

# Federal Register Request for Information

## Health Technology Ecosystem

A Notice by the [Centers for Medicare & Medicaid Services](#) on [05/16/2025](#) | Due: 06/16/25

### A. Definitions for Terms Used in This RFI

- *Digital tools*: web, mobile or other software applications, potentially leveraging sensors, wearables or other hardware.
- *Digital health products*: defined as digital tools that support individual health needs.
- *Health management applications*: Digital tools that leverage patients' data and other information to support patients with health decision-making.
- *Care navigation applications*: Digital tools that help patients identify, select, and access providers or auxiliary care services.
- *Personal health record apps*: Software applications that collect and organize an individual's health records and provider encounter data for viewing, sharing, and usage in digital health products.

### B. Patients and Caregivers – Perspectives shared by Terros Health patients

#### 1. Patient Needs

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

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

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.

#### Answers:

As an integrated behavioral health and wellness provider, Terros Health supports a patient population that frequently faces barriers not only to care, but to basic health navigation. Health management and care navigation apps that prove most beneficial are those that:

- Integrate behavioral and physical health data in one patient-accessible view.
- Provide actionable reminders tied to evidence-based care plans (e.g., “schedule a follow-up within 10 days of discharge”).
- Facilitate secure two-way communication with care coordinators or peer recovery support specialists.
- Translate data into plain-language, low-literacy summaries and provide culturally relevant insights.

a. Patients and caregivers commonly express the desire to:

- View care team recommendations in real time.
- Understand medication instructions and refill schedules.
- Track mood, stress, or substance use patterns in apps that integrate with their clinical records.
- Receive geo-targeted referrals for services like housing support or community-based recovery meetings.

b. A digital assistant modeled on Terros Health’s real-world Care Navigation teams would:

- Auto-schedule or patient-assist for follow-up appointments and transportation.
- Notify patients about eligibility for services (e.g., Medicaid/AHCCCS redetermination alerts).
- Pre-fill forms using previously collected EHR data.
- Alert patients when no-show patterns emerge, offering interventions before disengagement of the patient begins to occur.

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## **PC-2. Access to Consolidated Health Information**

PC-2. 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)?

**Answers:**

Terros Health patients and their caregivers often lack centralized access to comprehensive health records. While we support patient portals (e.g., NextGen and Intellicart in our company's case), these tools frequently do not span physical health and specialty providers or have comprehensive state-level HIE data included.

a. In rare cases where patients use third-party record aggregators (e.g., MyChart linked to multiple systems), they report:

- Easier time explaining their history during specialist visits.
- Reduced risk of duplicative tests or missed medication interactions.

b. A unified portal would have the most value in:

- Coordinated care plans between behavioral and physical health.
- Emergency care settings where provider access to medication or crisis plans is critical.
- Discharge planning, especially when moving between inpatient, outpatient, and residential care.

c. Commonly inaccessible data includes:

- PDF documentation sent by previous provider(s).
- Imaging records (X-rays, MRIs).

Obstacles include lack of integration between EHR systems (mergers and acquisitions), absence of standardized APIs, lack of bi-directional data flow between providers, and usability barriers for older or unhoused populations with limited device access.

**PC-3. Awareness of Useful Apps**

PC-3. Are you aware of health management, care navigation, or personal health record apps that would be useful to Medicare beneficiaries and their caregivers?

**Answers:**

Yes. Examples include:

- CMS' Blue Button portal
- myStrength, a behavioral health app offering CBT-based modules

#### **PC-4. Missing Features and Opportunities**

PC-4. 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?

#### **Answers:**

a. Missing features:

- Apps that dynamically adjust care plans based on claims or appointment data.
- Tools that allow peer coaches or case managers to document directly in the patient-facing platform.
- Systems that show benefit coverage in real time, including limits or prior auth thresholds.

b. Apps that should exist:

- A cross-payer navigator that shows what services are covered regardless of carrier.
- A care timeline visualizer that synchronizes points of care and medications, color-coded for behavioral, medical, and specialty care.

Why they most likely do not exist:

- Complex payer fragmentation
- Lack of incentives for integration
- Uncertain reimbursement.

c. CMS could uniquely offer:

- A federal navigation dashboard for dual-eligibles.
- API services for benefit decision trees (e.g., what SUD services are available by ZIP code and plan).
- A patient-facing recovery and support map, tied to Medicare and Medicaid program access rules.

