities:**
 - Incentivize standards that allow secure, bi-directional referrals and status updates with non-clinical partners using standardized APIs or FHIR-based protocols.
- **Incorporate Usability and Accessibility Testing into Certification:**
 - Evaluate certified products for compliance with WCAG 2.1, multilingual interface capabilities, and performance among low-digital-literacy populations.

- **Require Integration of Remote Monitoring and PGHD:**
 - Certification should include the ability to accept, process, and store device-based and patient-entered data in a clinically actionable manner.
 - **Promote Patient Attribution and Identity Matching Capabilities:**
 - Include functionality for patient identity resolution and attribution management—both of which are foundational to population health management under MSSP and other APMs.
-

Conclusion and Call to Action

ONC's Health IT Certification Program provides an essential baseline for clinical documentation, patient engagement, and interoperability. However, the current framework does not fully support the operational needs of value-based entities, particularly those serving high-risk and socially complex populations.

SOMOS urges CMS and ONC to evolve certification criteria in ways that:

- **Recognize SDOH, PGHD, and behavioral** health as core components of VBC
- **Incentivize data exchange** beyond traditional provider networks
- **Embed usability and equity** as foundational certification principles

As a safety-net ACO with proven digital infrastructure, SOMOS is prepared to assist in pilot testing and scaling these enhancements to better align ONC certification with the realities of modern, equitable accountable care.

VB-6. Health IT Capabilities Missing from ONC Certification That Could Benefit APMs

Question: *“What specific health information technology capabilities that could benefit APMs are not currently addressed by existing certification criteria and standards that should be included under the ONC Health IT Certification Program?”*

SOMOS Perspective

Our success in value-based care has required the deployment of non-traditional, equity-focused technologies—many of which lie outside ONC’s current certification scope. Based on this experience, SOMOS identifies several critical health IT capabilities essential for accountable care organizations (ACOs) and alternative payment models (APMs) that are not yet formally required or supported under existing ONC certification criteria.

Health IT Capabilities Missing from ONC Certification but Essential for APM Success

1. Social Determinants of Health (SDOH) Data Capture and Exchange

- **Gap:** Current certification criteria do not mandate structured fields, vocabularies, or interoperability for collecting and exchanging SDOH data.
- **Why It Matters:** Effective risk stratification and population health management in APMs depend on actionable SDOH insights (e.g., housing instability, food insecurity, utility needs).
- **SOMOS Experience:** SOMOS uses AHC-aligned screening tools via MediFlow to collect, track, and route SDOH needs, which are then manually incorporated into care plans due to EHR limitations.
- **Recommendation:** Expand ONC certification to require support for Gravity Project terminologies and FHIR-based exchange of SDOH assessments and closed-loop referrals.

2. Bi-Directional Interoperability with Community-Based Organizations (CBOs)

- **Gap:** Certified systems do not support standard APIs or referral workflows to connect with CBOs or public social services.
- **Why It Matters:** APMs succeed when clinical and non-clinical providers share information across domains; siloed systems prevent full-person care.
- **Recommendation:** Create certification criteria for interoperability with CBOs (e.g., standardized electronic referrals, status updates, and shared care goals across sectors).

3. Remote Patient Monitoring (RPM) and PGHD Integration

- **Gap:** There is no ONC certification requirement to ingest, validate, or clinically integrate data from wearables, connected devices, or patient-entered logs.
- **Why It Matters:** RPM is critical to managing chronic disease, reducing admissions, and enabling home-based care under APMs.
- **SOMOS Experience:** We deploy devices (e.g., blood pressure cuffs, glucometers) but must use third-party apps to collect and visualize data outside the EHR.
- **Recommendation:** Require certified EHRs to support secure PGHD intake (via FHIR or Direct) and flag this data for clinical review in workflows.

4. Digital Equity and Accessibility Tools

- **Gap:** Certification does not assess language access, readability, or WCAG 2.1 accessibility compliance.
- **Why It Matters:** APM success depends on patient engagement across diverse populations. Tools that are not culturally or linguistically adapted fail to reach underserved groups.
- **SOMOS Experience:** We have had to redesign patient portals and mobile tools to support Spanish, Mandarin, Haitian Creole, and other languages.
- **Recommendation:** Incorporate multilingual and accessibility functionality (e.g., alternative text for screen readers, visual contrast, simple English) into certification usability testing.

5. Dynamic Risk Stratification and Predictive Analytics

- **Gap:** While EHRs may contain decision support rules, current certification does not evaluate predictive modeling capabilities or the use of external AI/ML engines.
- **Why It Matters:** APMs rely on the ability to stratify risk dynamically, detect early deterioration, and proactively allocate care team resources.
- **Recommendation:** Include certification for platforms that support external risk engines, configurable risk scoring models, and equity monitoring of AI-driven outputs.

6. Attribution and Identity Matching Tools

- **Gap:** There is no requirement under ONC certification to support APM-specific attribution methodologies or cross-platform identity matching.
- **Why It Matters:** Accurate attribution is foundational for APMs; failure to match patients across payer, provider, and community data sets leads to gaps in care and measurement.
- **Recommendation:** Add optional certification criteria for attribution logic modules, master patient index (MPI) tools, and consent-aware identity reconciliation.

CMS Recommendation and Policy Implication

ONC's current certification framework establishes an important baseline for EHR functionality but lacks several key capabilities required for the success of ACOs and other value-based models—especially those serving Medicaid, dual-eligible, or socially complex populations.

To modernize the ONC Health IT Certification Program in alignment with APM needs, CMS and ONC should:

- Expand certification domains to include **SDOH, CBO integration, and PGHD support**
- Create optional certification pathways for **predictive analytics and attribution tools**
- Mandate **language access and accessibility compliance** to advance digital equity

SOMOS supports these enhancements and is available to partner in pilot testing expanded certification modules to validate their utility, feasibility, and equity impact in real-world APM environments.

VB-7. Balancing Complexity and Flexibility in Technology Requirements for APMs

Question: *“How can technology requirements for APMs, established through CEHRT or other pathways, reduce complexity while preserving necessary flexibility?”*

SOMOS Perspective

Our experience has shown that while CEHRT provides a necessary foundation for data integrity and interoperability, **rigid or overly complex technology mandates can inadvertently exclude smaller providers and stifle innovation**, especially in safety-net environments. We recommend that CMS pursue a balanced framework: standardize core technology requirements and outcomes to ensure alignment and equity across APMs, while allowing flexible implementation pathways to reduce administrative burden and support innovation.

Key Recommendations for Balancing Simplicity and Flexibility in APM Technology Requirements

1. Create a Modular, Outcomes-Focused Health IT Requirement Framework

- **Proposal:** Shift from requiring specific technologies to requiring demonstration of specific **functional outcomes** (e.g., care plan sharing, event notification, SDOH screening) using **modular technology options**.
- **How it Reduces Complexity:** Removes pressure to adopt monolithic EHR systems and allows entities to assemble best-in-class solutions.
- **How it Preserves Flexibility:** Enables APM entities to meet requirements through certified modules, middleware, HIEs, third-party apps, or custom tools.
- **SOMOS Example:** SOMOS uses a combination of CEHRT platforms and custom APIs to track SDOH referrals, patient-reported outcomes, and care plan adherence.

