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June 16, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

RE: Request for Information; Health Technology Ecosystem

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the "Request for Information: Health Technology Ecosystem", issued in the Federal Register on May 16, 2025 (90 FR 21034). We also appreciate and applaud your leadership to turn ideas into action so we can drive meaningful change in health care.

BCBSA is a national federation of 33 independent, community-based and locally operated BCBS companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. Our Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer, or purchase coverage on their own.

BCBSA shares the Centers for Medicare & Medicaid Services' (CMS) strong commitment to drive solutions that improve outcomes and reduce costs for patients. We strongly support CMS' framing of consumer choice as an important pillar of the recent innovation strategy for the Center for Medicare and Medicaid Innovation (CMMI). When patients have access to meaningful options, they are better positioned to engage in their health, choose quality providers, and choose forms of care that align with their personal preferences, needs and circumstances. Empowering individuals to make informed decisions about their care is foundational to improving outcomes and addressing health care costs. Patient empowerment is also essential to advance value-based care (VBC) – a top priority BCBSA shares with CMS.

As health care costs rise, BCBS companies are relentlessly pursuing affordability, and VBC models are a key solution to lower costs. Data from Blue Cross Blue Shield VBC programs empower providers to deliver the best care, and the results are clear: Patients who are treated

by BCBS-contracted VBC providers have 9.4% fewer ER visits and 13% lower utilization of ER visits for non-emergent care.

Better health equals lower costs. That is why we are committed to value-based models, because they prioritize both prevention and patient health, rather than the volume of services for episodic or emergent care. VBC promotes healthier lives by ensuring appropriate care and better chronic care management all while achieving $6 – 8 savings per attributed member per month. Payers and policymakers alike must continue to work towards shifting payments from a volume-based system to one that reimburses health care providers for high-quality, cost-effective care. It is a demonstrated fact that this approach improves patient outcomes and more efficiently utilizes health care resources. While progress has been made, advancing VBC in a system that is built on fee-for service (FFS) will ultimately fail to deliver the full potential of VBC in Medicare.

BCBSA supports CMS' objective of disrupting the status quo with meaningful improvements, so providers are encouraged and, in some circumstances, required to adopt meaningful VBC arrangements. BCBSA supports strong actions to shift providers to two-sided risk arrangements, including as a condition of participation in Medicare. When providers assume downside risk, they are financially responsible not only for potential savings but for any cost overages for poor outcomes. A recent study by BCBSA found that incentivizing or mandating provider participation in Medicare two-sided VBC would save taxpayers $54 billion.[1]

Across BCBS Plans, we have found that when providers face measurable downside risk in VBC models, their behavior changes significantly, leading to better engagement, better outcomes, and lower costs. CMS should look to Medicare Advantage (MA) to expand VBC. More than half of all Medicare beneficiaries choose MA for their coverage, given its strong foundation of coordinated care and focus on total health. At-risk MA patients experience higher quality care and lower utilization relative to fee-for-service (FFS), according to a recent study measuring 24 key outcomes—20 of which showed statistically significant improvements, with the remaining four showing no statistically significant difference. For example, the marginal risk for admissions was significantly lower in at-risk MA arrangements compared to FFS: 43.0% lower for COPD/asthma, 32.0% lower for heart failure, and 34.0% lower for bacterial pneumonia. These outcomes demonstrate the effectiveness of MA's value-based infrastructure in managing complex care needs. MA plans are ready-made partners to drive this transformation.

This fundamental change is predicated on the seamless and secure sharing of information across providers, health plans and CMS. Unfortunately, VBC is hindered today by fragmented data systems, limitations to interoperability, and access to timely, actionable information. Providers often lack timely access to key data, such as discharge summaries, referrals, or lab results, leading to gaps in care coordination and missed opportunities for interventions. Health plans may receive hospitalization data weeks after treatment, making it hard to support timely follow-up or manage high-risk patients. The inconsistent implementation of Application Programming Interfaces (APIs) limits effective data sharing across EHR systems. In addition, providers need better clarity on what health data can be appropriately shared to prevent the

[1]https://www.bcbs.com/media/pdf/BCBSA_affordability_solutions_for_the_health_of_america_2025_update

misinterpretation or overuse of HIPAA's "minimum necessary" standard which is a barrier to greater data exchange.

BCBS Plans have a long-standing commitment to improving the interoperability and transparency of health care information and believe that the secure and seamless flow of health data among patients, doctors, hospitals and insurance companies is essential to reducing costs and driving positive health outcomes. BCBSA and Blue Plans have been leaders on these issues, engaging in numerous initiatives to advance the access, exchange and use of health data. Blue Plans have invested in the digital and data infrastructure necessary to support VBC, including interoperable platforms, real-time analytics, remote patient monitoring, and artificial intelligence (AI)-powered tools for risk stratification and care coordination.

Driven by the expanded use of virtual care, AI, remote monitoring, and real-time health data exchange, our healthcare system is now undergoing digital transformation – something that is long overdue. This transformation is reshaping how healthcare is delivered, coordinated, and experienced across settings. The "Health Technology Ecosystem" Request for Information (RFI) represents an important – and urgent – opportunity to align federal policy and technology priorities with the actions needed to drive VBC adoption.

As providers, patients, and payers continue to adopt digital tools to support engagement, data sharing, care coordination and virtual care, federal policy must evolve to address new challenges and opportunities. Policy solutions will need to address the fragmented healthcare digital infrastructure, existing regulatory policies that hinder clinical data exchange, and ensure that digital tools enhance the patient experience. BCBSA supports solutions that drive large-scale, responsible adoption of health technology applications, reduce barriers to health data access and exchange, and leverage technology and innovation to advance value-based care.