#### **PC-5. Encouraging Adoption and Quality Review**

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

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

**Answers:**

a. CMS can support adoption by:

- Establishing a CMS-endorsed digital formulary, akin to Part D drug lists, allowing clinicians to “prescribe” digital tools.
- Integrating device and app access into benefits (e.g., covering smartphones with preloaded applications for specific populations).

Review role: CMS could review tools based on:

- Clinical evidence of outcome improvement.
- Health equity alignment, especially for marginalized or rural populations.
- Accessibility and digital literacy adaptations.

Policy levers:

- Reimbursement codes for patient education on digital health.
- Federally supported onboarding teams for patients new to portals or apps.
- Real-time data APIs shared with beneficiaries for personal use and third-party app integration.

b. Timely access hinges on:

- Bulk FHIR exports from EHRs.
- Releasing provider performance dashboards at a granular level.
- Reducing prior authorization complexity, allowing apps to pull this info for patients directly.

**PC-6. Accessibility Features for Medicare Populations**

PC-6. 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?

**Answers:**

Key features:

- Simplified interface modes with audio, contrast, and icon-driven navigation.
- Offline functionality for patients in unstable housing or limited connectivity.
- Touch-to-talk integration for those with mobility impairments.
- Access to live support or tutorial videos, possibly through community health workers.
- Optional caregiver proxy modes, allowing authorized family members or guardians to manage on behalf of the patient.

**PC-7. Real-World Impact Data Collection**

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

**Answers:**

CMS could collect post-market impact data by:

- Embedding evaluation modules in CMS-funded digital health pilots.
- Using claims data overlays to measure reductions in ED visits, inpatient stays, or medication nonadherence.
- Partnering with Medicare Advantage and ACO organizations to track utilization impact.
- Requiring manufacturers to submit real-world evidence dashboards as a condition of CMS listing.

**2. Data Access and Integration**

**PC-8. Health Data Availability and Value**

PC-8. 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?

**Answers:**

At Terros Health, patients and caregivers find basic appointment data, lab results, and medication lists accessible via the NextGen portal or Intellicart. However, critical gaps remain.

a. Valuable but hard-to-access data:

- Documentation from provider organizations considered 42 CFR Part 2 regardless of whether the individual content falls under the regulation.
- Referrals and intake documentation from Behavioral Health hospital systems and specialty providers not yet participating with state-level HIEs.

b. High-value non-clinical sources include:

- Public health agency data
- Housing program records
- Peer support and community recovery records not currently digitized or accessible via APIs.

c. Challenges:

- Lack of shared patient identifiers between state agencies, Medicare and Medicaid plans, payers, and providers.
- Absence of API connectivity across siloed systems
- Minimal interoperability incentives in non-hospital community care systems.
- Frequent use of scanned documents, PDFs, and fax-based communication that resist FHIR conversion.

**PC-9. Expanding CMS API Utility**

PC-9. Given that the Blue Button 2.0 API only includes basic patient demographic, Medicare coverage, and claims data (Part A, B, D), what additional CMS data sources do developers view as most valuable for inclusion in the API to enable more useful digital products for patients and caretakers?

- a. What difficulties are there in accessing or utilizing these data sources today?
- 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?

**Answers:**

a. Developers want access to:

- Real-time eligibility status
- Care management flags
- Prior authorization decisions
- Social determinant screenings

b. Difficulties include:

- Access to government-level resources to gain connection to the API data.
- Absence of data from Medicaid managed care organizations.
- Complex onboarding for developers, even with proper authorization.

c. To improve:

- Expose outcomes measures, not just services rendered.
- Include non-CMS entities like housing programs for integrated support

**PC-10. TEFCA and Patient Access**

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

- a. Please provide specific examples.
- 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?

