



VIA ELECTRONIC SUBMISSION: regulations.gov  
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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-0042-NC, P.O. Box 8013  
Baltimore, MD 21244-8013

**RE: SCAN Group and myPlace Health Response to Request for Information: Health Technology Ecosystem (CMS-0042-NC)**

**About SCAN Group**

SCAN Group is a mission-driven not-for-profit organization dedicated to tackling some of the biggest issues in healthcare for older adults, including chronic illness, access to care, homelessness, inequities, and loneliness. SCAN Group's Medicare Advantage health plan, SCAN Health Plan, is one of the nation's foremost not-for-profit Medicare Advantage plans and serves over 300,000 members in California, Arizona, Nevada, Texas, and New Mexico. Independence at Home, a SCAN Health Plan community service, provides vitally needed services and support to seniors and their caregivers. Since 2020, SCAN has launched four mission-aligned medical groups, including Healthcare in Action, Welcome Health, Homebase Medical and myPlace Health, each of which focuses on meeting the needs of older adults. SCAN's care delivery affiliates collectively serve more than 30,000 members. To learn more, visit [www.thescangroup.org](http://www.thescangroup.org).

**About myPlace Health**

myPlace Health, a member of SCAN Group's family of companies, was established in 2021 as an integrated care delivery organization that specializes in serving vulnerable older adults who wish to live in their homes and communities as they age. myPlace Health delivers comprehensive health coverage, services, and support through the PACE (Program for All-Inclusive Care for the Elderly) model and operates as a value-based provider working in partnership with health plans and community partners. To learn more, visit [www.myplacehealth.com](http://www.myplacehealth.com).

## **Response Comments to CMS RFI CMS-0042-NC**

### **C. Providers**

#### **Provider Recommendation 1: Modernize and Standardize Provider Directories as Critical Infrastructure for Interoperable Care**

##### **Issue Overview**

Accurate and up-to-date provider directories are essential for care coordination, referrals, payer-provider interactions, and patient access. However, current provider directory systems are fragmented, error-prone, and often outdated. These shortcomings undermine interoperability efforts, delay care, and expose organizations to compliance and financial risks.

##### **Current Gaps**

- Inaccurate and outdated information about provider locations, specialties, network status, and availability
- Lack of a centralized source of truth across payers, providers, and third-party systems
- Inconsistent formats and taxonomies, making it difficult to integrate across platforms
- Manual update processes, often reliant on self-reporting or administrative follow-up
- Limited use of real-time or predictive data to flag changes or errors
- Poor visibility into team-based or facility-based provider affiliations

##### **Proposed CMS Actions**

###### **1. Establish a National Provider Directory Framework**

- Partner with ONC to define a centralized, standards-based provider directory model using FHIR APIs and validated source data.
- Leverage existing efforts like NDH (National Directory of Healthcare Providers and Services) to enable real-time data access across the ecosystem.
- A centralized directory of provider directory endpoints for all payers will need to be maintained by CMS.

###### **2. Mandate Provider Directory Integration in Certified EMRs and Payers**

- Require EMRs, payers, and care platforms to support:
  - Automated directory synchronization via FHIR endpoints
  - Role-based affiliation management for team-based care (e.g., specialists, care managers, therapists)
  - Standardized data elements (location, NPI, network status, languages spoken, virtual availability)

###### **3. Implement AI for Data Reconciliation and Quality Scoring**

- Require EMR and payer systems to use AI algorithms for entity resolution, deduplication, and anomaly detection across multiple sources (e.g., CAQH, NPPES, claims).
- Score provider entries by data freshness, completeness, and accuracy to drive improvement and transparency.