We recommend that CMS and Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) prioritize the following goals as they develop their strategic goals regarding health technology and VBC and in the subsequent sections we provide specific actions aligned to each goal:

- Drive adoption of digital health tools in VBC programs to reduce administrative burden, drive coordination, and expand participation.
- Improve data sharing across plans, patients, and providers by reducing barriers to promote transparency, improved decision-making and stronger care management.
- Promote improved interoperability and essential health IT to support the scaling of VBC across the healthcare ecosystem.
- Encourage the responsible adoption of AI and other technologies to enhance approaches to patient engagement and promote efficiencies.
- Advance care access via digital health tools, particularly for rural communities with physical access barriers.

Our RFI response and recommendations below highlight areas where BCBS Plans are already leading, innovating, and collaborating with providers, and where targeted federal action in the health technology space can accelerate broader transformation and achieve the strategic goals

of CMS and ASTP/ONC. In addition, we provide responses to several of the targeted questions from the RFI.

We appreciate your consideration of our comments and look forward to continuing to work with CMS and ASTP/ONC to find ways to leverage digital health technologies, improve the interoperability of health data, cut administrative burden, and deliver quality care to patients. If you have any questions, please contact me or my colleague, Jennifer Jones, at 202.942.1269 or Jennifer.Jones@bcbsa.com.

Sincerely,

Anshu Choudhri
Vice President, Policy Development & Strategy

Specific Actions to Support Recommended Strategic Goals

1. **Drive adoption of digital health tools in VBC programs to reduce administrative burden, efficient coordination and expand participation**

The widespread adoption of digital health tools plays a pivotal role in scaling VBC. It equips healthcare systems with the capabilities needed to deliver more efficient, coordinated, and patient-centered care at scale. VBC depends on proactive management of patient health, prevention of avoidable complications, and continuous performance management, all of which require timely, accurate and actionable data. These technologies also have the potential to streamline quality reporting and reduce administrative burden through automation, making participation in value-based models more feasible for providers, especially those in small practices. Digital tools like electronic quality measurement (eCQMs), digital quality measures (dQMs), and care coordination platforms streamline reporting and performance tracking making it easier for providers to meet VBC requirements and expanding participation. Additionally, digital solutions help standardize documentation and workflows across payers, reducing complexity and duplication. To accelerate the adoption of digital health tools, CMS and ASTP/ONC should:

- **Align and simplify digital quality reporting across Medicare and commercial payers by standardizing eCQMs, dQMs, and digital submission processes** when similar measures are present across entities. Alignment reduces administrative burden on providers and payers, enabling more efficient data sharing and freeing up resources to focus on patient care.
- **Modify prospective payment systems across Medicare and Medicaid to include separate, nominal payments for digital infrastructure investments** that support value-based delivery such as platforms for telehealth, digital engagement tools, and care coordination technologies. For example, leveraging the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model primary care investment payment (the Enhanced Primary Care Payment) to include a separate nominal payment for the use of infrastructure investment in digital health technology, tied to access improvements. Creating financial incentives would encourage providers to invest in essential digital tools that improve care coordination and patient engagement, which are critical for successful VBC participation.

Plans are working to integrate digital tools into provider workflows and clinical quality programs. CMS can accelerate the transformation by modernizing payment structures and incentivizing technology adoption in ways that directly improve care quality and reduce administrative burden.

2. **Improve data sharing across plans, patients and providers by reducing barriers to promote transparency, improved decision-making and stronger care management**

Blue Plans identify data exchange and interoperability as critical to enabling value-based care strategies. Advancing interoperability enables seamless, secure exchange of health information across systems, settings, and stakeholders. Improved interoperability allows for the integration

of real-time clinical and claims data, helping identify care gaps, measure performance, and manage populations risk more effectively, while also offering a holistic view of a patient's medical history and treatment plans at the point of care. This is all crucial for making informed decisions in value-based care. With improved interoperability, patients can have greater access and ability to share their own health information which would improve engagement and care coordination. To allow for greater data access for plans, patients and providers we recommend that CMS:

- **Establish clinical data exchange requirements between providers and payers as a condition of participation in Medicare** to support shared decision-making and coordinated care. Timely data exchange is vital for effective care coordination and empowering patients to engage actively in their health management.
- **Incentivize the adoption of FHIR-based digital tools and ensure that payer-to-payer and provider data exchange is seamless under the Interoperability and Patient Access Rule.** Incentivizing the adoption of FHIR-based standards will facilitate interoperability by enabling secure, standardized data sharing, which improves clinical decision-making and operational efficiency.
- **Ensure that plans have appropriate, secure access to longitudinal patient data from providers** to support care coordination, identify gaps in care, and manage population health. Longitudinal claim and clinical data help plans identify health risks early and tailor interventions, which would drive better outcomes and lower costs in VBC.
- **Incorporate appropriate clinical data exchange requirements into shared savings programs as an alternative to a condition of participation in Medicare.** Tying data exchange to financial incentives promotes a continuous commitment to interoperability, which is necessary for achieving VBC goals for example, utilizing a performance measure indicating data exchange with payers through the CMS Promoting Interoperability Program

These actions will empower VBC participants with the data and insights needed to close equity gaps, reduce duplication and support outcomes-based care delivery. Most Blue Plans use comprehensive analytics and data sharing to support VBC integration and report resource constraints as the greatest challenge to progress in enhanced data exchange. Blue Plans are also investing in data-driven referral tools and navigation systems to guide members to higher performing providers including specialists.