**Answers:**

a. TEFCA's value is still theoretical for Terros Health patients. Unresolved challenges include:

- Identifier mismatches
- Lack of non-hospital data contributors
- Costs related to data exchange
- Technical expertise to deploy, support, and grow solutions

b. TEFCA may choose to:

- Incentivize local interoperability governance bodies to include behavioral health organizations
- Support event-based integration solutions, not just bulk or point-in-time data exchanges

c. High-impact use cases:

- Real-time crisis alerting to behavioral health teams.
- Pre-hospital discharge alerts and record synchronization for continuity of care purposes.

d. Working standards:

- United States Core Data for Interoperability (USCDI) standardized set of health data classes and elements that the health care ecosystem (e.g., clinicians, health information systems) uses to ensure consistent and accurate exchange of health information across systems and settings.
- SMART on FHIR a platform that enables secure and standard-based access to Electronic Health Record (EHR) data through the FHIR API.
- IHE PIX/PDQ for ID matching providing an MRN (Medical Record Number) and assigning authority to receive back the name and MPI ID of a single patient.

e. Underused but promising:

- Bulk FHIR for care transitions
- Consent management APIs (SMART authorization)

f. Redundancy:

- State and Regional HIEs and payer APIs duplicating efforts.

g. Alternatives:

- In Arizona, Contexture HIE and Tribal data exchanges.

### **PC-11. Health Information Exchanges (HIEs)**

PC-11. 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.)?

### **Answers:**

a. Contexture regional HIE for Arizona and Colorado is partially effective:

- High-value for emergency event notifications.
- Inconsistent specialty or community provider participation.
- Limited data completeness from rural clinics and behavioral health specialty hospitals.

b. Suggested changes:

- Mandate behavioral health data inclusive of privacy safeguards.
- Offer shared incentives for data exchange participation.
- Implement patient identifiers across data exchange systems.

c. High-performing model:

- Unknown

d. Ongoing role:

- HIEs should coordinate patient identifier standards, provider directories, crisis alerts, and care gap analytics.
- They should evolve to integrate with TEFCA, payer APIs, and state agency databases without duplicating structures.

## **PC-12. Operational Use Cases**

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

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?

### **Answers:**

a. Valuable use cases:

- Accurate provider availability integrated with insurance networks.
- Appointment management apps with no barrier to low-literacy users.
- Behavioral-specific quality metrics, such as post-hospitalization follow-up for SMI or MAT continuity.
- Provider-match tools based on condition and cultural alignment.

b. What's possible today:

- Partial implementation of provider finders

c. Near future:

- Real-time referral accept/decline integration.
- Benefit-eligibility APIs embedded in scheduling tools.

d. Valuable but hard:

- Dynamic cross-payer authorization visualization.
- Possible expectations based on provider clinical care models, longitudinal outcome indicators, and patient participation in services.

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### 3. Information Blocking and Digital Identity

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

#### Answers:

CMS could:

- Continuing awareness campaigns for healthcare providers and patients.
- Provide a template or wizard interface within patient portals to submit complaints seamlessly.
- Create patient education material tailored for low-literacy or elder populations.

Impact:

- Higher visibility identifying information-blocking entities.
- Course correction support of organizations lacking technical ability to appropriately release information.

### PC-14. Digital Identity Credentials

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

- What are the challenges today in getting patients/caregivers to sign up and use digital identity credentials?
- What could be the benefits to patients/caregivers if digital identity credentials were more widely used?
- What are the potential downsides?

- d. How would encouraging the use of CSPs improve access to health information?
- 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?

## **C. Providers**

This section is intended for all stakeholders to provide input on questions as they relate to use cases and workflows that involve providers. While we certainly want providers to answer questions in this section (and in other sections) from the provider point of view, we also invite all stakeholders to provide their viewpoints on the provider workflows as appropriate.

### **1. Digital Health Apps**

PR-1. What can CMS and its partners do to encourage providers, including those in rural areas, to leverage approved (see description in PC-5) digital health products for their patients?

- 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?

#### **Answers:**

##### **a. Challenges:**

- Many patients lack confidence in digital systems.
- ID verification for unhoused or undocumented users.
- Broadband and tech literacy remain barriers for some.

##### **b. Benefits:**

- Stronger authentication for easier API integration.
- Enables proxy management by caregivers

##### **c. Downsides:**

- Could exclude vulnerable populations unless fallback paths exist.