2. Standardize Core Data and Interoperability Standards Across Platforms

- **Proposal:** Require all APM participants to use standard data elements and exchange formats (e.g., FHIR APIs, USCDI v3, Gravity Project codes), regardless of platform origin.
- **How it Reduces Complexity:** Encourages vendor compliance and ensures consistency in data capture and exchange.
- **How it Preserves Flexibility:** Allows diverse vendors and tools to interoperate without mandating a single software solution.
- **SOMOS Perspective:** Unified FHIR-based APIs allow SOMOS to merge MDLand, eCW, and mobile app data for quality reporting and care coordination.

3. Enable "Shared Infrastructure" or Proxy CEHRT Participation for Small Providers

- **Proposal:** Allow APM entities to act as **technology proxies**—meeting CEHRT requirements on behalf of affiliated practices that may lack direct access to certified tools.
- **How it Reduces Complexity:** Relieves small, resource-constrained providers from costly system upgrades.
- **How it Preserves Flexibility:** Empowers ACOs like SOMOS to implement centralized care management platforms, analytics engines, and shared care plans at scale.
- **SOMOS Example:** SOMOS uses centralized technology to manage care coordination and quality reporting for independent practices operating on disparate systems.

4. Promote Federated Digital Identity and Patient Access Solutions

- **Proposal:** Allow APMs to use trusted identity verification systems (e.g., Login.gov, ID.me) to meet patient access and authentication requirements.
- **How it Reduces Complexity:** Eliminates the need for patients to maintain multiple logins across systems.
- **How it Preserves Flexibility:** Supports innovation in patient-facing tools—especially mobile-first or app-based platforms better suited to Medicaid and LEP populations.
- **SOMOS Experience:** SOMOS uses SMS-based access and federated authentication to engage patients who do not use tethered portals.

5. Create a Technology "Innovation Waiver" Process for Equivalent Capabilities

- **Proposal:** Develop a process for APM entities to request **waivers** from specific CEHRT functions—if they can demonstrate equivalent functionality through alternate tools or platforms.
- **How it Reduces Complexity:** Avoids duplicative systems or compliance workarounds.
- **How it Preserves Flexibility:** Encourages APMs to build culturally tailored, community-responsive innovations while still meeting policy objectives.
- **SOMOS Example:** SOMOS created a multilingual care navigation app that supports intake, PROMs collection, and appointment scheduling. While not CEHRT-certified, it meets equivalent functionality when mapped against criteria.

6. Align ONC Certification Roadmap with APM Technology Requirements

- **Proposal:** Coordinate CMS APM program requirements with ONC's future certification domains—particularly around:
 - SDOH and community-based interoperability
 - PGHD integration
 - Multilingual and accessible patient engagement
 - Consent-aware identity matching
- **How it Reduces Complexity:** Avoids fragmentation between federal programs and certification goals.
- **How it Preserves Flexibility:** Allows APMs to anticipate and adopt only those capabilities aligned with measurable outcomes.

Conclusion and Policy Implications

A one-size-fits-all approach to health IT in APMs risks disenfranchising smaller and safety-net providers who serve the most vulnerable populations. At the same time, lack of standardization in data and interoperability continues to impede scalable, equitable value-based care.

To reduce complexity while preserving innovation and inclusion, CMS should:

- **Define core outcomes and capabilities**, not rigid software requirements
- **Support modular and proxy-based participation models**
- **Encourage open data standards and shared platforms**
- **Enable customization and patient-centered design** through waiver and equivalency pathways

SOMOS supports this vision and stands ready to collaborate with CMS and ONC to validate, implement, and scale a flexible yet accountable technology infrastructure for the next generation of value-based care.

VB-8. Supplementing CEHRT Through Other HHS Policies and Overcoming Notification Barriers

Question: “How can other HHS policies supplement CEHRT requirements to better optimize the use of digital health products in APMs? As an example, requirements under the Conditions of Participation for hospitals (42 CFR 482.24(d)) require hospitals to transmit electronic patient event notifications to community providers. What barriers are in place preventing APM participants from receiving the same notifications?”

SOMOS Perspective

While CEHRT establishes a strong technical foundation, it does not fully enable the **real-time, cross-sector, and equitable information exchange** required by APM participants. We believe that other HHS policies—such as **Medicare Conditions of Participation (CoPs)**, **HIPAA flexibility**, and **ONC information blocking rules**—can and should be used to supplement CEHRT to ensure digital health optimization in accountable care arrangements.

How Other HHS Policies Can Supplement CEHRT to Optimize Digital Health in APMs

1. Strengthen Enforcement and Awareness of Hospital CoP Requirements

- **Policy Opportunity:** CMS should ensure hospitals comply with 42 CFR §482.24(d), which requires them to send electronic ADT (Admission, Discharge, Transfer) notifications to community providers.
- **Gap:** Many APM participants, especially small practices, FQHCs, and behavioral health providers, are not consistently receiving these notifications.
- **SOMOS Perspective:** Although our network receives some ADT alerts through HIE participation, coverage is inconsistent across hospitals, limiting proactive care management.
- **Recommendation:** CMS should issue clearer technical guidance and conduct targeted compliance audits. CMS could also publish public dashboards to track hospital compliance with ADT notification requirements.

2. Expand ADT Notification Mandates to All Settings and Payers

- **Policy Opportunity:** Apply similar event notification requirements across post-acute care, behavioral health, and managed care settings—not just inpatient hospitals.
- **Why It Matters:** APM participants need to know when patients are admitted to SNFs, psychiatric facilities, or emergency departments, particularly in Medicaid and dually eligible populations.

- **Recommendation:** HHS should consider expanding CoPs or issuing parallel guidance for managed care plans and post-acute providers, ensuring continuity of care across the full patient journey.

3. Leverage ONC Information Blocking Rules to Promote Cross-Sector Data Sharing

- **Policy Opportunity:** Enforce ONC’s information blocking provisions (45 CFR Part 171) to ensure that health systems, EHR vendors, and HIEs do not block APM participants from receiving patient data.
- **Barrier Identified:** Some hospitals and IT vendors restrict access to ADT feeds, citing proprietary concerns or charging excessive fees for data integration.
- **Recommendation:** HHS should clarify that **withholding ADT feeds** from contracted ACOs or refusing to integrate digital health tools constitutes **information blocking**. Encourage reporting of violations through the ONC complaint portal.

4. Align Medicare Advantage and Medicaid Managed Care Policy with CEHRT and Interoperability Goals

- **Policy Opportunity:** Extend similar digital data-sharing expectations to Medicare Advantage Organizations (MAOs) and Medicaid MCOs.
- **Gap:** APM participants often face inconsistent access to data held by managed care plans (e.g., pharmacy fills, behavioral health encounters, or supplemental benefits usage).
- **Recommendation:** CMS should require plans to adopt FHIR-based APIs (as outlined in CMS Interoperability and Patient Access final rules) and enforce parity in digital health expectations across FFS and managed care environments.

Barriers Preventing APM Participants from Receiving Electronic Event Notifications

Despite the hospital CoP requirements, ACOs and other APM participants continue to face major barriers to receiving timely electronic notifications, including:

1. Inconsistent Hospital Compliance and Interpretation of CoPs

- Some hospitals misinterpret the requirement, believing they must only notify existing “referring” or “treating” providers, and exclude ACOs, care managers, or delegated entities from alerts.
- **Recommendation:** CMS should explicitly recognize APM entities (including care coordinators and MSOs) as eligible recipients.