3. **Promote improved interoperability and essential health IT to support the scaling of VBC across the healthcare system**

Robust, interoperable health IT is the foundation of effective APMs and the broader move to VBC. Promoting interoperability and ensuring essential health IT capabilities is critical for enabling all types of providers to fully participate in VBC models. Interoperable Health IT is necessary for the reporting of costs, quality, and other metrics, which reinforce performance-based payment in APMs. To promote interoperability and essential health IT, CMS should:

- **Promote the use of digital tools** such as care coordination platforms, risk stratification, engines, and population health analytics by incorporating these capabilities into APM design requirements, including expectations for real-time data exchange and patient segmentation for targeted interventions. These essential tools and capabilities enable providers to manage complex patient populations effectively, improving outcomes and aligning with value-based payment models.
- **Align ONC Health IT Certification criteria with the functional needs of VBC participants**, ensuring tools support VBC workflows and are usable across large health systems, small practices, and rural providers. Certification requirements that support real-world provider needs would encourage the adoption of health IT solutions that genuinely facilitate value-based care.
- **Expand support for under-resourced providers to adopt essential technologies through grants, technical assistance, and shared services**. Targeted support would help close the technology gap for smaller or rural providers, promoting equity and broader participation in VBC programs.

Some Blue Plans are currently partnering with aggregators through interoperability to further enable provider participation and success in value-based models. By promoting interoperability and foundational health IT, CMS will empower providers and enable inclusive, scalable, and effective VBC.

4. **Encourage the responsible adoption of AI and other technologies to enhance approaches to patient engagement and promote efficiencies across the ecosystem**

Advanced digital health tools and AI can accelerate value transformation by identifying risk, optimizing care coordination, and engaging patients earlier in their care journey. These technologies help enable earlier interventions, more efficient care coordination, and personalized support across the care continuum. When integrated responsibility, digital tools like AI can help anticipate the needs of patients, reduce administrative burden, and close care gaps. To realize these benefits and scale AI and digital tools CMS should:

- **By preventing overburdensome standards and promoting best practices, incentivize AI-powered care management and early risk detection** tools that enhance patient engagement, reduce avoidable utilization, and promote preventive services. AI tools can identify high-risk patients earlier and support personalized care plans and help reduce hospitalizations and improve preventive care.
- **Promote the use of natural language processing (NLP) and machine learning (ML) to reduce documentation burden and automate chart review and improve data extraction for quality reporting** by issuing guidance on how NPL and ML tools can be leveraged to meet reporting requirements. These technologies streamline provider workflows, allowing clinicians to spend more time on patient care rather than administrative tasks.

- **Establish clear guidelines for bias mitigation, clinical oversight, and transparency in AI applications,** including through adoption of revised OMB SPD 15 standards for race and ethnicity data. This standard expands granular data collection, and when paired with appropriate AI systems development and governance processes, could enhance fair algorithm performance and fosters trust in digital tools. Blue Plans have identified and implemented AI tools to support a number of use cases, in accordance with all existing laws and consumer protections, including, increasing care coordination to identify hard-to-reach and at-risk population, fraud detection and prevention and enhancing the member experience by deploying AI in customer service centers.

5. **Advance care access via digital health tools, particularly for rural communities with physical access barriers**

To support the success of VBC across all populations and geographies, CMS and ASTP/ONC should invest in foundational digital infrastructure that enables care delivery beyond traditional settings. Value-based care depends on continuous, coordinated and patient-centered care, not just periodic in-person visits. Robust digital infrastructure enables providers to deliver care beyond traditional brick-and-mortar settings, for example, telehealth or home-based services. Providers in rural and underserved areas often lack the financial and technical resources to build and maintain this infrastructure. This limits their ability to proactively manage chronic conditions, engage patients between visits, and track quality outcomes, all of which are essential for successful VBC. CMS and ASTP can support this by:

- **Focusing requirements for providers within existing and future VBC models that promote the integration of digital health services into care delivery**, including remote monitoring, asynchronous telehealth and in-home diagnostics, with a particular emphasis on improving access and outcomes for rural populations through home-based and virtual care models. This would help to ensure patients in rural and underserved areas receive continuous, accessible care outside traditional settings, which is essential for managing chronic conditions and improving health outcomes in VBC models.
- **Establishing regional technical assistance hubs to support digital adoption among community-based and rural providers.** Many providers in these areas lack resources or expertise to implement digital tools effectively, so regional support hubs can accelerate adoption and improve care delivery capabilities. Operating under public-private partnerships, these hubs would provide tailored, hand-on support on cybersecurity, implementation, data analytics etc. to providers that often lack the resources, workforce, and infrastructure to effectively implement and use health IT systems. Establishing these hubs would help bridge the digital gap, promote systemwide interoperability, and support VBC.
- **Aligning with cross-agency broadband infrastructure initiatives to ensure connectivity for patients and providers in underserved areas**. Reliable broadband is fundamental to digital health and without it, patients and providers cannot fully participate in telehealth or remote care therefore, continuing disparities in rural health access. While agencies like the National Telecommunications and Information

Administration (NTIA), Federal Communications Commission (FCC), and U.S. Department of Agriculture (USDA) lead broadband development efforts, CMS and ASTP/ONC has not always been fully integrated into these initiatives. Health-centric use cases are not always prioritized in broadband infrastructure initiatives and CMS should be instrumental in making sure digital health use cases are considered.

These investments will allow more providers and patients in rural and high-need communities to engage in value-based models by enabling continuous coordinated care that meets patients where they are.

BCBSA Response to Select RFI Questions

1. **Payers**

PA-1. ***What policy or technical limitations do you see in TEFCA? What changes would you suggest to address those limitations? To what degree do you expect these limitations to hinder participation in TEFCA?***

TEFCA implementation currently poses several challenges which limit broad payer participation. A key concern is the uneven expectations on participants, specifically as health plans are expected to respond to health information requests while providers may decline to do so under the "minimum necessary" standard. Clarifying that there are reciprocal data sharing requirements and revising the "minimum necessary" definition would support more equitable exchange. Additionally, inconsistencies with privacy and consent management across federal, state, and contractual frameworks persist, complicate compliance and undermine trust for participants.

Another concern with TEFCA is the potential for data misuse, such as unregulated querying across the network or insufficient safeguards against bad actors. This risk raises significant security concerns, especially with open access among all participants, which may include non-HIPAA regulated entities.