###### **4. Require Real-Time Update Capabilities and APIs**

- Mandate all provider systems to support real-time updates via secure, traceable interfaces.
  - Enable bi-directional data sharing between health systems, payers, and HIEs.
5. Tie Provider Directory Accuracy to Reimbursement and Compliance
- Enforce directory accuracy standards as part of network adequacy compliance for MA and Medicaid plans.
  - Link incentive payments to directory update frequency, accuracy rates, and digital discoverability.
6. Support Directory Management for Small Practices
- Offer technical assistance and subsidized tools for small or rural practices to manage directory updates and integrate with national systems.
  - Promote use of validated referral management tools that automatically sync provider profiles.
7. Make Directory Data Accessible to Patients and Partners
- Require digital accessibility of directory information through provider search portals, referral platforms, and patient apps.
  - Include filters for appointment availability, language preference, virtual care, and patient ratings.

### **Expected Impact**

- Improved accuracy of referrals and faster care navigation
- Reduced administrative burden and duplicated data entry
- Better network visibility for providers, plans, and patients
- Fewer claim denials and misdirected communications
- Enhanced interoperability and data trust across systems

## **Provider Recommendation 2: Standardize and Modernize Provider Credentialing to Reduce Delays and Enable Faster Access to Care**

### **Issue Overview**

Credentialing is a critical but highly fragmented process required to validate a provider's qualifications for network participation, hospital privileges, and payer enrollment. Today, the process is manual, repetitive, and time-consuming, often taking 60 to 180 days. These delays limit provider onboarding, delay care delivery, and create unnecessary administrative costs.

#### **Current Gaps:**

- Redundant credentialing efforts across payers, health systems, and states
- Manual data submission and inconsistent verification practices
- Lack of real-time credentialing status tracking or standard timelines
- Limited data sharing between credentialing bodies, licensing boards, and provider directories

- No national system to verify or reuse credentialing artifacts
- Delays impact staffing flexibility, patient access, and revenue cycle

## **Proposed CMS Actions**

1. Establish a National Digital Credentialing Exchange
  - Fund and oversee a centralized, national credentialing verification platform that allows:
    - Providers to upload and maintain verified credentials in one place
    - Health systems and payers to query and retrieve credentialing data in real time
  - Leverage existing standards from CAQH, NCQA, and State Licensing Boards
2. Mandate Use of Standardized Digital Credentialing Formats
  - Require all participating organizations (payers, hospitals, health centers) to use a standard digital format for credentialing artifacts, including licensure, malpractice history, certifications, and peer references
  - Utilize FHIR and blockchain-based verifiable credentials for data integrity and interoperability
3. Implement Real-Time Credentialing APIs
  - Require credentialing platforms and EMRs to support real-time status updates, credential pushes, and expiration tracking via secure APIs
  - Eliminate email/fax-based document exchanges
4. Create a National Credentialing Timeframe Policy
  - Establish clear SLAs (service-level agreements) for credentialing completion, e.g.:
    - 10 days for re-credentialing
    - 30 days for standard new enrollments
  - Tie adherence to these timelines to network participation requirements and performance-based reimbursement
5. Support Delegated and Provisional Credentialing
  - Encourage delegated credentialing models where provider organizations verify credentials once and extend them to multiple payers or facilities
  - Allow provisional credentialing with oversight during initial enrollment to reduce gaps in care
6. Incorporate Credentialing into Provider Directory and Enrollment Systems
  - Integrate credentialing data directly into CMS provider directory systems and PECOS, reducing redundant data entry and improving visibility
7. Fund AI Tools for Credential Review and Alerts
  - Support tools that use AI to:
    - Auto-validate credentialing documents
    - Detect gaps or inconsistencies in history
    - Send expiration alerts and renewal reminders

## **Expected Impact**

- Reduced provider onboarding time from months to weeks or days
- Improved network adequacy and faster access to care for patients
- Lower administrative burden on provider organizations and payers
- Increased data integrity and provider satisfaction
- Better support for rural, mobile, and urgent staffing needs

### **Provider Recommendation 3: Mandate Integration of Prior Authorization Workflows Within Certified EMRs to Streamline Care Delivery**

#### **Issue Overview**

Prior authorizations are a major source of care delays, provider frustration, and administrative burden. The process is often disconnected from clinical workflows, requiring providers to leave the EMR to submit information through payer portals, fax, or phone calls. This results in repeated documentation, lost time, and potential harm due to treatment delays.