2. Technical and Financial Gatekeeping by EHR Vendors or HIEs

- EHR vendors and some HIEs charge high integration fees or require proprietary interfaces, limiting real-time connection for small practices and community organizations.
- Recommendation: Enforce price transparency and limit unreasonable fees under information blocking and TEFCA implementation policy.

3. Lack of Infrastructure Among Safety-Net Providers

- Smaller ACO-affiliated practices may lack the IT capacity to consume HL7-based ADT messages or interpret them into actionable workflows.
- Recommendation: CMS should support grants, technical assistance, or shared infrastructure models (e.g., centralized dashboards) to help APMs receive and act on notifications.

4. Absence of National Standards for ADT Routing

- No uniform policy governs how ADT feeds are routed, formatted, or filtered, leading to variability and missed notifications.
- Recommendation: ONC should publish minimum technical specifications (e.g., FHIR-based event notification standards) and promote voluntary certification of ADT intermediaries.

CME Recommendation and Policy Implication

To fully optimize digital health product use in APMs and ensure equity in access to critical event data, CMS and HHS should take the following steps:

- **Strengthen enforcement of existing hospital CoP ADT requirements**, ensuring APM entities are recognized recipients
- **Extend real-time notification expectations to managed care plans, SNFs, behavioral health, and post-acute providers**
- **Leverage information blocking enforcement** to address technical or contractual barriers to ADT access
- **Provide funding and technical support** to help small or underserved APM participants receive, interpret, and act on electronic notifications
- **Standardize routing, formatting, and eligibility rules** across all HHS-funded systems and networks

SOMOS stands ready to support CMS and ONC in piloting scalable, real-time notification infrastructure for community-based and safety-net APM participants. Ensuring timely, actionable data exchange is foundational to accountable, equitable care delivery.

VB-9. Technology Requirements Specific to APM vs. Non-APM Organizations

Question: *“What technology requirements should be different for APM organizations when comparing to non-APM organizations (for example, quality reporting, and interoperability)?”*

SOMOS Perspective

From our experience, **APM organizations have fundamentally different needs and responsibilities** than those operating under fee-for-service (FFS) models. Therefore, CMS should establish **differentiated health IT requirements** for APM participants that are performance-aligned, equity-focused, and operationally feasible.

APM Organizations Should Be Required to Meet More Advanced Data and Technology Standards

1. Enhanced Quality Reporting and Outcome Monitoring

- **Expectation:** APM entities should be required to submit **digital quality measures (dQMs)** using FHIR-based standards, with capacity to stratify by demographic and social risk factors.
- **Contrast with non-APM:** FFS entities may report via claims or encounter data alone, but APMs should be held to higher standards due to financial accountability and care coordination goals.
- **SOMOS Experience:** SOMOS supports electronic abstraction from multiple EHRs and aligns internal QI dashboards with HEDIS, CMS, and NCQA metrics in near real time.

2. Population Health and Risk Stratification Capability

- **Expectation:** APM participants should demonstrate the ability to **analyze clinical, claims, and social data** to stratify patients and proactively assign interventions.
- **Contrast with non-APM:** FFS models are reactive and do not require population-level analysis.
- **SOMOS Experience:** Our custom risk models combine Medicaid claims, encounter data, lab results, and SDOH screens to prioritize outreach for rising-risk patients.

3. Event Notification and Real-Time Data Exchange

- **Expectation:** APM organizations should be required to **receive and act on ADT feeds**, access statewide or regional HIEs, and integrate event data into care workflows.
- **Contrast with non-APM:** These providers often lack infrastructure or incentives to act on real-time data.

- **SOMOS Experience:** We use ADT alerts to trigger post-discharge outreach within 24–48 hours, which reduces readmissions and improves TCM billing performance.

4. Closed-Loop SDOH Referral Tracking

- **Expectation:** APM entities should track social care referrals and outcomes using digital tools that integrate with clinical records.
- **Contrast with non-APM:** There is no current requirement for SDOH tracking in FFS settings.
- **SOMOS Experience:** Through MediFlow, SOMOS captures social needs, generates referrals to CBOs, and documents closure of the referral loop.

CMS Should Preserve Flexibility for Innovation in APM Technology Pathways

- **Proposal:** While APMs should meet higher expectations, **they should not be locked into a single CEHRT pathway**. CMS should allow modular or proxy participation (e.g., through MSOs or delegated IT vendors), so that small and safety-net providers can meet advanced expectations without unaffordable platform overhauls.
- **SOMOS Perspective:** SOMOS serves as a proxy health IT platform for hundreds of community-based practices that individually lack CEHRT, but collectively meet CMS standards through our shared infrastructure.

APM-Specific Technology Expectations Should Focus on Outcomes, Not Software Ownership

CMS should anchor APM technology requirements in **performance capabilities**, not simply the presence of CEHRT or licensed tools. Examples of APM-specific expectations include:

Function	APM Requirement	FFS Standard
Quality Reporting	FHIR-based dQMs + PROMs/PREMs + equity stratification	Claims-based or chart review
Population Health	Risk stratification, data segmentation, predictive analytics	Not required
Care Coordination	Shared care plans, ADT-based alerts, transitions tracking	Optional, not reimbursed in real-time
PGHD/RPM Integration	Remote monitoring data in EHR/workflows	Optional
Social Care Integration	SDOH screening, referral, and outcome capture	Rarely implemented

Function	APM Requirement	FFS Standard
Patient Engagement	Multilingual access tools, mobile-first, identity verification	Portal-based, less adapted for low-literacy

Align APM Technology Expectations with Payment Incentives

- **Recommendation:** CMS should tie APM-specific tech expectations to **graduated incentives** within MSSP, Direct Contracting, ACO REACH, and Medicaid IAPDs.
- APMs that demonstrate digital maturity (e.g., successful ADT integration, PGHD capture, social care data exchange) should qualify for:
 - Shared savings enhancements
 - Infrastructure funding
 - Streamlined reporting pathways

CME Recommendation and Policy Implication

APM organizations require **more advanced and integrated digital infrastructure** than non-APM providers because they are responsible for **total cost of care, quality, and equity outcomes**. CMS should:

- **Establish differentiated technology standards** for APMs, centered on outcomes such as digital quality reporting, care coordination, risk stratification, and patient engagement.
- **Allow flexibility in how those standards are met**, especially for small or safety-net practices operating under shared infrastructure models.
- **Align payment incentives** with digital maturity, rewarding APMs that adopt and operationalize health IT tools that advance whole-person, equitable care.

SOMOS is committed to working with CMS and ONC to design, test, and scale such APM-specific digital requirements, especially in underserved and multilingual urban communities.

