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Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

Dr. Thomas Keane
Assistant Secretary for Technology Policy
National Coordinator for Health IT
U.S. Department of Health and Human Services

Re: CMS-0042-NC; Request for Information; Health Technology Ecosystem

Dear Administrator Oz and Assistant Secretary Keane:

Thank you for the opportunity to provide comment in response to the Request for Information (RFI) on the Health Technology Ecosystem.

Accountable for Health is a non-partisan, national advocacy and policy organization accelerating the adoption of effective accountable care. We aim to support policymakers to advance the movement in the health care system toward accountable care that achieves better outcomes, improved care experiences, increased access, and lower costs.

Health technology plays a critical role in enabling providers in accountable care arrangements to deliver high-quality, efficient care while maximizing patient outcomes. Developing the infrastructure required to ingest and interpret health records, claims, and health information exchange (HIE) data from multiple payers is a costly process in which a practice must invest in both a data platform and additional staffing.[1] Accountable for Health applauds the Administration's commitment to reducing undue burden and promoting seamless and secure flow of health information between patients, providers, and payers, which will not only support providers currently participating in accountable care arrangements but also make value-based care more attractive to late adopters who remain in fragmented fee-for-service delivery.

Moving forward, we urge the Centers for Medicare & Medicaid Services (CMS) to ensure technology policies give flexibility for total cost of care organizations to pick technology that works best for them to achieve their clinical and financial goals. The government should reward entities taking risk for patient populations for the outcomes they are able to achieve without prescribing the technology tools that should be leveraged to achieve those goals. Total cost of care or global risk entities have a built-in incentive to use high impact, low-cost tools where they are most useful.

Furthermore, in prioritizing digital health tools, we urge the Administration to prioritize and focus on digital health opportunities that are easy for patients and caregivers (e.g., text message, phone

[1] Berkely Research Group, "Transitioning to Value-Based Care: Financial Implications for Providers and Policymakers."

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calls, etc.) to engage with. Digital technologies that are burdensome for beneficiaries to use will not be successful.

Our responses to specific questions of the RFI are below.

Responses to RFI Questions

1. Digital Health Adoption

VB-1. What incentives could encourage APMs such as accountable care organizations (ACOs) or participants in Medicare Shared Savings Program (MSSP) to leverage digital health management and care navigation products more often and more effectively with their patients? What are the current obstacles preventing broader digital product adoption for patients in ACOs?

Advanced alternative payment model (APM) participants should receive financial incentives to leverage technologies to reduce readmissions and improve outcomes. Today, Accountable for Health members invest in technology to improve patient experience and outcomes, such as utilizing a patient navigator in nursing facilities to improve post-acute care but receive no support or incentives to make such investments beyond the nature of two-sided risk arrangements.

CMS must foster an environment with both stability in payment models and flexibility in permitted technologies so APM participants can be successful. A key obstacle preventing broader digital product adoption for patients in accountable care organizations (ACOs) are restrictions on what constitutes "treatment" under HIPAA in terms of entitlement to data needed to support key prevention and population health activities. Currently, digital health service providers struggle to access timely data. Digital health organizations, such as those providing patient navigation services working with a physician practice, should have the ability to be classified as an extension of the treating physician to receive access to data under the "treatment" use case.

Data quality also presents a significant challenge for APMs. Provider organizations have many different electronic health records (EHRs). It should be easier to aggregate data to get comprehensive patient information. This is particularly important for small, independent, or rural practices. CMS should ensure these practices can access incentives and/or subsidies to support adoption (e.g., preferential quality scoring/benchmark treatment for demonstrating active use of certified digital tools or allowing ACOs to use prepaid shared savings for digital health adoption investment).

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

To successfully deliver accountable care, providers must attain a robust set of competencies which enable strong care management, modernized data capabilities to inform decision-making, and accountability for quality and cost. CMS should consider key technologies that support these specific themes and competencies.