Current Gaps:

- Manual and fragmented workflows that operate outside the EMR
- Lack of real-time feedback on authorization status or requirements
- Non-standardized forms and criteria across payers
- Little to no visibility for clinical and administrative staff on PA progress
- No use of patient context or AI to determine necessity or urgency
- Inefficiencies in attachments, documentation, and follow-up

#### **Proposed CMS Actions**

##### **1. Mandate EMR-Payer Integration for Electronic Prior Authorizations (ePA)**

- Require certified EMRs to support end-to-end electronic prior authorization workflows that:
  - Check in real-time if PA is required
  - Auto-fill prior auth forms using EHR data
  - Transmit documentation electronically
  - Display authorization status and decisions within the EMR interface

##### **2. Adopt and Enforce HL7 Da Vinci Prior Auth Standards**

- Use CMS authority to mandate adoption of HL7 Da Vinci Project's Prior Authorization Support (PAS) FHIR implementation guides.
- Require payers and EMRs to implement these standards for consistent exchange of data and decisions.

##### **3. Tie Prior Auth Integration to Promoting Interoperability and MIPS**

- Incorporate PA integration as a certification criterion for EMRs and as a performance measure in MIPS and Promoting Interoperability programs.

##### **4. Incentivize Real-Time Decisioning and Coverage Discovery**

- Encourage or require payers to implement real-time PA decisioning engines that provide instant responses for common services.
- Use FHIR-based coverage discovery APIs to identify plan-specific rules and documentation at the point of care.

#### 5. Embed Smart Clinical Decision Support

- Require EMRs to incorporate AI-driven decision support tools that:
  - Alert providers when PA is likely required
  - Recommend alternative covered treatments when PA is denied
  - Suggest clinical documentation that will increase approval likelihood

#### 6. Create a National PA Transparency Dashboard

- Build a CMS-managed dashboard that tracks payer-level performance on:
  - PA volume
  - Approval/denial rates
  - Average response times
  - Appeals and overruns
- Use this data to inform enforcement, plan ratings, and provider-payer collaboration

#### 7. Support Integration for Small Practices and Safety Net Providers

- Provide grants or technical assistance to enable small clinics and rural practices to implement EMR-integrated PA tools without added cost or complexity.

#### 8. Pricing Transparency

- Provide pricing transparency for cost of services to patients by providers and health plans at the time of prior Auth.

### **Expected Impact**

- Faster time to treatment with fewer authorization-related delays
- Reduced provider administrative burden and burnout
- Higher compliance with payer requirements through automation
- Improved patient experience and continuity of care
- Data-driven insights into prior auth patterns and inefficiencies

## **E. Technology Vendors, Data Providers, and Networks**

### **Vendor Recommendation 1: Mandate Seamless and Affordable Access to Health Data During Vendor Transitions**

#### **Issue Overview**

Healthcare organizations increasingly rely on electronic systems such as EMRs, billing platforms, and care coordination tools to support clinical and operational workflows. However, when transitioning away from a current vendor, many providers face major challenges in

accessing their own data. This lack of data portability undermines continuity of care, stalls innovation, and creates costly burdens—particularly for smaller providers. Despite progress in promoting interoperability through CMS and ONC initiatives, there is no standardized requirement ensuring that vendors deliver timely, complete, and usable data when a provider ends its contract.