VB-10. Flexibility in CEHRT Requirements for Advanced APMs

Question: *“In the Calendar Year (CY) 2024 Physician Fee Schedule final rule (88 FR 79413), CMS established that CEHRT requirements for Advanced APMs beyond those in the “Base EHR” definition should be flexible based on what is applicable to the APM that year based on the area of clinical practice. What certification criteria should CMS identify under this flexibility for specific Advanced APMs, or for Advanced APMs in general? Are there specific flexibilities or alternatives to consider for smaller or resource-constrained (such as rural) providers in meeting CEHRT requirements without compromising quality of care or availability of performance data?”*

SOMOS Perspective

Based on our frontline implementation experience, we strongly support CMS’s decision to adopt **a more flexible approach to CEHRT requirements** under Advanced APMs. However, this flexibility must be structured, equity-conscious, and outcomes-driven. Our recommendations below detail how CMS can tailor CEHRT expectations by **clinical context** and **provider capacity**, while preserving the core goals of **data exchange, quality accountability, and patient empowerment**.

CEHRT Certification Criteria to Tailor Based on APM Type or Clinical Domain

Not all CEHRT functionalities are equally relevant or feasible across all APM settings. SOMOS recommends CMS adopt a **modular certification model**, where the following CEHRT requirements are classified as “*conditional*” based on the scope of the APM or the clinical practice focus:

1. Immunization Registry Reporting

- **Why Flexibility Is Needed:** Irrelevant for specialties like nephrology, psychiatry, or surgical bundles.
- **Recommendation:** Make optional or replaceable with HIE-based population immunization status for non-primary care APMs.

2. Electronic Prescribing (eRx)

- **Why Flexibility Is Needed:** Some specialties, including procedural or consultative services, may prescribe infrequently or operate in environments where medication orders are not part of the core care function.
- **Recommendation:** Allow attestation of alternative prescribing workflows if medications are not routinely managed.

3. Syndromic Surveillance and Reportable Conditions

- **Why Flexibility Is Needed:** These are often only relevant in ED or hospital-based APMs and public health surveillance contexts.
- **Recommendation:** Make optional or delegate responsibility to affiliated hospitals or local public health departments in community-based APMs.

4. Clinical Decision Support (CDS) Tools

- **Why Flexibility Is Needed:** Specialty practices may use payer-defined, evidence-based pathways not embedded within EHRs.
- **Recommendation:** Permit external, payer-validated CDS mechanisms to fulfill certification expectations in lieu of native EHR integration.

5. Patient-Generated Health Data (PGHD) Integration

- **Why Flexibility Is Needed:** Integration of data from apps, devices, or wearables requires technical investment that may not be practical across all specialties or settings.
- **Recommendation:** Allow phased implementation for APMs where home monitoring is not mission-critical, or require only review of submitted PGHD without full EHR ingestion.

Flexibility and Alternatives for Small, Rural, and Resource-Constrained Providers

1. Proxy or Shared CEHRT Compliance Through MSOs or ACOs

- **Proposal:** CMS should allow entities like SOMOS to act as **CEHRT proxies**, satisfying certification on behalf of affiliated practices through centralized care coordination systems, analytics engines, and reporting infrastructure.
- **Impact:** Alleviates burden on solo and small group practices while preserving interoperability and quality reporting.
- **SOMOS Example:** Our centralized MediFlow and population health tools integrate data from MDLand and eCW and fulfill CEHRT-aligned functions (e.g., risk stratification, eQMs, patient engagement).

2. Tiered Implementation Schedules

- **Proposal:** Offer a two-phase pathway where small practices (<10 clinicians or <\$2M revenue) have up to 24–36 months to adopt complex CEHRT criteria (e.g., FHIR APIs, PGHD ingestion, open scheduling).
- **Rationale:** Recognizes limited capital and IT staffing while maintaining longer-term compliance expectations.

3. Middleware-Based Certification Alternatives

- **Proposal:** CMS and ONC should recognize **certified third-party platforms** (e.g., SMART on FHIR apps, TEFCA QHINs, SDOH referral engines) that fulfill CEHRT functions without requiring a full EHR upgrade.
- **Policy Alignment:** Mirrors the model CMS is advancing through the Interoperability and Patient Access Rule for MA plans and Medicaid MCOs.

4. Performance Equivalency or “Alternative Use” Certification Pathway

- **Proposal:** Permit APMs to demonstrate **functional equivalency** to CEHRT modules through validated alternative processes (e.g., consistent medication reconciliation via telephonic outreach documented in non-CEHRT systems).
- **Safeguard:** Require attestation and audit trails to ensure data validity.

5. Technical Assistance, IAPD Funding, and Incentive Alignment

- **Proposal:** Expand availability of Medicaid IAPD funding and grant-based technical assistance to help APMs and small providers integrate flexible CEHRT solutions.
- **SOMOS Suggestion:** Prioritize funding for HIE integration, FHIR API enablement, and multilingual/mobile-first patient engagement platforms.

Aligning Certification Flexibility with APM Accountability and Equity

To preserve care quality and data integrity under flexible CEHRT pathways, CMS should:

- **Define Core vs. Conditional Certification Domains** based on APM type (e.g., primary care, behavioral health, surgical bundles, dual-eligible care).
- **Anchor Flexibility in Outcomes:** Require attestation to the *function* (e.g., data exchange, patient access, clinical review of PGHD), not the tool or vendor itself.
- **Embed Equity Expectations:** Ensure that any proxy systems or modular certifications still support accessibility, language access, and usability for underserved populations.

CME Recommendation and Policy Implication

CMS’s movement toward flexible CEHRT requirements for Advanced APMs is a necessary and welcome evolution. However, to ensure this flexibility improves access and outcomes without reducing accountability, CMS should:

- **Tailor certification criteria** based on clinical relevance and practice setting
- **Allow shared or proxy CEHRT models** through MSOs and ACOs
- **Support modular certification and performance-based alternatives**
- **Invest in implementation assistance** for small, rural, and safety-net participants

SOMOS strongly supports this direction and is prepared to collaborate with CMS and ONC to design and test flexible, equitable CEHRT pathways that promote high-performance care in value-based systems—regardless of practice size, geography, or specialty.

Technical Standards

VB-11 through VB-15

VB-11. Interoperability Challenges in Implementing Value-Based Care Programs

Question: *“What specific interoperability challenges have you encountered in implementing value-based care programs?”*

SOMOS Perspective

As an accountable entity tasked with driving quality and reducing cost across a high-risk population, **interoperability is central to our success—but also our greatest operational challenge**. Through our experience, we have identified several **persistent, systemic barriers to interoperability** that hinder effective care coordination, accurate reporting, and equitable performance in APMs.

Fragmentation Across EHR Platforms and Lack of Data Liquidity

- Challenge:

SOMOS providers use multiple EHRs (e.g., MDLand, eClinicalWorks, Athena), which often lack seamless data exchange capabilities—even when technically “certified.”

- Interfaces are often non-standard, with high costs for custom development.
- Clinical data is siloed across systems with inconsistent mapping (e.g., different terminologies for labs, conditions, and medications).
- Referral and follow-up data are often delayed or missing.

- Impact:

- Delays in patient risk stratification, leading to missed intervention windows.
- Gaps in care coordination, particularly for transitional and specialty care.
- Increased staff workload to manually reconcile data across platforms.

CMS Recommendation:

CMS should require **standardized FHIR-based APIs** and offer **subsidized integration assistance** for ACOs and MSOs seeking to unify data across disparate systems.

Limited Real-Time Data Exchange from Hospitals and Payers

- Challenge:

- Many hospitals do not reliably transmit **real-time ADT (Admission, Discharge, Transfer) alerts** to ACOs or community providers, despite Conditions of Participation requirements.
- Payers often **withhold timely claims data** or require manual processes to access encounter and pharmacy information.