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New policies focused on APM core competencies should reflect that data quality is often extremely poor. Accountable for Health members frequently run into situations where providers are not following workflow and using proprietary codes. There is also significant waste due to a lack of standards. The data mapping work ACOs must undertake to get accurate data is a significant burden, including creating a unique patient record, standardizing units of measure reporting and nomenclature standards. We are hopeful based on early indications of the adoptions of Fast Healthcare Interoperability Resources (FHIR) Application Programming Interfaces (APIs) in healthcare, such as the United States Core Data for Interoperability (USCDI), that the mapping can be tested and regulated at scale. We recognize this does not solve the whole problem, and feel this is an incremental win towards the healthcare infrastructure of the future.

Finally, CMS should also consider opportunities for public-private partnerships to improve data standardization across claims, admission discharge and transfer (ADT) feeds, etc. Improving data quality on the front end would reduce the time and resources currently spent cleaning the data on the back end.

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

Accountable care entities managing clinical and financial risk require scalable and interoperable infrastructure to execute risk-oriented outcomes. The healthcare infrastructure relies heavily on interoperability and EHRs for which most of the market are on-premises resources (limited computing power/electricity).

To be successful in managing risk, APM participants must have modern, highly interoperable shared operational transactions that enable timely care management. This includes clinical data exchange, claims data exchange (both adjudicated and pre-adjudicated), real-time prior authorizations (including those associated with CMS waivers (e.g., SNF 3-Day Waiver)), and real-time checks on current performance to date (e.g. the use of Da Vinci Value-Based Performance Reporting Implementation Guide) instead of performance at a quarterly or yearly basis. It is also important for accountable care entities to have access to admission/discharge/transfer (ADT) data for their aligned beneficiaries across the care continuum in as close to real-time as possible to proactively manage their care. To achieve this, HIPAA transactions need to be modernized and utilize modern computing capabilities, such as the use of APIs.

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

Accountable care entities benefit from data sources – including clinical data, charge data, claims data and HIE/ADT/facility data – managed by the federal government (e.g., VA data). These data sources are preferable to retrospective flat files or Blue Button data. The essential data set to manage under risk is a full source of clinical data (e.g., USCDI Core elements and their evolution), claims and cost data of aligned patients, a provider directory of those participating in the network, and member/patient identity. Historical HL7 transactions, such as ADTs and other patient monitoring transactions, are also necessary. For an ACO with practices across various EMRs to support its participants as an extension of the physicians, it is important to incorporate scheduling

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and appointment data into the USCDI Core elements. This addition will help eliminate barriers to patient care coordination, reduce provider burden, and enhance patient engagement.

ACOs also face issues with beneficiaries opting out of data sharing, as it challenging to effectively manage patient care with limited claims history. We encourage CMS to consider ways to either require data sharing as a condition of participation or exclude those beneficiaries from certain programs to hold ACOs harmless.

2. Compliance and Certification

VB-5. In your experience, how do current certification criteria and standards incorporated into the ONC Health IT Certification Program support value-based care delivery?

Current certification criteria and standards provide a good platform for providers to collect data, but are limited in their utility to accountable care entities such as ACOs.

In Accountable for Health member experiences, providers often do not provide accountable care entities with access to data. As a result, ACOs frequently have to work directly with EHR vendors to build data extracts, which can cost anywhere from $5,000 to $45,000. On top of this cost, practices participating in the ACO must pay maintenance fees on annual basis to keep extracts flowing, which can be a significant hurdle for small and independent practices. ACOs also regularly face challenges when validating the data from EHRs to ensure accuracy by verifying data against the primary source. Practices utilizing regulated FHIR APIs such as USCDI Core see a reduced, if not zero, cost for use. APIs outside of those that are regulated are charged for services, which can be costly at scale. This underscores the importance of regulated APIs to reduce burden to the entire ecosystem.