- Exorbitant data extraction fees at contract termination
- Delayed or restricted access to full patient and operational records
- Non-standard, unstructured, or unusable export formats
- Limited visibility into historical clinical and billing data
- Absence of documentation to support data import into new systems
- No regulatory cap or enforcement mechanism to prevent vendor data blocking

### Proposed CMS Actions

#### 1. Mandate Exit Data Access as a Vendor Certification Requirement

- Require certified Health IT vendors to:
  - Provide full data exports within 30 days of contract termination
  - Include structured (e.g., clinical data, billing, scheduling) and unstructured data (e.g., clinical notes, messages)
  - Ensure no data silos are left behind during transition

#### 2. Enforce Standardized Export Formats for Data Portability

- Mandate use of HL7, FHIR, and other ONC-recognized standards for data extraction
- Standardize documentation including data dictionaries, field definitions, and mapping files
- Ensure data is delivered in formats that support immediate usability and import

#### 3. Regulate and Cap Data Extraction Fees

- Require vendors to:
  - Disclose all extraction-related fees in initial contracts
  - Adhere to CMS-defined fee caps based on organization size and data volume
- Any fees above the cap must be justified and pre-approved by CMS

#### 4. Tie Data Portability to CMS Participation and Value-Based Program Eligibility

- Make compliance with exit data access requirements a condition for:
  - ONC Health IT Certification
  - Participation in Medicare and Medicaid payment models, including ACOs and bundled payments
  - Eligibility for Promoting Interoperability and related incentive programs

#### 5. Establish Oversight, Audits, and Enforcement Mechanisms

- Launch a formal complaint and audit process for providers facing data access delays or denial
- Impose penalties, certification loss, or public reporting for non-compliant vendors
- Encourage transparency by publishing vendor compliance metrics

## 6. Support Small and Safety Net Providers During Transitions

- Provide grant funding or technical assistance to:
  - FQHCs, rural hospitals, and small practices
  - Offset the cost of data migration and vendor transitions

## 7. Promote National Alignment on Data Portability Protections

- Coordinate with ONC, state Medicaid agencies, and private payers to:
  - Align contractual language and enforcement across jurisdictions
  - Create a unified framework for provider rights during system transitions

### Expected Impact

- Reduced burden and cost of vendor transitions
- Increased competition and innovation across the health IT market
- Improved continuity of care and data integrity across systems
- Greater transparency and provider empowerment in tech contracting
- Stronger foundation for interoperability and digital transformation initiatives across CMS programs

## F. Value-Based Care Organizations

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

### **VB Recommendation 1: Advance EMR Standards to Support Value-Based Care Delivery**

#### **Issue Overview**

Current EMRs are largely optimized for Fee-for-Service (FFS) billing, focusing on encounter documentation and CPT coding. As the healthcare system transitions to Value-Based Care (VBC), these platforms fall short in enabling whole-person care, team-based workflows, and outcomes-focused documentation. The disconnect limits the ability of providers and care teams to succeed in alternative payment models.

#### **Key Gaps in Today's EMRs:**

- Designed around FFS encounters, not longitudinal, team-based care
- Lack of support for non-billable workflows, such as social work, transportation, and care coordination
- Poor integration of care planning, goal tracking, and risk stratification
- Limited tools for shared accountability and interdisciplinary collaboration

#### **Proposed CMS Actions**

##### 1. Create a "VBC-Ready EMR Certification" Framework

- Similar to Promoting Interoperability or ONC certification, develop a VBC-specific certification for EMRs.
- Define minimum capabilities such as team-based documentation, goal-oriented care plans, quality measure capture, and population health tools.