- **Impact:**

- Missed opportunities for early post-discharge intervention.
- Delayed access to utilization data for quality and cost performance evaluation.
- Fragmented view of the patient journey across payers.

CMS Recommendation:

- Enforce compliance with ADT notification rules.
- Strengthen **payer interoperability mandates** for timely, FHIR-based claims data sharing across all APMs, including Medicaid and Medicare Advantage.

Lack of Interoperability With Social and Community-Based Organizations (CBOs)

- **Challenge:**

- Certified EHRs are not designed to share data with non-clinical partners such as food assistance programs, housing services, or legal aid—despite their relevance in VBC models.
- No standard exists for **closed-loop referrals** or bidirectional SDOH tracking across medical and community sectors.

- **Impact:**

- Incomplete coordination for patients with social risk factors.
- Inability to track the outcomes of referrals or integrate CBO feedback into care plans.
- Manual tracking systems lead to data loss and workflow inefficiency.

CMS Recommendation:

- CMS and ONC should define standards (e.g., FHIR Gravity-based SDOH exchange) for **CBO interoperability**.
- Include **social care integration capabilities** in ONC certification and APM participation criteria.

Identity Matching and Attribution Gaps

- Challenge:

- Patients are often registered under slightly different names or addresses across different systems, leading to **failed record matching** and inaccurate attribution.
- Attribution algorithms used by CMS and payers do not account for real-time patient-provider interactions.

- Impact:

- Inaccurate panel rosters reduce engagement and outreach effectiveness.
- Providers are held accountable for patients they don't actually see, or miss opportunities to care for those who are active but unattributed.

CMS Recommendation:

- Adopt **nationwide digital identity and attribution standards** that include consent-aware, federated identity tools (e.g., Login.gov).
- Allow ACOs to submit supplemental attribution evidence based on recent visits, screenings, or patient communication.

Proprietary Constraints and Cost Barriers From Health IT Vendors

- Challenge:

- Many vendors impose “**information blocking**” practices by charging high fees for API access, interfaces, or data exports.
- Participation in interoperability frameworks like Carequality or CommonWell often requires licensing costs that small practices cannot absorb.

- Impact:

- APM entities are forced to create redundant documentation workflows or pay unsustainable integration costs.
- Smaller or safety-net providers are disproportionately affected.

CMS Recommendation:

- Enforce ONC's information blocking regulations with targeted audits and penalties.
- Promote a **vendor-neutral certification marketplace** and offer grant programs for low-resource APM participants to cover integration costs.

Insufficient Support for Patient-Generated Health Data (PGHD) and Remote Monitoring

- Challenge:

- Most EHRs do not natively accept or flag PGHD from devices or apps in a clinically actionable way.
- Custom APIs are often required to integrate home BP monitors, glucometers, or symptom trackers.

- Impact:

- Limits APM capacity to expand chronic disease management or remote care models.
- Undermines patient engagement and self-management, especially in home-based care programs.

CMS Recommendation:

- Develop ONC certification requirements and CMS incentives for **PGHD ingestion and workflow integration**, particularly for chronic care and behavioral health APMs.

CMS Recommendation and Path Forward

SOMOS has faced a broad range of interoperability challenges in implementing value-based care—spanning **technical, regulatory, and structural barriers**. These challenges delay interventions, fragment care, and undermine performance, especially for patients with complex medical and social needs.

To advance interoperability in support of VBC, CMS should:

- **Enforce real-time data exchange mandates** for hospitals, payers, and vendors.
- **Standardize FHIR APIs, SDOH exchange, and attribution logic** across APMs.
- **Invest in technical assistance** for shared infrastructure and identity matching tools.
- **Align CEHRT and ONC certification criteria** with VBC-specific requirements such as PGHD, social care, and equity stratification.

SOMOS is eager to support CMS and ONC in piloting and scaling interoperability solutions that prioritize both care quality and provider sustainability in value-based systems.

VB-12. Standardization That Supports Flexibility and Innovation in APM Technology

Question: *“What technology standardization would preserve program-specific flexibility while promoting innovation in APM technology implementation?”*

SOMOS Perspective

We strongly support CMS’s goal to establish a health IT environment where **standardization enables interoperability and comparability**, while **flexibility permits tailored innovation**, especially for diverse populations, varied clinical models, and multi-payer arrangements. In our experience, **standardizing the inputs and outputs** of health IT systems—not the tools themselves—is the key to balancing these priorities.

1. Promote Standards for Data, Not for Software

CMS should focus on standardizing **data content, exchange protocols, and measurement formats**, while allowing flexibility in **platform choice, workflows, and user interfaces**.

Data Exchange Standards (FHIR, USCDI+)

- **Proposal:** Require APM participants to use FHIR-based APIs and support U.S. Core Data for Interoperability (USCDI v3 or higher), including social determinants of health (SDOH), behavioral health, and patient-reported outcomes.
- **Impact:** Enables consistent data flow across platforms (EHRs, HIEs, apps, registries), while allowing flexibility in how data is collected or visualized.

Modular Functional Certification Instead of Monolithic Systems

- **Proposal:** Encourage technology certification around **capabilities** (e.g., SDOH screening, risk stratification, RPM ingestion) instead of full EHRs.
 - **Impact:** APMs can mix and match tools to meet specific needs, such as mobile intake apps, analytics dashboards, or CBO referral systems.
-

2. Standardize Performance Measurement and Reporting Formats

Digital Quality Measurement (dQMs) Using FHIR

- **Proposal:** Require APMs to report quality measures via digital means (eCQMs/dQMs) using FHIR-based structures, enabling consistency and automation.

- **Impact:** Promotes innovation in how APMs gather and act on quality data, while ensuring comparability across models.

Stratified Reporting for Equity

- **Proposal:** Standardize data elements for demographic, language, and social risk stratification in quality reporting.
 - **Impact:** Allows CMS to track and compare equity outcomes across diverse APMs, while enabling providers to use tools that fit their communities.
-

3. Standardize Interoperability Expectations Across Entities and Tools

National Patient Identity Matching and Attribution Frameworks

- **Proposal:** Adopt or promote a CMS-endorsed standard for patient matching, consent-aware identity resolution, and beneficiary attribution to APM entities.
- **Impact:** Supports continuity of care across systems and across care settings, even when providers use different platforms.

Real-Time Event Notification Standards

- **Proposal:** Develop minimum technical standards for ADT (Admission/Discharge/Transfer) alerts and other real-time notifications, regardless of the system source.
 - **Impact:** APMs can innovate how they use event data (e.g., centralized dashboards, alerts to community health workers) without needing to build custom feeds for every hospital.
-

4. Support Innovation Through Federated APIs and Plug-and-Play Architecture

Encourage SMART on FHIR, CDS Hooks, and Modular APIs

- **Proposal:** Promote adoption of interoperable app ecosystems through SMART on FHIR and CDS Hooks specifications, allowing plug-and-play innovation.
- **Impact:** APMs can customize tools to serve diverse workflows (e.g., multilingual intake, behavioral health assessments) without altering core data standards.