Before implementing standards and requirements, CMS must also undertake sufficient real-world testing to ensure EHR capabilities are adequate. Using Bulk FHIR capabilities as an example, our members experience has highlighted that most EHRs are not ready for this load of compute on the application. In addition to requiring Certified EHR Technology (CERHT) to make USCDI Core data elements available for data sharing, CMS should also include performance requirements as part of the certification process (e.g., the EHR bulk FHIR / SMART on FHIR API should allow successful data transaction of X number of records for X number of resources on X number of patients within X number of hours).

VB-7. How can technology requirements for APMs, established through CEHRT or other pathways, reduce complexity while preserving necessary flexibility?

CMS should move beyond the focus on CEHRT. Current CEHRT requirements, combined with quality reporting requirements in the Merit-based Incentive Payment System (MIPS) and the Medicare Shared Savings Program (MSSP), are burdensome and unnecessary.

Given experience with CEHRT and the issues overly specific requirements have created, CMS should be less detailed in what is required. A better approach would be to set up broad, total cost of care incentives and allow APMs to determine how to adopt the technology in a way that solves

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the problems. Any intervention should be focused on removing barriers or solving collective action problems (e.g., stricter requirements around making data available).

CMS should also reconsider policies finalized in recent years that have significantly increased burden and complexity for MSSP ACOs reporting through MIPS, including requiring all MSSP ACOs report either eCQMs or CQMs for all patients, across all payers, and in all practices; this includes additional quality reporting requirements with the Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure Set and a new policy requiring MSSP participants to report the MIPS Promoting Interoperability performance category measures. Alternatively, if CMS is willing to share the burden of data aggregation and patient de-duplication, it could allow ACOs to submit eCQMs multiple times for the same quality measure without overriding previous submissions. This could ease the strain on ACOs to collect clinical data from various EHRs and practices for reporting purposes.

CMS could also reduce complexity by zeroing out MIPS performance bonus payment and penalties. This will have the dual benefit of eliminating the current financial incentive for fee-for-service reimbursement and eliminating the administrative burden associated with today's complicated and non-impactful MIPS reporting structures. If CMS chooses not to pursue this path, CMS should instead eliminate and/or streamline MIPS requirements for accountable care entities starting with the recommendations highlighted above.

VB-8. 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?

CMS should maintain and strengthen current requirements related to event notifications, as event notifications play a central role in alerting established providers that their aligned patient has had an acute episode. In some cases, ACOs are able to work with hospitals to obtain event notifications for a roster of aligned patients. In other cases, hospitals are unwilling to work with the ACO entity itself and/or accept a roster for notifications. CMS should require event notification transmissions to be near real-time in order to enable effective care coordination.

Policies that could be helpful to clear barriers to consistent implementation of the event notification Condition of Participation (CoP) include:

- Requiring hospitals to enable roster-based approaches for notifications.
- Requiring any hospital receiving reimbursement from CMS under any risk-bearing program (e.g., Medicare Advantage, MSSP, ACO REACH) to participate in electronic patient event notifications to community providers.
- Eliminating the ability for EHRs to control what they are willing to contribute.
- Further development of ADT messaging standards to support inclusion of new data elements and/or types of notifications, such as facility name, address, and NPI. Consider a FHIR API transaction and the standard implementation guides that exist (e.g. Da Vinci Unsolicited Notifications). This also supports reduced burden to manage any ACO waivers.

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- Expansion of the patient population to whom the CoP applies to include patients who present in the ED and are subsequently discharged without being admitted, as well as those patients who are admitted in observational status.
- Expansion of the minimum information in the notification to include the discharge disposition data field, giving more information about the outpatient care recommended to the patient.

VB-9. What technology requirements should be different for APM organizations when comparing to non-APM organizations (for example, quality reporting, and interoperability)?

CMS should strive to eliminate all unnecessary, undue burdens and regulations. Accountable care entities are inherently incentivized to invest in these technologies to be successful. The degree to which the Administration implements requirements for non-APM entities depends on its technology goals for this population.

