BUENA VIDA Y SALUD (ACO)
GOOD LIFE & HEALTH

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June 16, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Attention: CMS-0042-NC
RIN 0938-AV68

RE: Request for Information on the state of data interoperability and broader health technology infrastructure

Dear Administrator Oz:

Thank you for the opportunity to share information, insight, and suggestions regarding data interoperability and health technology.

PC-2: "Access to you or your loved one's health information in one location":

b. It would be valuable if the various health care providers, facilities, labs, pharmacies, etc. had interoperability and a universal application that could provide access to a copy of a patient's record across all provider types. At this time, this is not possible. Not all systems are bidirectional or have functional FHIR (Fast Healthcare Interoperability Resources), let alone those providers who are in paper type systems. Healthcare functions as multiple different silos with varying degrees of digital engagement. As a patient, it would be more effective to be able to have a single application that could sync across multiple care settings to create and have a unified consolidated record. I, as the owner of my medical record, would have the ability to share it, and give access to any healthcare provider that I need to engage for my health and wellbeing; placing myself in the driver's seat of my care. I strongly believe that if we could develop such an application, it would also help patients manage their total cost of care, making each of us aware of the financial impact of our choices.

c. At this time, access to x-rays has challenges due to the need to connect the picture archiving and communications systems (PAC). I sit on the board of a regional health information exchange (HIE). The HIE has experienced a number of technical challenges integrating PACs. We need additional advancements and financial support to connect the various systems to create the desired interoperability. Without government investment, costs are a significant barrier to connect some of these systems and the HIE does not have a financially sustainable model for connecting the PAC systems.

PC-8: "...what health data is readily available and valuable.."

a. "What data is valuable, but hard....to access for appropriate and valuable use..." From a physician's perspective, it would be helpful to overlay EMR, claims, pharmacy and hospital data in a brief summary popup type screen at point of care. Pharmacy prescription filling data is not accessible, but would help at point of care, along with the patient cost for the prescriptions and if the medication is on formulary.

b. Pharmacy data would be helpful for both the patient and the physician.

c. Challenges: It is very helpful to have consolidated and normalized data for use in presenting meaningful, engageable medical data for healthcare providers and other users in the healthcare market place. The primary challenge with consolidation and normalization of data is the cost. The HIE I work with has not been able to find a financial model to sustain the process and is considering discontinuing the consolidating and normalizing the data. We need a low cost process to consolidate and normalize data, including unified and standardized structured data fields. Government investment in this process would be beneficial.

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

a. In our experience, the HIE data is valuable and accurate. It is a significant asset to our organization and the physician practices we work with. When the HIE was able to consolidate and normalize the data, the data was much easier to work with. Due to cost associated with the process, it had to be suspended. We now have to look through each encounter to be able to find the information points needed for patient care. The HIE also provides admit/discharge data from hospital visits, which assists with care transitions.

b. We suggest the following changes: 1) Make the HIE a subsidized utility. It needs to be less expensive for the various components of the healthcare market place to connect. 2) The electronic medical record vendors charge too much for the HIE connections which reduces the number of connected providers. The electronic medical record vendors should include the HIE interface and maintience as part of the standard package. 3) Make it easy and inexpensive for other components of the healthcare market place to connect to the HIE, such as skilled nursing facilities, pharmacies, long-term care facilities, home health, hospice, etc. 4) Patient Facing application – due to the cost and inability to monetize a patient facing application that provides patients access to their health record in the HIE, our regional HIE has not been able to implement this service. We think having a patient facing application would be highly valuable to engaging patients in their care. We need a method of funding for a patient facing application service.

d. We see an ongoing role for the HIE. It is easier for an entity to manage one interface, thus a single connection to the HIE can provide the physician and other providers with access to the other records in the region. We think this model has great potential. The HIE can be the aggregator of multiple different data points in establishing a data lake for all regional healthcare providers, in addition to interfacing as a federated model to national data points. There are two concerns for HIEs: 1) creating a financially sustainable model and, 2) engaging providers to interface. There continues to be many healthcare providers (across the spectrum of healthcare) that cannot connect.

PC-12: "What are the most valuable operational health care use cases for patients..."

a. (3) For third party appointment management to work – it will have to address the appointment times necessary for various appointment types. It will also have to address referral and prior authorization requirements. If the application does not take these items into account, it will create frustration and will be abandoned.

PR-1: "What can CMS and its partners do to encourage providers, including those in rural areas, to leverage approved digital health products."

a. Obstacles: 1) Slow and unstable or non-existent internet; 2) Cost of conversion and maintience of an electronic health record (this is an additional cost) which will not be recovered; 3) Electronic health record documentation reduces the number of patient that can be seen per day (thus reducing access to care) and increases the administrative burden; 4) staff training challenges and digital literacy of the providers and staff.

b. What information should be shared with patients: Medications (list of each mediation, dosage, frequency and what is it treating), allergies, diagnosis, surgical history, vaccines, laboratory and x-ray reports, hospitalization and emergency room visits

PR-5: "FHIR APIs: We think the FHIR API communication/interface methodology has potential." The HIE we work with had a proof-of-concept grant, where they worked with an electronic medical record (EMR) and a small local practice to activate a FHIR button in the EMR. We are proud to announce the HIE was successful in activating the FHIR API, but the costs of implementation, deployment and continued maintience, made the FHIR API application prohibitive to maintain. Thus it was discontinued after the grant ended. The project showed what was possible and it produced an excellent addition for direct patient care. We now need to find a way to make this financially sustainable.

TD-7: "To what degree has USCDI improved interoperability...."

a. Data Elements – The USCDI is great work in the right direction – it sets a universal standard for mapping. The issue is electronic medical record (EMR) vendors are not up to the latest version – they have to be at v3 by January 2026. Yet many health care organizations, such as accountable care organizations, need to have mapped data sets in 2025 for which some EMR vendors are not able to provide.

A second point on Data Elements has to do with patient matching. There should be consideration for adopting AHIMA naming standards to improve patient matching, which is essential backbone to interoperability. If approved and promoted, the healthcare industry as a whole will need significant education, along with the general public as to why the accuracy legal name matters.

PR-9: Digital Identity Credentials: This is an interesting concept. Until all entities in healthcare can agree to a patient naming convention and ensure the same legal document is used to identify the legal name of the patient, this process may or may not work. There is a significant amount of duplication of patients due to different entities documenting a person's name differently. If the Digital Identity Credentials will eliminate duplication of a patient, then it will be helpful. There is an issue to take into consideration for those patients who want the right to remain anonymous. There will need to be a way to fully protect a patient's anonymity.

Thank you for this opportunity to provide information from what we see in the healthcare industry.

Respectfully,

Sheila Magoon MD
Executive Director