Furthermore, the inability for payers to connect to multiple QHINs and the fees imposed by providers or other payers impose additional barriers to entry. Real interoperability also requires a harmonized privacy framework and consistent enforcement mechanisms. These barriers undermine the core goal of interoperability, which is to enable seamless and secure exchange of health data across the ecosystem. Where payers cannot connect to multiple QHINs or face variable fees, it fragments access and increases costs, especially for smaller or regional plans. Similarly, without a harmonized privacy framework and consistent enforcement stakeholders face uncertainty around data sharing obligations. Payers may remain hesitant to participate due to cost, compliance, and data protection concerns without these changes, particularly as the benefits are not yet fully realized.

Lastly, there is a lack of payer specific use cases in TEFCA across QHINs. Current use cases are primarily provider oriented. ASTP should prioritize the development of use cases to support Payment and Healthcare Operations Exchange Purposes. Enhanced payer use cases would be of interest to payers and would therefore be more likely participate in TEFCA.

PA-2. ***How can CMS encourage payers to accelerate the implementation and utilization of APIs for patients, providers, and other payers, similar to the Blue Button 2.0 and Data at the Point of Care APIs released by CMS?***

BCBS Plans have continued to demonstrate a commitment to move to FHIR-based APIs and are investing significant resources to implement the APIs outlined by the CMS Interoperability and Prior Authorization Final Rule. While Plans have done outreach to inform patients and providers of the value of these tools, we anticipate substantial variability in adoption, most notably among providers who should have more capacity to implement and utilize the tools. A key concern for health plans is that the APIs, particularly the prior authorization API, will be underutilized and the opportunity will not be realized for the APIs to streamline processes, reduce burden and optimize patients' access to care when and where they need it.

CMS can play a critical role in driving adoption among providers and patients. For patients, the limited uptake of the Patient Access API likely stems from a lack of perceived value, limited awareness among patients, and insufficient integration into existing workflows. Additionally, patients may prefer to access their health information through existing provider portals. CMS should recognize these preferences and support complementary access models that allow provider-mediated or hybrid solutions, while ensuring adherence to interoperability standards. CMS can also help support Patient Access API by demonstrating the benefits through concrete use cases and improving public education similar to CMS's Blue Button 2.0 initiative. The public education effort was aimed at raising awareness among Medicare beneficiaries about accessing personal health data through APIs.

For providers, CMS should explore ways to expand provider access to data sources like the National Plan and Provider Enumeration System (NPPES) and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) making provider directories easier to update. Expanding provider access would help with the adoption of APIs by improving the accuracy, consistency, and reliability of foundational data that APIs rely on. The foundational improvement would enhance the utility and reliability of the APIs for provider use cases like patient record location and care coordination, therefore making APIs more functional and easier to implement in practice. CMS and ASTP/ONC should work to identify opportunities to require EHRs to meet updated CEHRT criteria that support payer-facing API interactions and require provider use. This would enhance the accuracy of provider attribution and support easier data exchange.

CMS should also consider requiring alignment across Medicaid agencies and integrating prior authorization functionality into APIs but do so in stages to allow for testing and feedback from stakeholders. Providers currently face a variety of state-specific Medicaid processes and payer-specific prior authorization systems, which lead to inconsistent data formats, duplicative documentation, and manual work that takes more time. Aligning Medicaid agencies on a common API approach would reduce this variability, allowing providers to adopt a single set of standards that work across multiple payers and programs. This standardization simplifies integration into HER workflows and makes API-enabled tools more practical and valuable at the point of care.

PA-3. *How can CMS encourage payers to accept digital identity credentials (for example, CLEAR, ID.me, Login.gov) from patients and their partners instead of proprietary logins?*

CMS should first support education and engagement efforts for both providers and members. Increased uptake by providers and members will drive demand for digital access, making it more likely that payers will adopt and support the use of digital identity credentials. CMS can encourage payers to accept digital identity credentials by requiring the adoption of recognized standards for secure authentication. Current technologies like SMART on FHIR and OAuth 2.0 support app-to-app communication using asymmetrical keys, enabling secure and interoperable access; however, human digital identity verification still depends heavily on individual company policies. Aligning payer requirements with NIST digital identity guidelines and incorporating these standards into HIPAA Security Rule or CAQH certification processes can further promote adoption. We however have concerns regarding the implementation costs and the collection of extensive personal information which may be perceived as intrusive and consequently slow uptake. CMS should provide clear guidance and incentives to address these barriers.

PA-4. *What would be the value to payers of a nationwide provider directory that included FHIR endpoints and used digital identity credentials? Who should publish such a directory, and should users bear a cost?*

A nationwide provider directory that integrates FHIR endpoints and digital identity credentials would significantly improve the accuracy and efficiency of managing provider data for payers, providers, and patients. It will alleviate the burden on providers and payers of updating numerous directories and verifying information in multiple locations frequently. It will mitigate the negative impact on care quality caused by inaccurate or incomplete directory information, such as delays in care when a Prior Authorization cannot be efficiently submitted. It will also enable payers and providers to effectively and securely exchange standards-based electronic healthcare information across the care continuum, overcoming previous limitations due to known digital endpoints.

To facilitate data exchange between payers and providers, as well as between different payers, it is essential to primarily focus on providers, payers, and their organizational affiliations. Typically, individual providers do not possess an endpoint; instead, the endpoint will be associated with an organization. Therefore, understanding provider affiliations is crucial. For effective endpoint discovery and to support the identification of providers and payers in a national directory, it is beneficial to include at least provider demographic information and provider and payer identity information, such as National Provider Identifier (NPI) or Tax Identification Number (TIN).

BCBSA has built an interoperable provider data system that leverages FHIR APIs, validates addresses, validates provider NPI's through NPPES, and pulls in additional data from third-party sources resulting in higher data quality. We have found a 30-35% reduction in data-related inquiries and an approximate 60% reduction in the average time Plans take to resolve inquiries originating from members and partner Plans as a result of the real-time nature of this solution.