##### 2. Mandate Support for IDT Workflow Integration

- Require certified EMRs to accommodate documentation and workflow needs for all care team members, including those in non-billable roles (e.g., CHWs, care coordinators, social workers).
  - Enable role-based views, task assignments, and shared notes within a unified care record.
3. Embed Care Planning and Coordination as Core EMR Modules
    - Care plans should be interactive, longitudinal, and participant-centered, not static PDFs.
    - Systems must support real-time updates, risk-based alerts, and tracking of goals, interventions, and barriers across disciplines.
  4. Align EMRs with Quality Measurement and Risk Adjustment Needs
    - Integrate tools to track VBC quality metrics, manage care gaps, and document conditions relevant to HCC and other risk-adjusted models.
    - Automate suggestions for documentation improvement to ensure accurate coding and appropriate reimbursement.
  5. Support Longitudinal and Predictive Data Views
    - Encourage EMRs to offer timeline-based views of care, highlight trends, and surface predictive risk scores.
    - Include patient-reported outcomes and social determinants data as structured, actionable fields.
  6. Tie Certification and Adoption to VBC Model Participation
    - Require VBC EMR capabilities as a condition for participation in CMS ACOs, REACH, MSSP, and PACE programs.
    - Offer financial incentives for providers adopting VBC-certified systems.
  7. Have access to POLST, DNR, Advance Directives
    - CMS to mandate all Provider organizations to share POLST, DNR and Advance Directives to all providers through any Interoperable paradigm (FHIR or HL7)

### **Expected Impact**

- EMRs that reflect the real-world dynamics of value-based models
- Increased engagement and effectiveness of interdisciplinary care teams
- Better documentation of whole-person care, improving outcomes and reimbursement
- A stronger foundation for proactive, coordinated, and accountable care

## **VB Recommendation 2: Improve Interoperability and Technology Standards Across PACE Vendor and Source Systems**

### **Issue Overview**

PACE (Program for All-Inclusive Care for Elderly) Organizations (POs) across the country typically rely on a variety of vendor applications and services to coordinate and deliver participant care and fulfill their obligations as health plan. However, many of these vendors are siloed, poorly integrated, and lack modern interoperability standards. Since POs typically lack enough scale to hire the technology teams and support the infrastructure required to integrate this ecosystem of vendors, the fragmentation of vendors can lead to significant challenges to POs in their ability to lead effective care coordination and care management, and other inefficiencies and outdated processes. Some of the major challenges include:

- Lack of integration across the various EMRs, care coordination, billing, pharmacy, and transportation vendors that serve POs
- Limited access to real-time data and ADT (admit, discharge, transfer) feeds
- Heavy reliance on paper-based processes and spreadsheets
- Poor mobile access and support for field-based staff
- Brittle interfaces that are costly to build and maintain
- Reactive reporting, with limited predictive insights
- No uniform approach to creation and maintenance of care plans

## **Proposed CMS Actions**

### **1. Mandate PACE-Certified EMR Systems**

- Establish a national PACE EMR Certification Program, similar to ONC's certification for ambulatory and inpatient EHRs.
- Require certification for vendor participation in CMS-funded PACE programs to ensure a common baseline of functionality and interoperability.
- Require EMRs to natively support interdisciplinary team workflows, with tools for collaborative care planning, role-based task assignment, and automated documentation tracking.
- Mandate all Provider organizations to share POLST, DNR and Advance Directives to all providers through any Interoperable paradigm (FHIR or HL7)
- Require PACE-certified EMR and other vendor tools e.g. Transportation, Care Coordination, Home Health tools to offer mobile-responsive platforms or apps for field clinicians and IDT members, including offline capabilities where needed.
- Ensure PACE EMRs include or integrate with scheduling and dispatching tools for transportation, reducing manual work and improving participant access to care.
- Require PACE EMRs to provide built-in dashboards that deliver real-time reporting, quality reporting, population health analytics, and other early warning indicators for care deterioration.
- Enable risk-based care plan updates using AI models trained on clinical and utilization data.

### **2. Require Modern Data Exchange Standards for PACE Vendors**

- Mandate EMR support for FHIR APIs, HL7, and secure web-based APIs for core modules: care plans, encounter data, referrals, and ADT events.
- Ensure compatibility with national networks such as TEFCA and local HIEs to support participant-level data exchange.

### **3. Ensure Access to ADT and HIE Feeds**

- Incentivize or require connection to regional HIEs and ADT alert systems for all PACE participants.