- Potential for third-party identity vendors to mishandle or commercialize data.

d. Credentialing could:

- Unify identity across CMS portals, apps, and provider systems.
- Reduce forgotten password incidents.

e. CMS role:

- Supporting credentialing services for patients.
- Making sign-up a default part of onboarding.

f. Encourage via:

- Incentivizing providers to recognize credentials
- Bundling identity with access benefits (e.g., digital appointment reminders, secure message center)

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### **PR-1. Encouraging Provider Adoption of Digital Health Products**

#### **1. Digital Health Apps**

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

CMS and its partners can catalyze adoption of digital health tools in organizations like Terros Health through three critical levers: reimbursement alignment, integration support, and behavioral health inclusion.

a. Current obstacles include:

- Funding demonstration projects to:
  - Support clinicians in streamlining care, enhancing patient follow-through, and reducing administrative load.
  - Serve as adjuncts to person-centered care, particularly for underserved populations who face structural or geographic barriers.
  - Expand access without displacing the irreplaceable role of behavioral and mental health professionals.
- Lack of integration: Digital tools often exist outside EHR ecosystems (e.g., standalone apps), creating burdensome workflows.
- Reimbursement misalignment: No structured payment exists for onboarding or maintaining digital tools within community-based behavioral health.
- Licensing confusion and data risk: Uncertainty about compliance liabilities, lacking in technical, and/or financial ability to deploy and support third-party tools for patients.

b. What providers should share:

- Scope of the tool's function as an extension of clinical care.
- Privacy limitations and opt-out rights.
- Whether the app is part of a treatment plan or an optional adjunct.
- Data pathways (i.e., whether provider sees the input/output).

c. Provider responsibilities:

- Ensure tools used meet minimal standards of data security and health literacy.
- Maintain consistency with clinical guidelines when integrating recommendations.
- Support patients in interpreting digital tool feedback in context of their care plan.

## **PR-2. Obstacles to Physician Workflow Applications**

PR-2. What are obstacles that prevent development, deployment, or effective utilization of the most useful and innovative applications for physician workflows, such as quality measurement reporting, clinical documentation, and billing tasks? How could these obstacles be mitigated?

**Answers:**

Digital opportunities remain blocked due to:

- Quality Reporting Fragmentation: Reporting mechanisms differ between CMS, state Medicaid systems, and private payers, with little reusability.
- Documentation Redundancy: Behavioral health EHRs often require duplicative entries for intake, consent, and care plan tracking.
- Billing Task Complexity: Authorization management, service restrictions, and encounter-level compliance documentation remain largely manual processes or are burdened with overly complicated configurations between provider and payer systems.

Mitigation Recommendations:

- CMS could fund template-based data bridges between EHRs and MACRA/MIPS systems.
- Require or incentivize EHR-based auto-populated forms for common Medicare workflows.
- Offer a “Workflow Sandbox” for certified vendors to test interoperability features in live provider environments, with CMS certification points awarded for field-tested tools.

**PR-3. Importance of Full EHR Data Accessibility**

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

- a. Current challenges in accessing different data formats.
- 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.



**Answers:**

It is critical for appropriate care coordination.

a. Current challenges:

- Received PDFs are not easily parseable.
- Faxed records stored as images are not query searchable.
- Free-text clinical notes have minimal usability for care summaries or reporting.

b. Impact on care:

- Patients are re-interviewed repeatedly, reducing trust.
- Missed medication interactions may occur due to lack of information.
- Increased clinician time spent cross-checking scanned referral documentation and intake assessments.

c. Technical barriers:

- Lack of FHIR mapping for scanned/archived data.
- Database structures not conducive to enabling import/export of data elements.
- Recruitment and retention of technical staff

d. Cost/privacy implications:

- High integration costs due to proprietary formats and HIE fees.
- Data security concerns when converting non-standard content.

e. Priority level:

- High. As data complexity increases, fragmented formats impede clinical decision-making and population-level reporting.

**PR-4. Access to Administrative Workflows via Patient Apps**

PR-4. 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?

**Answers:**

Digital health products should have API-based access to:

- Prepopulated intake forms using existing patient demographic or history data.
- Provider calendars with availability, restricted by plan eligibility or prior auth status.
- Appointment creation with workflow triggers (e.g., automatic referrals, post-discharge follow-ups).