Certification or Vetting of Interoperable Innovation Tools

- **Proposal:** Create a CMS-vetted "App Library" of third-party tools that meet data, security, and performance standards.

- **Impact:** Reduces risk for APMs adopting new solutions, encourages vendor alignment, and promotes a market for innovation.

5. Create a Flexibility Framework Within a Standardized Infrastructure

CMS should provide APM participants with a clear “**Core + Flexible**” architecture:

Core Standards (Mandatory)	Flexible Implementation Options
FHIR-based API support	EHR-based, HIE-based, or app-based integration
USCDI data elements	Modular platforms (e.g., SDOH, PROMs, PGHD tools)
Digital quality reporting formats	Certified registry, in-house tool, or vendor-based submission
Identity/attribution framework	CMS-aligned APIs, HIEs, or MSO-driven proxy matching
Interoperability with TEFCA/QHINs	Via direct participation or through regional HIE proxy models

This approach allows CMS to **enforce consistency where it matters** (e.g., data fidelity, privacy, performance tracking), while giving APMs and their tech partners room to design **population-specific and innovation-driven solutions**.

Recommendation to CMS and Call to Action

The future of value-based care requires a health IT framework that is both **standardized and adaptive**. CMS can preserve program-specific flexibility while promoting innovation by:

- Standardizing data formats (e.g., FHIR, USCDI, digital measure structures)
- Certifying capabilities instead of full systems
- Supporting federated APIs, identity resolution, and modular app ecosystems
- Enabling performance equivalency across diverse implementations

SOMOS supports this vision and is prepared to work with CMS and ONC to pilot standard-aligned, equity-driven innovation models across urban, multilingual, and resource-limited provider networks.

VB-13. Improving Standards to Advance Value-Based Care and Reduce Provider Burden

Question: “What improvements to existing criteria and standards would better support value-based care capabilities while reducing provider burden?”

SOMOS Perspective

They often serve underserved, multilingual communities using a mix of commercial EHRs, regional HIEs, and custom-built tools. Our experience shows that while current ONC certification criteria and data standards provide a critical foundation, they must evolve to better support **VBC-aligned workflows, reduce documentation overload, and enable equitable care delivery** at scale.

1. Streamline and Prioritize Certification Criteria That Align With VBC Outcomes

Simplify eCQMs and Align With Real-World Workflows

- **Challenge:** Current electronic clinical quality measures (eCQMs) often require excessive manual entry or complex EHR queries.
- **Recommendation:** CMS and ONC should prioritize fully digital quality measures using **FHIR-based standards** that map directly to structured fields already used in clinical workflows (e.g., vitals, labs, visit types).
- **Impact:** Reduces duplicate documentation and aligns measurement with care delivery.

Rationalize and Consolidate Public Health and Reporting Requirements

- **Challenge:** Practices participating in multiple programs (e.g., PCMH, MSSP, Medicaid) face overlapping or contradictory reporting mandates.
 - **Recommendation:** CMS should create a **unified reporting framework** across APMs that uses shared data definitions and minimizes redundant certification pathways (e.g., one submission for quality, population health, and social care).
 - **Impact:** Frees up time for clinical care and reduces audit anxiety.
-

2. Improve Certification Criteria for Interoperability With External and Non-Clinical Partners

Expand Certification for Social Determinants of Health (SDOH) and Community-Based Integration

- **Challenge:** Existing certification lacks support for structured SDOH documentation and data exchange with community-based organizations (CBOs).
- **Recommendation:** Incorporate **Gravity Project standards**, FHIR-based social risk referrals, and closed-loop reporting into certification programs.
- **Impact:** Enables APMs to screen, refer, and track social needs without creating external workaround systems.

Mandate Bi-Directional APIs With HIEs and CBOs

- **Challenge:** Most certified products prioritize provider-to-provider exchange, ignoring bidirectional communication with CBOs or HIEs that host population-level data.
- **Recommendation:** Expand ONC's certification program to include **community integration modules** with APIs for electronic referrals, service verification, and client status updates.
- **Impact:** Strengthens care coordination and reduces "shadow systems" maintained by care managers or MSOs.

3. Embed Equity, Language Access, and Usability in Certification Criteria

Require Usability and Accessibility Standards

- **Challenge:** Certified tools often lack multilingual interfaces, mobile responsiveness, or accessibility for patients with disabilities or low health literacy.
- **Recommendation:** Add WCAG 2.1 compliance, minimum language support, and human-centered design usability testing into ONC certification for patient-facing modules.
- **Impact:** Improves patient engagement and reduces staff time spent on workarounds and manual support.

Stratify Quality and Reporting by Equity Metrics

- **Challenge:** Certification supports only general reporting; there's limited expectation to stratify performance by race, ethnicity, language, or SDOH.
- **Recommendation:** Include equity stratification capabilities in certified reporting modules, with standardized fields for REL (race, ethnicity, language) and ZIP code-linked SDOH proxies.
- **Impact:** Enables APMs to track, report, and improve equity without increasing manual data collection.

4. Reduce Redundant Documentation and Prior Authorization Burden

Standardize Clinical Data Exchange Formats for Prior Authorization

- **Challenge:** APMs face mounting administrative burden from non-standardized prior authorization requirements that divert clinical resources.
- **Recommendation:** Accelerate implementation of **HL7 Da Vinci Prior Authorization standards** and mandate payer-EHR integration via FHIR APIs as part of VBC participation.
- **Impact:** Automates care approvals and frees up clinical staff time.

Simplify Patient-Generated Health Data (PGHD) Capture

- **Challenge:** PGHD is increasingly important in chronic care and remote monitoring, but existing certification requires high integration effort.
- **Recommendation:** Create a light-weight PGHD certification track focused on **ingestion, review, and optional storage** of patient-submitted data (e.g., BP logs, symptom checkers).
- **Impact:** Reduces IT lift while enabling key functions like home-based monitoring and patient engagement.

5. Enhance Alignment Across ONC, CMS, and State Medicaid Requirements

Harmonize Federal and State Reporting and Certification Expectations

- **Challenge:** Providers in multi-payer APMs (e.g., Medicare ACO REACH, Medicaid VBP) face conflicting technology mandates.
- **Recommendation:** CMS should work with ONC and states to align certification incentives and reporting formats across **QPP, MSSP, Medicaid VBP, and IAPD programs**.
- **Impact:** Reduces friction, supports multi-payer interoperability, and simplifies compliance.

Recognize Proxy Certification and Shared Infrastructure Models

- **Challenge:** Small practices often cannot maintain CEHRT individually.
- **Recommendation:** Expand ONC criteria to recognize “**shared services certification**”—where MSOs, HIEs, or ACOs meet certification standards on behalf of affiliated providers.
- **SOMOS Use Case:** SOMOS fulfills population health, quality, and reporting functions through a shared middleware platform and centralized registry integrations.

Conclusion and Policy Recommendations

To better support value-based care and reduce provider burden, CMS and ONC should:

- Streamline certification to focus on **outcome-aligned, workflow-integrated capabilities**
- Prioritize **data exchange and reporting standards** that minimize manual entry and redundant compliance
- Require certified tools to be **equity-ready, accessible, and community-integrated**
- Encourage **shared infrastructure models** to alleviate the burden on small or resource-limited providers

SOMOS is committed to partnering with CMS and ONC to test and scale a next-generation health IT certification framework that advances value-based care delivery, supports health equity, and protects frontline provider capacity.