Housing a nationwide provider directory under a federal entity, ideally within HHS and an ASTP/ONC or CMS-led initiative where providers can update their information, would ensure

consistent governance, and reduce errors and fragmentation. Furthermore, this directory should include FHIR endpoints and could leverage public endpoints, making it easier to create a comprehensive directory. Users should not bear direct costs to access the directory, this would encourage widespread use and adherence. Funding should be managed at the federal level to maintain fair access and minimize barriers.

PA-5. *What are ways payers can help with simplifying clinical quality data responsibilities of providers? How interested are payers and providers in EHR technology advances that enable bulk extraction of clinical quality data from EHRs to payers to allow them to do the calculations instead of the provider-side technology?*

Payers can simplify clinical quality data responsibilities by advocating for and participating in the alignment of the digital collection methods for quality measures across CMS programs and state Medicaid agencies. Streamlining eCQMs and adopting consistent formats, such as standardized FHIR profiles and common clinical terminologies like SNOMED CT, would reduce redundancy and improve data comparability. There is significant interest in bulk data extraction technologies to extract data from EHRs, an important feature that would enable payers to perform quality calculations centrally. However, this approach also presents risks related to data privacy, consent management, and data abuse and must be mitigated through appropriate controls on data access management and member opt-out options. While payers having the ability to make the quality calculations would increase payer access to clinical quality data, it would also increase our compliance responsibilities under Patient Access API requirements.

CMS can play a role by simplifying provider responsibilities by aligning quality measures across federal programs and with commercial payers, promoting the use of harmonized, outcomes-based core measure sets and sunsetting duplicative or low-value metrics. CMS should also invest in shared infrastructure and technical assistance, CMS should also continue to convene public-private collaborations to build consensus on digital measurement standards, promotes best practices, and ensure equitable implementation.

PA-7. *How can CMS encourage payers to submit information blocking complaints to ASTP/ONC's Information Blocking Portal? What would be the impact? Would it advance or negatively impact data exchange?*

Under the current guidance, there is ambiguity around what constitutes as a violation. CMS should encourage payers to submit information blocking complaints to the Information Blocking Portal by providing clearer, actionable guidance and examples of violations on which payers can submit a complaint. Data sharing between the provider and payers typically fall within healthcare operations definition under HIPAA. There are many payers and providers that are unsure about what constitutes a reportable offense, especially if the data being withheld by providers could be justified under HIPAA's "minimum necessary standard."

2. **Technology Vendors, Data Providers, and Networks**

TD-1. *What steps can CMS take in the short and long term to stimulate digital health product development?*

Digital Health Product Development:

CMS plays a critical role in fostering the growth of digital health, and its policies should prioritize solutions with demonstrated clinical effectiveness and real-world benefit. We encourage CMS to support innovation through mechanisms such as real-world pilots, phased implementation strategies, and initiatives that allow technologies to validate their impact over time. Digital tools should only be required for coverage when there is clear evidence, they improve care and outcomes. Mandating unproven technologies risks adding unnecessary costs and potentially compromising patient safety. To further advance responsible innovation, CMS should support provider adoption with flexible regulatory frameworks and uphold strong data privacy protections. Evidence-based, practical policies that meet the needs of patients, providers, and payers will be key to sustainable digital health integration.

Federal Procurement of Digital Health Tools:

We support the April Executive Order[2] emphasizing the use of commercially available products in federal procurement. For CMS and other federal agencies, this directive should guide a procurement strategy that prioritizes proven, off-the-shelf digital health tools and avoids unnecessary customization that can hinder timely adoption. Agencies should maintain a diverse portfolio of commercial solutions, engage vendors to ensure consistent licensing terms over time, and allow consideration of customized or open-source technologies where they offer clear added value. This approach will help ensure flexibility, cost-effectiveness, and long-term value in federal digital health investments.

TD-7. *To what degree has USCDI improved interoperability and exchange and what are its limitations*?

USCDI has brought the necessary consistency to the structure and content of exchanged health information by defining a core clinical data set required for certified EHR technology. USCDI's inclusion of clinical notes, problems, medications, and allergies has enabled payers to more effectively support risk adjustment and care management and has enhanced provider access to key patient history across visits. However, the frequency and volume of updates to the USCDI present challenges for implementation, particularly for plans and vendors with long development timelines. Moreover, the USCDI lacks key administrative and social data elements critical for value-based care, such as prior authorization status, claims, and social risk factors.

To improve usability and reduce burden, CMS should consider a three-year update cycle and require a clear, evidence-based rationale for additions. The current pace and volume of USCDI updates can overwhelm stakeholders, especially smaller organizations, who require significant time and resources to incorporate new data elements into their systems, validate workflows, and ensure compliance. Frequent changes can lead to versioning issues, inconsistent adoption, and an increased burden on implementers who must constantly adapt to evolving standards without sufficient lead time.

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[2] https://www.whitehouse.gov/fact-sheets/2025/04/fact-sheet-president-donald-j-trump-enforces-requirement-of-cost-effective-commercial-solutions-in-federal-contracts/

By moving to a predictable three-year cycle, CMS would give stakeholders the stability and planning lead way they need to align development timelines, budget for necessary upgrades, and support thorough testing and training. Requiring a clear, evidence-based justification for new data elements would also ensure that USCDI evolves in a purposeful way, prioritizing elements that have clear clinical, operational, or policy value, particularly for advancing interoperability, value-based care, and health equity. This measured approach would increase usability of USCDI while reducing implementation burden and supporting more consistent adoption across the health care system.

Stakeholders have also urged ASTP/ ONC to prioritize structured data formats and avoid relying on free-text or unstructured inputs that increase downstream processing complexity.