To enable this, CMS could:

- Create a baseline administrative data schema (FHIR-based) required of certified EHRs.
- Encourage integration with provider directory APIs including appointment and credentialing information.
- Incentivize use of multi-tenant patient experience platforms that sit above fragmented EHR environments.

## **2. Data Exchange**

### **PR-5. FHIR APIs and Capabilities in Use**

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

- a. Patient Access API.
- b. Standardized API for Patient and Population Services.
- c. Provider Directory API.
- 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).

## **Answers:**

Terros Health supports API and FHIR integrations with some direct functionality and others managed through intermediaries (e.g., HIE vendors). Below is the breakdown:

### **a. Patient Access API**

- *Model:* Individual queries via third-party patient portals
- *Use Case:* Patients accessing appointment history, medications
- *Constraints:* Limited cross-system visibility

### **b. Standardized API for Patient and Population Services**

- Not yet fully implemented
- *Constraint:* Current infrastructure lacks bulk support for population-level SUD/SMI analytics

### **c. Provider Directory API**

- Partially used internally via provider credential systems
- *Constraint:* No federated access across regions

### **d. Provider Access API**

- Under consideration
- *Barrier:* Vendor API licensing and lack of uniform guidance

### **e. Payer-to-Payer API**

- Partially completed with some payers
- *Observations:* Some payers do not yet support reciprocal transfer formats; Implementing APIs for each payer is time consuming, costly, and a redundant process for the organization.

### **f. Prior Authorization API**

- Not supported
- *Impact:* Manual submission delays

### **g. Bulk FHIR (Group ID-based queries)**

- Not currently in use

- *Constraint:* NextGen's export tools are not yet aligned with CMS group filtering standards

#### **h. SMART on FHIR (EHR-launched & standalone)**

- *Standalone:* Partially supported via NextGen API layer
- *EHR-launched:* Not yet proven viable or internally configured
- *Process:* Our team is working on test integration environments

#### **i. CDS Hooks**

- Not active
- *Potential:* Could support decision support in suicide risk stratification and MAT dose management

### **PR-6. TEFCA and Provider Access**

PR-6. 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?

#### **Answers:**

a. Current value:

- TEFCA has not yet had material impact at Terros Health. In general, behavioral health organizations remain underrepresented in current implementation priorities, and identity resolution is unreliable.

b. Recommended changes:

- Mandate inclusion of behavioral health nodes, including community-based organizations and SUD clinics.
- Fund middleware translation services to support smaller orgs lacking FHIR-native systems.

c. Other options:

- In Arizona, Contexture HIE and direct payer and/or provider API integrations

d. Redundancies:

- TEFCA overlaps with payer-specific data pipes (e.g., Arizona Complete Health and MercyCare API infrastructures), without unifying ID logic.

### **PR-7. CMS Strategies for Interoperability Support**

PR-7. What strategies can CMS implement to support providers in making high-quality, timely, and comprehensive healthcare data available for interoperability in the digital product ecosystem? How can the burden of increasing data availability and sharing be mitigated for providers? Are there ways that workflows or metrics that providers are already motivated to optimize for that could be reused for, or combined with, efforts needed to support interoperability.

#### **Answers:**

CMS can support providers by:

- Offering EHR connector kits that transform raw system output into FHIR-compliant exchanges.
- Supporting role-based data access profiles (e.g., different views for peer specialists vs psychiatrists).
- Reusing existing provider workflows (e.g., treatment planning, 42 CFR Part 2 consent) as data triggers for structured exchanges.

Burden mitigation:

- Fund cross-EHR bridge tools (similar to single sign-on, but for data interoperability)
- Replace duplicative state and federal reporting pipelines with a single, certified bulk reporting utility.

### **PR-8. Simplifying Clinical Quality Data Submissions**

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

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

**Answers:**

a. Bulk FHIR for Quality Reporting:

- Terros Health supports this concept. The current burden of reporting to multiple systems (CMS, SAMHSA block grant systems, Arizona AHCCCS, individual payers, etc.) is substantial.
- Preferred model: Agreed upon national patient identifiers; Exports of patient-level data to CMS and Regional/State HIE who could then redistribute information sharing of standardized data sets and metrics.

b. Consolidating interoperability and reporting responsibilities:

- CMS could allow one data set submission to count for both quality reporting and interoperability audits.
- Require alignment between EHR vendors and payers on terminology, measurement timing, and patient attribution.

c. Registry requirements:

- Could allow continuous submission, not just annual or quarterly batches.
- Must support 42 CFR-compliant behavioral data (e.g., no forced de-identification of sensitive info).
- Should expose benchmark feedback dashboards to providers timely.