- Ensure timely visibility into acute events (hospitalizations, ER visits) to drive proactive care adjustments. This is required to meet the regulatory requirements of PACE to be able to respond to an acute care episode with care plan updates within 48 hours.

#### 4. Integrate AI and Scribing Tools

- Encourage or require EMRs to integrate with AI-powered scribing and documentation assistants to reduce clinician burden and increase accuracy of records.

### Expected Impact

- Stronger interdisciplinary collaboration and care coordination
- Reduced administrative burden and manual workarounds
- Faster, data-driven interventions through real-time alerts and insights
- Better participant outcomes through predictive care planning
- Lower system maintenance costs and improved vendor accountability
- Help guide choices for EMTs, doctors and caregivers in end-of-life situations and honor patients' treatment preferences

## **VB Recommendation 3: Mandate Polypharmacy and Drug Interaction Management as a Standard Use Case in Certified EMRs**

### Issue Overview

Polypharmacy, particularly among older adults and complex patients, increases the risk of adverse drug events (ADEs), hospitalizations, and poor clinical outcomes. Despite this, many EMRs lack robust, embedded tools to manage drug interactions, medication overload, and therapeutic duplications in real time. Without integrated polypharmacy management, care teams face blind spots in medication safety and reconciliation.

#### Current Gaps:

- EMRs often lack comprehensive drug-drug, drug-condition, and drug-lab interaction checking
- Limited support for medication review workflows across IDT (e.g., pharmacists, nurses, PCPs)
- No visibility into non-prescribed or over-the-counter medications
- Drug alerts are often poorly prioritized, leading to alert fatigue and overrides
- Inadequate support for deprescribing protocols or step-down therapy plans
- No risk scoring or predictive analytics for cumulative medication burden

### Proposed CMS Actions

#### 1. Mandate Polypharmacy Management as a Required EMR Capability

- Include a formal polypharmacy use case in ONC's Health IT Certification Criteria.
- Require all certified EMRs to include built-in tools for:
  - Drug interaction checks
  - Duplicate therapy detection

- Renal/hepatic dose adjustment suggestions
  - Medication time-in-therapy tracking
  - Alert prioritization based on clinical relevance
2. Embed Pharmacist and IDT Collaboration Tools
    - Ensure EMRs enable shared medication review workflows for clinical pharmacists, primary care, nursing, and social work.
    - Support annotations, recommendations, and medication action plans within the shared record.
  3. Integrate Predictive Risk Models for Medication Burden
    - Require EMRs to include or integrate with AI-driven tools that:
      - Identify patients at risk of ADEs based on polypharmacy thresholds
      - Flag high-risk regimens for elderly or frail populations
      - Recommend deprescribing pathways or alternative therapies
  4. Link to National Drug Databases and Claims History
    - Mandate connection to state PDMPs (Prescription Drug Monitoring Programs) and integration with payer pharmacy claims for complete medication history.
    - Use FHIR and NCPDP standards to automate real-time medication reconciliation.
  5. Support Mobile and Patient-Facing Medication Management Tools
    - Require EMRs to allow participants or caregivers to confirm medication use, track adherence, and report side effects using integrated mobile apps or portals.
  6. Tie Medication Safety Capabilities to Participation in VBC and Chronic Care Models
    - Make polypharmacy risk management tools a condition for EMR use in PACE, ACOs, REACH, and chronic care models.
    - Offer implementation subsidies for safety-net and aging-focused programs.