TD-9. *What are the benefits and drawbacks of prioritizing API capabilities in health IT certification?*

Redefining certification to prioritize FHIR API-enabled capabilities would help ensure that certified health IT systems are built with interoperability in mind from the outset. API-first certification requirements should extend beyond patient-facing APIs to include provider- and payer-facing endpoints for treatment, operations, and payment use cases. This includes APIs to access clinical notes, diagnostic imaging, laboratory results, and prior authorization data. By expanding certification requirements beyond patient-facing APIs to include provider and payer facing endpoints, CMS and ASTP can support more seamless, secure data exchange across the full range of treatment, care coordination, operations and payment workflows. This is essential for reducing administrative burden, improving clinical decision-making, and enabling real-time access to key data such as clinical notes, lab results, diagnostic imaging, and prior authorization information.

Key improvements could include requiring API support for real-time access to the full patient record (not just the USCDI), mandating publication of open, documented endpoints, and requiring vendors to support standardized authorization protocols such as OAuth 2.0 and SMART on FHIR. Certification should also include testing for real-world usability and data completeness.

To drive provider responsiveness to API-based data requests, CMS should tie these capabilities to participation in value-based payment models and to compliance incentives under programs such as MIPS and Promoting Interoperability (PI). Currently, MIPS requires clinicians to use the 2015 Edition of Certified Electronic Health Record Technology (CEHRT) which includes FHIR-based APIs to meet specific PI measures such as providing patients with electronic access to their health information via certified APIs. However, these requirements are limited to patient-directed access and do not extend to payer or third-party API requests. CMS has not yet established mandates for provider responsiveness or timeliness in fulfilling such requests, nor does it require API-based access to the entirety of a patient's EHI beyond USCDI. To close these gaps, CMS could also establish penalties for non-responsiveness or delays in fulfilling FHIR API requests, particularly when payer access to clinical data is necessary for risk adjustment or quality measurement.

Additionally, CMS and ASTP should make sure that providers are required to exchange data using industry standard, open APIs like those based on FHIR and SMART specifications rather than proprietary EHR-specific tools. The emergence of platforms like Epic's Payer Platform, which often mandate the use of vendor-controlled pathways, highlights the risk of fragmenting interoperability and placing unnecessary barriers on payer-provider data exchange. Certified health IT should not restrict access or force stakeholders into closed systems, but should instead enable consistent, standards-based exchange across all certified entities. Otherwise, it would undermine the foundational goals of interoperability, increase administrative burden and impede care coordination.

TD-12. *Should CMS endorse non-CMS data sources and networks, and if so, what criteria or metrics should CMS consider?*

CMS should endorse qualified non-CMS networks and data sources that meet nationally recognized standards for privacy, security, governance, and interoperability. Examples could include networks such as Carequality, CommonWell, and Surescripts, as well as payer and provider APIs that adhere to HL7 FHIR standards. CMS endorsement could reduce uncertainty for providers and payers selecting data exchange partners and support broader alignment with private-sector innovation. Evaluation criteria for which sources and network to endorse should include adherence to FHIR and SMART specifications; support for the TEFCA common agreement; transparent data use policies; patient access capabilities; and demonstrated performance metrics such as query success rate, response time, and data completeness. These evaluation criteria are essential because they help ensure that the networks and sources CMS endorses and technically interoperable operationally reliable and aligned with national exchange goals. Requiring adherence to FHIR and SMART standards promotes consistency and scalability, which are foundational for enabling real-time data exchange and reducing custom interfaces. Support for participation in TEFCA signals a commitment standardized, nationwide interoperability frameworks and fosters trust among data exchange participants.

It is important to make all data related to comprehensive patient care accessible across the healthcare system. This encompasses both clinical and administrative data, as well as resources like Community Resource Network data that facilitate the integration of healthcare and social needs, by linking public and private resources to adequately support patients. The healthcare ecosystem consists of a network of interconnected public and private supports and services. Enhancing the capabilities of digital health IT to utilize all available data will enable providers and payers to better serve patients holistically, potentially leading to improved health outcomes and reduced costs.

TD-13. *What new opportunities and advancements could emerge with APIs providing access to the entirety of a patient's EHI? What are the primary obstacles and tradeoffs compared to USCDI?*

APIs that support access to the entirety of a patient's EHI and not just USCDI would make advanced use cases possible, such as longitudinal patient tracking, AI-enabled risk prediction, and real-time care plan coordination across settings which would empower both and providers to move beyond minimum data sharing toward more proactive and collaborative care

management. For example, payers could more accurately identify care gaps or avoid duplicative services by integrating clinical notes and encounter/administrative details not currently in the USCDI. Providers could receive better decision support, and patients would gain more complete transparency.

However, the breadth and variability of full EHI data poses significant technical and operational challenges. These include inconsistent formatting, lack of normalization, and difficulty in extracting structured information from PDFs, scanned documents, or unstructured notes. Compared to USCDI's concise and curated dataset, full EHI APIs require greater investment in infrastructure, data governance, and validation processes. To address this, CMS should develop clear implementation guidance, fund pilots, and incentivize EHI-focused innovation through Health IT certification or payment programs.

TD-17. *Given operational costs, what role should CMS or ASTP/ONC have in ensuring viability of healthcare data sharing networks?*

CMS and ASTP/ONC should take an active role in supporting the viability of data sharing networks, preferably a nationwide network, through a combination of funding, regulation, and technical assistance. They can expand investment in shared digital infrastructure, particularly in rural and underserved regions where provider organizations often lack the capital to participate in health information exchange. CMS could also consider offering sustainability grants, low-interest financing, or participation bonuses for providers that join qualified networks or implement FHIR APIs as ways to support the establishment and maintenance of key infrastructure. ASTP can facilitate this by maintaining an up-to-date registry of networks that meet performance and interoperability benchmarks. Without these actions there is a risk that smaller or under-sourced providers will be left behind, exacerbating digital disparities and creating uneven access to interoperable exchange. Uneven participation and technical readiness across the healthcare system could slow the broader adoption of APIs, reduce the impact of federal interoperability effort and hinder the ability to scale VBC models equitably.