### **3. Digital Identity**

#### **PR-9. Patient Matching and Identity Resolution**

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

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?

**Answers:**

Patient matching is a persistent structural barrier as identity mismatches create patient record separation, undermine care coordination, impede billing, and erode trust.

**a. Mismatch types:**

- Clients may present with aliases, lack of government ID, or use shelters as address proxies.
- Medicaid rosters and CMS datasets use different ID matching logic than local systems (e.g., DOB variance tolerances).

**b. Impact:**

- Referrals from may become new patient charts instead of being linked to an existing record.
- Records are not able to be shared or linked between provider organizations appropriately creating duplicate charts and causing a loss of information availability for the provider.

**c. Needed solutions:**

- Implement a universal health patient identifier and standard data set and exchange formats.
- Require EHRs to expose APIs for chart merging and duplicate detection, with standard logic for community clinics.

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**PR-10. National Provider Directory APIs**

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

- a. What are the challenges and benefits for providers?
- 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?

**Answers:**

Terros Health supports CMS requiring API-accessible national directories.

a. Primary barriers:

- Payers often keep directory systems closed, especially behavioral networks.
- Providers are required to manually update multiple directories, each with different validation rules.

b. Current state:

- Access to national credentialing system interfaces are not available.
- Payer directories are often out of date.

c. Proposal:

- CMS could create a Federated Provider Verification Layer that:

Allows clinics to publish once, validate once

Syncs with commercial and public plans

Uses SMART on FHIR directory extensions to publish availability and scope of services

**PR-11. Interoperability Burdens by Practice Size**

PR-11. 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?

**Answers:**

Terros Health supports dozens of small, mid-sized, and large service locations.

a. Top challenges for small sites:

- FHIR onboarding cost: Vendors charge high fees to activate APIs even in certified systems.
- Duplicate data entry: Some programs are required to manually log into state and CMS reporting systems with no EHR integration options (original source of the documented information).



- Lack of technical resources: Some sites cannot support real-time data troubleshooting.

b. Requested solutions:

- CMS could provide technical assistance by supplying:

No-code connector templates

Embedded TEFCA nodes

Direct integration grants for certified providers

#### **4. Information Blocking**

##### **PR-12. Data Portability (42 CFR, API-based exchange)**

PR-12. 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?

##### **Answers:**

Behavioral data remains difficult to transmit due to legal constraints, vendor challenges, and general lack of understanding across entities.

a. Constraints:

- 42 CFR Part 2 data often excluded entirely rather than managed with consent layers.
- Many APIs exclude critical information by default.
- No standard method exists for dynamic consent refresh in behavioral workflows.

b. Recommendations:

- CMS could issue clear federal guidance aligning 42 CFR consent with FHIR-based token systems.
- Create a national consent management broker compatible with SMART apps and Medicaid enrollment workflows.
- Fund a demonstration program focused on behavioral episode continuity across systems.

##### **PR-13. Information Blocking Complaints**

PR-13. 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?

**Answers:**

From a provider's perspective:

a. Filing barriers:

- Hesitation to accuse upstream entities, fearing retaliation.
- Complaint portals are legalistic and intimidating.

b. Fixes:

- CMS could:

Allow anonymous patient or peer-assisted complaints.

Create a "blocking alert" API that notifies CMS of failed data queries across systems.

**PR-14. Interoperability and EHR Vendors**

PR-14. 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?

**Answers:**

a. EHR limitations:

- NextGen has incomplete FHIR support, especially around group queries, CDS Hooks, and real-time prior auth.
- API activation costs are costly; often \$5K–\$20K per endpoint.

b. Proposals:

- CMS could:

Require all certified EHRs to include zero-cost, core FHIR endpoints for small provider use.

Create a public EHR Interoperability Scorecard, including pricing transparency for APIs, onboarding time, and compliance.

Penalize vendors that delay implementation of certified features.

**D. Payers**

*Section not applicable to Terros Health*