### **Expected Impact**

- Fewer adverse drug events and hospitalizations due to high-risk medication interactions
- Safer and more personalized medication management for vulnerable populations
- Better collaboration among clinical pharmacists and care teams
- Improved quality scores tied to medication adherence and chronic disease control
- Higher patient and caregiver confidence in their care regimen

## **VB Recommendation 4: Modernize and Standardize Medical Records Request Processes**

### **Issue Overview**

The current process for requesting and transferring medical records is outdated, fragmented, and often burdensome for both providers and patients. It creates barriers to timely care, contributes to compliance risk, and erodes patient trust. Key gaps include:

- Manual and paper-heavy processes with fax or mail as common methods
- Long turnaround times, often exceeding regulatory windows

- Lack of standardization across request formats, fulfillment workflows, and delivery channels
- High compliance risk, especially regarding HIPAA and right of access regulations
- Poor patient experience, with limited visibility, control, or ease of use

### **Proposed CMS Actions**

#### **1. Enable AI-Powered Record Retrieval and Summarization**

- Promote the adoption of tools that use Natural Language Processing (NLP) and AI-driven summarization to fulfill record requests based on context, such as diagnosis or clinical episode (e.g., “cardiac event”).
- Incorporate these capabilities into certified EHR and HIE platforms under ONC and CMS requirements.

#### **2. Automate Request Triage and Classification**

- Require digital intake portals that can triage record requests by type (clinical, legal, insurance) and urgency.
- Establish turnaround time tiers based on classification to streamline high-priority requests.

#### **3. Mandate Smart Redaction and Privacy Checks**

- Standardize and certify tools that can automatically redact sensitive data based on the request type and legal authorization.
- Use AI-based compliance checks to ensure only appropriate information is shared per HIPAA, 42 CFR Part 2, and state-specific laws.

#### **4. Support Predictive Workflow Management**

- Encourage the use of predictive analytics to forecast request volume trends, estimated fulfillment times, and staffing needs.
- Integrate predictive dashboards within EHRs and HIEs to guide medical records teams in prioritizing workloads.

#### **5. Facilitate Access Through Consumer Health Tech Integration**

- Require EMRs to integrate with personal health apps like Apple Health, enabling patients to access and share records directly.
- Use FHIR-based APIs to empower patient-mediated data sharing while maintaining audit trails.

### **Expected Impact**

- Significant reduction in time and labor for record fulfillment
- Improved compliance with Right of Access and HIPAA regulations
- Enhanced experience and empowerment for patients
- Reduction in repeat testing and care delays
- Scalable, intelligent workflows adaptable to varying record volumes and use cases

## **VB Recommendation 5: Eliminate the Use of Paper Fax in Healthcare Communication**

### **Issue Overview:**

Despite widespread digitization in other sectors, fax machines remain heavily used in healthcare, creating inefficiencies, delays, and risks to data privacy. Fax is predominantly used for:

- Referrals between providers
- Medical records requests for continuity of care
- Authorization and claims submissions to payers
- Pharmacy communications and prescription clarifications
- Coordination with home health and post-acute care providers
- Communication with small clinics (especially those with fewer than 25 providers)

### **Proposed CMS Actions:**

1. Promote and Incentivize Direct Messaging Adoption
  - Expand requirements under CMS interoperability programs to include certified messaging systems for all provider-to-provider communication.
  - Tie adoption to Promoting Interoperability Program incentives for eligible providers and hospitals.
2. Accelerate FHIR-Based Interoperability
  - Mandate FHIR APIs for referrals, prior authorizations, and records exchange.
  - Encourage payer-provider real-time data exchange using Da Vinci Project use cases (e.g., prior auth support, documentation templates).
3. Centralize Provider Networks and Referral Management
  - Fund the development or integration of national and statewide referral management platforms that streamline provider lookup, appointment booking, and record transfer.
  - Require Medicaid and Medicare Advantage plans to participate in these platforms.
4. Digitize and Standardize Commonly Faxed Forms
  - Create a national digital library of standardized, machine-readable forms (e.g., for prior authorization, consult referrals, DME orders).
  - Mandate vendor and provider use as part of CMS certified workflows.
5. Support Small Practices with Subsidies
  - Offer free or subsidized EHR adoption and digital fax alternatives for small clinics and solo providers.
  - Include funding through CMMI pilots or HITECH-style grants.
6. Use Reimbursement Leverage to Enforce Change
  - Require digital submission of claims, authorizations, and medical records for reimbursement eligibility.
  - Offer higher reimbursement rates or expedited processing for providers using digital channels.
7. Launch Training and Education Initiatives

- Fund provider and staff training on secure digital communication, Direct messaging, and referral platforms.
- Provide toolkits for low-resource providers transitioning away from fax.