Burden reduction is a key benefit for providers who participate in accountable care models, particularly two-sided risk models. In enacting MACRA, Congress recognized that participants in advanced APMs were undertaking many of the desired behaviors of cost control and quality improvement through their model designs. For this reason, clinicians participating in advanced APMs are exempt from MIPS. This longstanding policy rationale has led to CMS attempting wherever possible to remove, waive or align model requirements, removing burden or duplication in favor of empowering the movement to accountable care. In contrast, CMS recently finalized a requirement that participants in the MSSP report the MIPS Promoting Interoperability performance category measures instead of the attestation requirement. This requirement adds, rather than reduces, burden for APM participants. CMS should rescind this requirement and differentiate APM requirements from MIPS to the greatest extent possible.

CMS should also further streamline quality measurement for accountable care entities, such as what has been done in the ACO REACH model. ACO REACH model includes a streamlined set of claims-based quality measures, which are calculated by CMS, and an attestation approach to EHR certification. CMS should retain the streamlined requirements for ACO participants whether in MSSP or a future Innovation Center model.

Finally, CMS should consider using technology to reduce administrative burden including documentation requirements. Technology can be helpful in ensuring care is appropriately provided and paid for without physical documentation. Shadow data testing could be one approach.

3. Technical Standards

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

Data interoperability presents a major challenge for integration and innovation, largely due to slow and inconsistent adoption of industry standards like FHIR. While the industry is making progress, uptake remains sluggish, often hindered by major EHR vendors who make integration difficult for competitors. The lack of interoperability and standard adoption continues to represent a critical

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barrier to efficient data exchange and technological advancement. Addressing the issue requires not only better technical solutions and unified standards, but also greater collaboration and governance across organizations.

VB-12. What technology standardization would preserve program-specific flexibility while promoting innovation in APM technology implementation? **AND** ***VB-13. What improvements to existing criteria and standards would better support value-based care capabilities while reducing provider burden?***

Greater adoption of interoperability standards like FHIR would bring significant benefits to healthcare by enabling seamless, secure data exchange between disparate systems and organizations. With standardized data formats and protocols, healthcare providers could access complete and up-to-date patient information regardless of which EHR system is used, reducing errors and improving care coordination. Patients would benefit from a smoother experience, as their medical history could follow them effortlessly between doctors, specialists, and hospitals, empowering them to be more engaged in their own care. Additionally, standardized interoperability paves the way for innovative healthcare technologies, data analytics, and population health initiatives, ultimately leading to better patient outcomes, increased efficiency, reduced provider burden, and lower costs across the healthcare system.

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

A nationwide provider directory of FHIR endpoints would be very useful to accountable care entities. Accountable for Health members currently spend significant time and resources mapping providers and specialties to ensure that they are managing their patients' care throughout their care journey. A nationwide provider directory would allow access to the right data for the right entity, at the right time; reduce time to market; improve patient quality of care; and create an ecosystem for the next generation of health care technology.

This resource would enable faster and more accurate retrieval of patients' medical histories and insurance records, which is crucial for care coordination, transitions of care, and minimizing duplicate tests or procedures. Additionally, clarity about where claims data resides—and how to access it through FHIR APIs—would support more effective analytics, eligibility verification, and value-based care initiatives.

In building the directory, CMS should also take into consideration data broker models of the past. We do not wish to layer more technology on the healthcare ecosystem, and a trusted exchange should be considered in the form of an entity that hosted the availability of endpoints and may not be the holder of the endpoints. Trust can be established in many ways, and it will be important in taking advantage of a nationwide provider directory. We would support a library, but do not support the tax of a broker model.

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Conclusion

Accountable for Health appreciates the opportunity to provide comments on this RFI. If you have any questions about our comments or need more information, please do not hesitate to contact Mara McDermott, mmcdermott@accountableforhealth.org.

Sincerely,

Mara McDermott
CEO
Accountable for Health