Moreover, CMS should align its policies, such as prior authorization reform, value-based payment programs, and quality reporting, with incentives for real-time data sharing. For example, requiring participation in TEFCA or FHIR-based APIs as a condition for advanced APM participation would create a stronger business case for sustained investment in interoperability across the ecosystem.

3. Value-Based Organizations

<u>Digital Health Adoption</u>

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

Stronger financial and operational incentives are necessary to encourage ACOs and other MSSP participants to adopt digital health management and care navigation products more broadly and effectively. While current programs offer some incentives for digital quality reporting, these are not sufficient to offset the costs of implementation or encourage the comprehensive use of digital tools. CMS should expand incentives tied to the use of eCQMs and digital quality measures (dQMs) and offer financial support for infrastructure investments. CMS should provide support in the form of forgivable loans and grants to help ACOs implement health IT systems more broadly.

Key obstacles include the high costs, complexity associated with integrating digital tools into existing infrastructure and variability in access, particularly for small and rural ACOs. CMS can address some of these barriers through targeted funding, streamlining health IT requirements and offering support for implementation to promote broader digital adoption.

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

To fully realize the promise of VBC, these themes and technologies should be more integrated into APMs through thoughtful incentive alignment and infrastructure support. While components like quality measurement, patient engagement and risk adjustment are currently embedded in many models, additional emphasis should be placed on care coordination infrastructure and digital enablement strategies. For example, CMS could tie incentives to the adoption of real-time data sharing platforms and care planning tools that support care coordination, especially for complex patients.

CMS should also encourage the use of responsible AI and population health analytics for use cases that can support VBC and drive improved outcomes for patients, such as predictive modeling, clinical decision support, and early identification of care gaps. These tools can optimize risk stratification and identification and make way for proactive targeted interventions.

CMS could also lower the cost and technical thresholds that currently limit use of advanced analytics and engagement tools in smaller or under-resourced provider organizations. Offering explicit, flexible and scalable funding options or allowing shared savings to be reinvested in digital infrastructure would support more widespread integration of these capabilities. Ultimately, integrating these tools requires user-friendly design to reduce clinician burden and ensuring APMs are rewarded for using technologies that demonstrably improve quality and outcomes.

VB-3. *What are essential health IT capabilities for value-based care arrangements? What other health IT capabilities have proven valuable to succeeding in value-based care arrangements?*

Essential health IT capabilities for value-based care include a comprehensive suite of technologies that support data sharing, care coordination, analytics, and patient engagement, including:

- **Population Health Analytics**: These platforms allow ACOs and other VBC models, to identify high-risk patients, monitor chronic conditions, and target interventions, forming the backbone of proactive, preventative care delivery.
- **Risk Stratification and Predictive Analytics**: AI-driven tools that assess demographic, clinical, behavioral, and social factors help forecast patient needs, enabling early interventions and better resource allocation. These tools, when adopted responsibly and with appropriate human involvement and transparency, have the capacity to meaningfully impact overall patient health.
- **Care Coordination Tools**: Capabilities like referral tracking, discharge planning, and real-time event notifications (ADT feeds) are critical to ensuring smooth transitions across care settings and avoiding unnecessary utilization.
- **Data Interoperability**: Seamless exchange of information across disparate systems supports collaboration across providers and payers. Use of FHIR APIs, standardized terminology (e.g., SNOMED, LOINC), and robust patient identity matching is fundamental.
- **Longitudinal Health Records**: Aggregating data from EHRs, remote monitoring devices, claims, and social services enables comprehensive, person-centered care planning.
- **Real-Time Data Access**: Clinicians benefit from timely insights during encounters, supporting more informed clinical decision-making and patient conversations. In addition, supporting this real-time across providers with payers would support optimization of predictive analytics and care coordination tools that can be invaluable to supporting clinicians and driving whole person-centered, VBC.
- **AI and Machine Learning Workflow Tools**: Tools that enable personalized care planning, workflow automation (e.g., pre-visit planning, prior authorization support), documentation assistance (e.g., ambient listening, NLP), and detection of care gaps or waste have shown significant promise.
- **Patient Engagement Technologies**: Tools such as remote monitoring, digital health coaching, medication reminders, and shared decision-making platforms have the potential to improve health outcomes but also drive patient satisfaction and accountability.
- **Quality Performance Measurement Infrastructure**: Digital quality measurement (eCQMs, dQMs) and performance dashboards provide ongoing insight into provider performance, supporting continuous improvement.

These capabilities are interdependent and together form the technical foundation needed for successful participation in value-based arrangements. Policymakers should prioritize policies and standards that support implementation, data fluidity, and equitable access to these tools across diverse provider types.

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

Successful VBC relies on access to comprehensive, standardized, interoperable data. This includes real-time or near-real-time clinical data (diagnoses, labs, vitals, medications), accurate patient attribution data, claims and utilization history (including ER visits and hospitalizations), risk inputs (demographic, clinical, behavioral, and social risk factors), and performance metrics (including outcomes and patient-reported measures). Data on transitions in care and care coordination (e.g., discharge summaries and referrals) is also essential as these moments are also some of the highest points of risk for patient safety, care continuity and preventable readmissions. Standardized formats and timely data access are critical to maximizing analytic insights and informing care. With seamless access to this data plans can proactively engage in post-acute care coordination, support medication reconciliation, and initiate timely follow-up care, particularly for high-risk or chronically ill members. HHS revisiting the “operations” definition under HIPAA to include care-coordination and case management would facilitate this access for plans.