VB-14. Improving Value-Based Care Through Digital Identity Credentialing

Question: “How could implementing digital identity credentials improve value-based care delivery and outcomes?”

SOMOS Perspective

From our experience, **standardized digital identity credentials—especially those that are federated, secure, and patient-friendly—can dramatically improve the performance and equity of value-based care.** CMS has an opportunity to lead the national shift toward **trusted, universal digital identity tools** that enhance care coordination, promote patient empowerment, and reduce system-level friction in APMs.

Benefits of Digital Identity Credentialing for Value-Based Care

1. Streamlined and Secure Patient Access Across Systems

- **Challenge:** Many patients—especially low-income or elderly Medicare and Medicaid beneficiaries—struggle with managing multiple patient portals and logins.
- **Impact:** This leads to reduced engagement, missed preventive care, and duplicative services.
- **Benefit:** A **single digital identity credential** (e.g., Login.gov, ID.me, or other NIST-aligned federated identities) allows patients to authenticate across platforms (e.g., ACO, hospital, pharmacy, CBO), simplifying access to health records, telehealth, and care plans.

2. Improved Attribution Accuracy and Care Coordination

- **Challenge:** APMs rely on correct beneficiary attribution to track outcomes, share data, and assign accountability. Identity mismatches across systems create gaps in care.
- **Benefit:** Digital credentials that support **cross-system identity matching** (e.g., via unique identifiers, demographic verification, and consent-aware linkage) ensure patients are accurately attributed to their care team, improving continuity and reporting.

3. Enhanced Quality and Risk Stratification

- **Challenge:** Disconnected identity systems can lead to incomplete data aggregation, reducing the accuracy of risk scores and quality reporting.
- **Benefit:** When patients use **trusted digital IDs** across EHRs, HIEs, and payer systems, providers can more easily unify records and clinical events—enhancing population health analytics, risk adjustment, and early intervention strategies.

4. Expanded Patient Engagement and Self-Management

- **Challenge:** Many ACO beneficiaries do not engage with digital tools due to technical barriers, mistrust, or login confusion.
- **Benefit:** A digital ID system that enables **one-click, multilingual, mobile-first access** to care plans, lab results, or medication lists can empower patients to manage their health, participate in PROMs, and communicate securely with care teams.

5. Reduced Fraud, Duplication, and Administrative Waste

- **Challenge:** Without a trusted identity layer, systems must rely on name, DOB, and manual verification for each encounter, which is error-prone and labor-intensive.
- **Benefit:** Digital credentials reduce administrative burden by enabling real-time identity verification during scheduling, telehealth, or benefits eligibility checks.

Equity and Implementation Considerations for CMS

SOMOS urges CMS to ensure that digital identity solutions are designed with **health equity, accessibility, and flexibility** in mind.

1. Multilingual, Low-Literacy, and Mobile-First Interfaces

- Ensure digital ID systems are usable by non-English speakers and those with low literacy through SMS login options, voice-enabled tools, and language localization.

2. Include Undocumented and Marginalized Populations

- Enable digital identity credentialing that is **not solely dependent on government-issued photo ID**, to ensure Medicaid, dual-eligible, and immigrant populations can safely participate without fear of exclusion.

3. Allow APM Entities to Integrate with Federated Systems

- Permit ACOs and MSOs to integrate with federal identity networks (e.g., Login.gov) via open APIs or shared services infrastructure, avoiding duplicative patient authentication systems.

4. Layer Consent and Privacy Preferences into Digital IDs

- Build tools that allow patients to **control data-sharing preferences**—e.g., consent for SDOH data sharing, behavioral health visibility—using standardized settings tied to their digital credential.

Recommendation to CMS

To implement digital identity credentialing that supports VBC and promotes equity, CMS should:

- **Require or strongly encourage federated digital identity use** (e.g., Login.gov, ID.me) across APM programs, payer APIs, and provider portals
 - **Provide implementation guidance and technical toolkits** for integration of federated identity solutions with CEHRT, HIEs, and ACO platforms
 - **Incentivize APM participants** to adopt digital identity infrastructure through:
 - Shared savings bonuses for digital access rates
 - Risk adjustment credit for identity-linked data completeness
 - Technical assistance grants for safety-net integration
 - **Work with ONC and NIST** to ensure digital identity credentialing standards align with privacy, equity, and patient-centered design goals.
-

Conclusion and Call to Action

Digital identity credentials are foundational to the future of value-based care. They offer a powerful tool to unify care delivery, improve data integrity, simplify patient access, and close equity gaps. For patients, they mean less friction. For ACOs and CMS, they mean more complete data, better attribution, and smarter interventions.

SOMOS strongly supports CMS adoption of federated, secure, and inclusive digital identity credentialing systems—and we are prepared to collaborate on pilot programs and scalable integration models tailored to underserved communities and high-risk populations.

VB-15. Nationwide FHIR Endpoint Directory for Data Access and Claims Transparency

Question: *“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?”*

SOMOS Perspective

We strongly support the development of a **nationwide directory of FHIR endpoints** to improve **interoperability, data liquidity, and real-time care coordination**, particularly for safety-net ACOs navigating multiple health IT systems. A centralized directory would help providers, payers, and health IT developers **identify trusted data sources**, reduce administrative burden, and close care gaps—core goals of value-based care.

Benefits of a Nationwide FHIR Endpoint Directory

1. Accelerates Real-Time Data Exchange

- **Current Challenge:** APM entities often struggle to locate or verify FHIR endpoints for hospitals, specialists, labs, or payers—delaying care coordination and limiting the use of real-time APIs.
- **Improvement:** A national directory enables providers and care managers to **quickly discover and connect** with verified FHIR endpoints for both clinical and claims data sources, streamlining integration.

2. Reduces Redundant Data Requests and Manual Labor

- **Current Challenge:** Without a centralized endpoint directory, providers must manually search for endpoints, fax records, or rely on outdated directories maintained by regional HIEs or payers.
- **Improvement:** Automation of endpoint discovery reduces fax reliance, accelerates referrals, and enables programmatic access to patient health and utilization data.

3. Enhances Claims Data Visibility and Attribution Accuracy

- **Current Challenge:** ACOs often lack clarity into **which payer systems hold patient claims**, particularly for dual-eligible or high-mobility populations.
- **Improvement:** A directory that includes FHIR endpoints for **payer claims APIs** (e.g., via the CMS Interoperability and Patient Access Rule) allows APM entities to retrieve comprehensive, cross-payer utilization histories and support better attribution and risk scoring.

4. Improves Interoperability and Care Continuity for Multisite Networks

- **Current Challenge:** SOMOS operates across numerous facilities with varying systems. When providers refer patients to external specialists, the receiving facility's endpoint is often unknown or inaccessible.
- **Improvement:** A national FHIR directory allows for **pre-visit exchange** of clinical records and **automated post-visit follow-up**, minimizing data fragmentation and missed handoffs.

5. Enables Faster Onboarding of Digital Tools and Apps

- **Current Challenge:** Many patient engagement apps and care navigation platforms must individually request and configure endpoints with each data holder.
- **Improvement:** A centralized directory with OAuth URLs, token endpoints, and metadata accelerates app deployment and interoperability certification.