#### **Expected Impact:**

- Improved care coordination and timeliness of services
- Reduction in administrative burden and fax-related errors
- Enhanced data security and HIPAA compliance
- Stronger participation in national interoperability efforts

### **VB Recommendation 6: Mandate Seamless Integration Between EMRs and Immunization Registries to Strengthen Public Health Surveillance**

#### **Issue Overview**

Immunization data plays a vital role in public health, preventive care, and outbreak response. Yet, many providers still struggle with inconsistent, delayed, or incomplete reporting to state and regional Immunization Information Systems (IIS). The lack of streamlined integration between EMRs and registries hampers population health tracking, vaccination compliance, and readiness for future public health emergencies.

#### **Current Gaps:**

- Manual or batch-based submission of immunization data
- Lack of real-time bi-directional exchange between EMRs and IIS
- Variable reporting standards and formats across states
- Limited visibility into historical vaccination data for clinicians
- Disparate systems for adult and pediatric immunization tracking
- No unified national immunization data pipeline

#### **Proposed CMS Actions**

1. Mandate Bi-Directional IIS Integration for All Certified EMRs
  - Require EMRs to:
    - Automatically submit immunization records in real time
    - Retrieve a patient's full immunization history from state IIS
    - Reconcile discrepancies and flag missed vaccines during encounters
2. Adopt and Enforce HL7 and FHIR Standards for Immunization Exchange
  - CMS should mandate the use of HL7 v2.5.1 and FHIR Immunization Implementation Guides for interoperability between EMRs and immunization registries.
  - Standardize fields for vaccine type, lot number, manufacturer, site, and encounter type.
3. Tie Registry Integration to Quality Programs and Incentives
  - Include IIS reporting capability as a core measure in Promoting Interoperability, MIPS, and Medicaid EHR Incentive Programs.

- Offer bonus payments for providers who meet real-time, complete, and bi-directional data exchange benchmarks.
4. Support National Alignment Across State IIS Systems
    - Coordinate with the CDC and state agencies to develop a federated national immunization registry framework, enabling cross-state access and consistent reporting protocols.
    - Eliminate gaps in tracking when patients receive vaccines across different states or provider systems.
  5. Leverage AI to Improve Immunization Intelligence
    - Promote tools that use AI and machine learning to:
      - Identify patients overdue for vaccines based on guidelines
      - Predict uptake trends during seasonal campaigns
      - Detect reporting gaps and recommend workflow improvements
  6. Provide Technical and Financial Support to Safety Net Providers
    - Offer grants, subsidies, or shared services to help small clinics, rural health centers, and FQHCs integrate with their state's IIS without high implementation costs.
  7. Public Health Reporting Dashboard and Transparency
    - Require EMRs to generate automated audit reports of immunization submissions and rejections.
    - CMS and CDC can create regional dashboards to track immunization reporting performance and population-level vaccine coverage.

### **Expected Impact**

- Improved completeness and timeliness of vaccine data
- Better coordination during outbreaks, pandemics, and public health initiatives
- Increased vaccination rates through proactive tracking and alerts
- Reduced duplicate vaccinations and improved clinical efficiency
- Stronger national immunization infrastructure for future crises

Thank you for the opportunity to provide input in response to the CMS Request for Information. We appreciate your continued efforts to advance innovation, interoperability, and equity across the healthcare system, and we welcome the chance to support these important initiatives.

For clarifications or further details on any of the above recommendations, please contact –

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