VB-5. *How does the current certification criteria and standards incorporated into the ONC Health IT Certification Program support value-based care delivery?*

The ONC Health IT Certification Program, particularly the requirement to use Certified Electronic Health Record Technology (CEHRT) for Advanced APM participants, provides a critical infrastructure for VBC. This requirement facilitates consistent quality reporting across payers and supports care coordination by ensuring systems can exchange data and helping APM participants meet complex quality and performance measurement requirements.

However, challenges remain, especially for MSSP ACOs navigating MIPS Promoting Interoperability (PI) requirements. The complexity and variability of these requirements can create confusion and administrative burden as some ACOs have to comply with both programs’ criteria. Overall, the certification program is essential to promoting interoperable systems but could benefit from further alignment and simplification to better support ACOs and other APMs.

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

Technology requirements can reduce complexity by streamlining expectations across programs and offering flexibility where appropriate. For example, CMS should refine the scoring under the MIPS PI category to better support VBC, such as incorporating eCQM reporting, expanding CEHRT functionality requirements and prioritizing tools that enable real-time data exchange. Establishing a more modular, use-case-driven CEHRT requirement tied to functions like care coordination or real-time data access, can preserve flexibility while minimizing administrative burden. Reducing duplicative or overly prescriptive mandates will help ACOs focus resources on transformation activities rather than compliance minutiae.

VB-8. *How can other HHS policies supplement CEHRT requirements to better optimize the use of digital health products in APMs?*

To optimize the use of digital health products in APMs, HHS policies should focus on reducing barriers for small and rural providers by implementing waivers or flexible requirements that account for their unique resource constraints. Small practices often face challenges in adopting CEHRT due to financial and technical limitations; thus, cost-receptive programs or grants are essential to encourage their participation and ensure equitable access to digital tools. Policies that facilitate easier connectivity to health information exchanges and support interoperability with community providers would enhance care coordination and data sharing capabilities, particularly benefiting providers in less resourced settings. Furthermore, incentivizing the adoption of standardized digital quality measures and event notifications (such as hospital admission, discharge, and transfer alerts) through conditions of participation can improve timely care transitions and outcomes. Overall, HHS should encourage flexibility in CEHRT certification and provide targeted support to promote widespread and effective digital health adoption across all provider types.

VB-10. *CMS established that CEHRT requirements for Advanced APMs beyond those in the "Base EHR" definition should be flexible based on what is applicable to the APM that year based on the area of clinical practice. What certification criteria should CMS identify under this flexibility for specific Advanced APMs or for Advanced APMs in general? Should other flexibilities be made for certain providers such as rural?*

It is important that CMS continue to allow and clarify flexibilities in CEHRT certification criteria tailored to the clinical focus of specific Advanced APMs. Such flexibility would reduce provider burden and better align technology requirements with care delivery realities. Consistency across programs, such as alignment between MSSP and ACO REACH standards, would mitigate confusion and administrative complexity. Additionally, special accommodation should be made for rural, small, and resource-limited practices to ensure these providers are not disproportionately disadvantaged. Flexibilities could include extended timelines, scaled certification requirements, or alternative compliance pathways that maintain essential interoperability and data sharing standards while recognizing local constraints. These adjustments would support broader participation and enhance value-based care adoption in underserved areas.

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

Interoperability challenges remain a significant barrier for many ACOs, and providers engaged in value-based care. Despite progress, variations in technology adoption levels persist, with some providers still reliant on paper claims or non-electronic systems, impeding timely data exchange. The shift toward digital quality measures (dQMs) places additional demands on providers who may lack the infrastructure or workforce capacity to fully implement required standards. This situation risks penalizing providers who are slower to transition or serve vulnerable populations, underscoring the need for phased approaches and supportive incentives. Furthermore, inconsistencies in data formats, incomplete patient identity matching, and limitations in real-time claims data access further hinder seamless information flow. To address these challenges, incentives should promote smooth transitions to electronic systems

with minimal administrative burden, and CMS should consider graduated penalties or alternative participation options that foster inclusion without compromising care quality.

Technical Standards

VB-13. *What improvements to existing criteria and standards would better support value-based care capabilities while reducing provider burden?*

Standardizing how payers communicate gaps in care to providers is critical to driving timely patient engagement and follow-up care. Current variability in notifications and reporting creates inefficiencies and confusion. Establishing uniform, actionable gap-in-care alerts integrated into provider workflows can enhance care delivery and reduce missed opportunities for intervention. Additionally, refining certification criteria to prioritize interoperability and data exchange functionality over prescriptive technology features would allow providers to adopt solutions that best fit their practice context. Simplifying reporting requirements, harmonizing measures across programs, and leveraging automated data extraction and normalization tools can further reduce administrative burden and improve data accuracy.

VB-14. *How could implementing digital identity credentials improve value-based care delivery and outcomes?*

Implementing standardized digital identity credentials can significantly enhance value-based care by improving data accuracy, patient matching, and secure information exchange. A national standard for identity proofing, possibly managed through a centralized National Master Patient Index, would reduce duplication and errors, thereby streamlining care coordination and quality measurement. This approach would facilitate faster, more reliable data sharing across providers and payers while safeguarding patient privacy. Accurate identity management is foundational to integrating diverse data sources, enabling comprehensive longitudinal records essential for effective risk stratification, population health management, and patient engagement.

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 transformative in advancing interoperability by providing a centralized, standardized repository of API endpoints for providers, payers, and other healthcare entities. This directory would streamline data sharing by simplifying discovery of valid endpoints and ensuring consistent connection points for electronic health data exchange. Adherence to national standards, such as the National Healthcare Directory FAST, would ensure consistency and reliability, enabling faster integration, reducing technical barriers, and supporting real-time clinical and administrative data exchange necessary for effective value-based care. Key data elements should be discussed and approved by stakeholders, and must also account for privacy, security, compliance burdens, and the protection of competitively sensitive information.