Recommended Key Data Elements for a National FHIR Endpoint Directory

To maximize effectiveness, the nationwide directory should support **machine-readable discovery**, **organizational relationships**, and **trustworthy metadata**. Key elements include:

1. Organizational Metadata

- Legal entity name
- Organizational type (ACO, health system, payer, provider group, FQHC, etc.)
- National Provider Identifier (NPI) and/or Tax Identification Number (TIN)
- Location(s) and service area

2. Endpoint Metadata

- **FHIR endpoint URL** (public base URL)
- API type (clinical, payer claims, patient access, provider access, etc.)
- Supported FHIR versions (e.g., R4, R5)
- Endpoint availability status (active, deprecated, etc.)
- API capabilities (read/write, bulk data, SMART on FHIR support)
- OAuth 2.0 authorization and token endpoints (where applicable)
- Endpoint sponsor or vendor

3. Directory Structure and Governance Metadata

- Affiliated organizations (e.g., provider group A is part of ACO X)
- Trust framework participation (e.g., TEFCA/QHIN, Carequality, CommonWell)
- Security and compliance attestations (e.g., HIPAA, NIST-aligned)
- Directory update timestamp and change history

4. Technical Support and Contact Fields

- IT contact for endpoint configuration
 - Support URLs or issue resolution email addresses
 - Preferred data exchange methods (e.g., batch vs. real-time)
-

CMS Recommendations and Policy Implication

To ensure this directory delivers value for APMs and providers, CMS should:

- **Mandate participation in the directory** for all CMS-contracted entities (e.g., ACOs, Medicare Advantage plans, QHINs, Medicaid MCOs)
 - **Ensure public API access** with secure query protocols to support automated endpoint discovery by apps and EHRs
 - **Integrate the directory into TEFCA** and existing CMS interoperability initiatives (e.g., FHIR API rule, Provider Data Catalog)
 - **Offer implementation grants or IAPD matching funds** for Medicaid states and safety-net providers to integrate directory services into clinical workflows
 - **Create feedback mechanisms** to validate and update endpoint data through provider self-attestation and trusted intermediaries
-

Conclusion and Call to Action

A nationwide FHIR endpoint directory would be a foundational asset for accelerating **data exchange, improving care coordination, and increasing transparency** in claims and utilization data across the healthcare ecosystem. For APM entities like SOMOS, this infrastructure would simplify integration, support digital tool deployment, and improve performance across multiple value-based care programs.

We encourage CMS to lead the development of a **standards-based, equity-oriented directory** that empowers both large systems and small, under-resourced providers to deliver smarter, more connected care.

Glossary of Terms

ACO (*Accountable Care Organization*): A group of doctors, hospitals, and other healthcare providers who voluntarily come together to give coordinated, high-quality care to Medicare or Medicaid patients, in order to reduce unnecessary spending and improve patient outcomes by sharing savings with providers who meet cost and quality benchmarks.

ADT (*Admission, Discharge, Transfer*): A type of HL7 message used in health information exchange to notify providers of a patient's status and movements in a hospital or clinical setting—such as when a patient is admitted, discharged, or transferred between units.

API (*Application Programming Interface*): A set of software tools and protocols that allows different software applications to communicate, exchange data, and perform integrated functions.

APM (*Alternative Payment Model*): A payment approach developed by CMS and other payers that incentivizes high-value care rather than volume-based services, which include models like ACOs, bundled payments, and episode-based payments, and can be categorized into advanced APMs that offer shared risk or full capitation.

CBO (*Community-Based Organization*): A nonprofit or local organization that provides social services and support to individuals and families within a specific community, often partnering with providers to address social determinants of health (SDOH) such as housing, food insecurity, transportation, and language access—factors that significantly influence health outcomes.

CDA (*Consolidated Clinical Document Architecture*): A widely adopted standard developed by Health Level Seven International (HL7) for structuring clinical documents such as discharge summaries, progress notes, and referral letters.

CHW (*Clinical Healthcare Worker*): A frontline public health worker who is a trusted member of the community they serve, bridging gaps between health systems and underserved populations by providing culturally appropriate education, care coordination, and connections to medical and social services.

CRD (*Coverage Requirements Discovery*): A standards-based application programming interface (API) developed under the HL7 Da Vinci Project that allows providers to determine, in real time and within their EHR workflow, whether a given service requires prior authorization, and what documentation is needed.

CEHRT (*Certified Electronic Health Record Technology*): Health information technology that meets the certification criteria established by the Office of the National Coordinator for Health IT (ONC)

DEQP (*Digital Electronic Quality Measurement Program*): A framework or initiative for electronically capturing, transmitting, and analyzing clinical quality measures (CQMs) using standardized digital formats and workflows.

DTR (*Documentation Templates and Rules*): A standards-based solution developed by HL7 and Da Vinci Project to support automated prior authorization and clinical documentation workflows.

EHR (*Electronic Health Record*): A digital version of a patient's paper chart that contains comprehensive health information, including medical history, diagnoses, medications, treatment plans, immunization dates, allergies, and lab results.

ETF (*Electronic Health Record Technology*): Not a formally recognized acronym in federal health IT policy; used informally or mistakenly in place of CEHRT (Certified Electronic Health Record Technology).

FHIR (*Fast Healthcare Interoperability Resources*): A modern health data exchange standard developed by HL7 (Health Level Seven International) that enables electronic health information to be shared easily and securely across different healthcare systems.

GSA (*General Services Administration*): A U.S. federal agency that supports the basic functioning of other federal agencies by managing government buildings, procurement, and digital services.

ID (*Identity*): In health IT, ID typically refers to digital identity, which includes the technical and policy infrastructure needed to authenticate users securely.

IPA (*Independent Physician Association*): A network of independently practicing physicians who join together to contract with health plans, share resources, and participate in value-based care arrangements while maintaining their independent practices.

MSO (*Management Services Organization*): An entity that provides non-clinical administrative and business support services to healthcare providers, such as billing, IT infrastructure, compliance, human resources, and contracting.

NCPDP (*National Council for Prescription Drug Programs*): A not-for-profit standards development organization that creates and maintains industry standards for the electronic exchange of pharmacy-related information, including e-prescribing, medication history, eligibility, and claims transactions.

PAS (*Prior Authorization Submission*): A standardized process or protocol—often based on HL7 and X12 standards—for electronically submitting prior authorization requests from providers to payers.

PGHD (*Patient-Generated Health Data*): Health-related data created, recorded, or gathered by patients (or their family members or caregivers) outside of clinical settings.

QHIN (*Qualified Health Information Network*): A central participant in the Trusted Exchange Framework and Common Agreement (TEFCA), designated by the Office of the National Coordinator (ONC) to facilitate secure, nationwide health information exchange.

REL (*Race, Ethnicity, and Language*): A standardized demographic data set collected in healthcare to identify and address disparities in care delivery.

URL (*Uniform Resource Locator*): In healthcare interoperability, a public base URL often refers to the publicly accessible endpoint where an API or FHIR server is hosted, allowing certified applications or partners to access health data securely.

USCDI (*U.S. Core Data for Interoperability*): A standardized set of health data classes and elements defined by the Office of the National Coordinator for Health IT (ONC) to support nationwide, interoperable health information exchange.