June 16, 2025

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

Submitted electronically to: https://www.regulations.gov

RE: Request for Information; Health Technology Ecosystem (RIN: 0938-AV68)

Dear Administrator Oz:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the Health Technology Ecosystem request for information (RFI). NAACOS is a member-led and member-owned nonprofit of nearly 500 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of healthcare providers across the nation to improve quality of care for patients and reduce health care costs. Collectively, our members are accountable for the care of over 9.5 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and ACO REACH.

Transforming care delivery and improving clinical outcomes are cornerstones of accountable care. ACOs and providers in accountable care regularly use data and technology, integrating claims and clinical data, adopting tools that engage patients in their care delivery, and leveraging emerging technologies (e.g., AI) to advance innovative solutions and improve population health. NAACOS applauds your focus on improving data interoperability and the broader health technology infrastructure for all stakeholders, as well as reducing provider burden and better engaging patients in care delivery and decision-making.

We strongly encourage the Administration to leverage ACOs and providers in accountable care as partners in designing approaches to these areas to ensure that health information flows across the care continuum. With responsibility for total cost of care and clinical outcomes, accountable care requires (1) bi-directional capture of data that are seamlessly integrated at the point of care, (2) merged data across multiple care settings, users, and endpoints, (3) tools to engage and empower patients in their care, and (4) the ability to leverage data sets for multiple purposes including population health, quality measurement, and patient engagement. Ultimately, ACOs and providers in accountable care are the best test cases for ensuring that data is not locked away in silos.

To date, approaches to meeting these requirements have been burdensome and costly. We ask that CMS, Assistant Secretary for Technology Policy (ASTP), and the Office of the National Coordinator for Health Information Technology (ONC) principally address the following:

- Factor in the additional testing, resources, costs, and implementation time required for these technologies, particularly for small/rural providers.

- Provide incentives for participants in Alternative Payment Models (APMs) to encourage adoption and widespread use of these technologies.
- Broaden certification criteria and standards to facilitate population health management needs including data aggregation across various data types.
- Avoid new requirements that place undue burden on providers and maintain flexibility to adopt approaches best suited for their patient populations.

We look forward to continued engagement with CMS and ASTP on designing thoughtful approaches to unleash data to improve management of chronic conditions, empower patients, and reduce administrative burdens. Our comments below in response to the RFI questions reflect the opinion of our members and our shared goals to improve value-based care and empower patients through the effective and responsible adoption of technology in healthcare.

Response to RFI Questions

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

To meet the cost and outcome parameters of an APM, providers must adopt technology-enabled approaches. Often, providers make these investments using shared savings achieved through the model and advanced APM incentives, which are received long after the performance year. Up-front incentives (i.e. pre-paid shared savings and capitation options) have enabled providers to make more timely investments in technology. Accordingly, we must ensure that the current incentive approaches are able to sustain continued investment in health technology. Specifically, CMS must address challenges with ratcheting benchmarks and consider the impact of expiring advanced APM incentives.

NAACOS supports potential incentives to develop or make digital health products available to members of an APM as part of the APM funding. This approach is particularly helpful for small, independent, rural, and other providers who lag in technology adoption. The cost to purchase these products is often a barrier to participants, so financial incentives can promote their purchase and use. Incentives could be in the form of per-member per-month (PMPM) payments to the ACO for patient use of products or allowing patient bonuses for use of digital health products.

In any incentive approach, we encourage consideration of prior obstacles.

- Overcome provider and patient uncertainty: There is a need to demonstrate the use and value of these products to both providers and patients, as patient and provider knowledge of products can be limited.
- Test prior to adoption:. Support APMs in testing and implementing these technologies without suffering any consequences of technology failure, or unforeseen consequences. For example, a testing lab that allows APMs to gain experience with the products before full scale implementation may be one solution to this problem and incentivize use.
- Avoid overly prescriptive approaches: In lieu of requiring any one technology or approach, CMS should focus on achieving a particular outcome and allow APMs the ability to adopt technologies based on their patients' and the organization's needs and capabilities.

- Prevent an overabundance of data: The proliferation of patient digital health products could potentially overwhelm practices; there must be limits on the type and amount of data that are sent to providers/care teams so that they receive the information that is most relevant for clinical decision-making.

Finally, there is also concern with the interoperability of digital products with various electronic health records (EHRs). APMs typically interface with multiple – sometimes hundreds – of instances of EHRs. Based on the recent MSSP reporting experiences, ACOs report that there is already significant variability in system and system version capabilities. It is essential that APMs and their practices be able to easily interface with these products and address some of the potential solutions to this concern in responses to the questions on certification.

Beyond incentives, CMS/ASTP should consider other approaches for alleviating cost burdens. For example, CMS could explore cost sharing arrangements between CMS and APMs, like the Medicaid State Systems where the Federal government provides a percentage of the cost. Additionally, CMS could sponsor group purchasing arrangements for these initiatives to enable individual provider use without needing individual contracting.

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

ACOs and providers in accountable care currently use tools and technologies with these themes and see opportunities for improved use. As we stated above, barriers of cost, education, return on investment (ROI), and compatibility with EHRs are major obstacles to overcome. **Removing these barriers will improve adoption without requiring them as part of the APM model or participant requirements.** That is, if these tools and technologies show their expected results for individual APMs, we expect them to be adopted. For example, many ACOs are adopting AI to improve patient stratification for population health management. Additionally, given the significant differences among APMs and their providers, voluntary adoption rather than requirements would be a better approach since APMs should be able tailor their solutions based on their needs and patients.

CMS/ASTP could undertake certification of these products to give providers some guidance as to their capabilities. Specifically, consideration should be given to:

- The costs and benefits of individual adoption of products and their capabilities in developing reports provided to the public.
- Integration into clinical workflows to minimize disruption and burden with specific attention to whether these tools can integrate across all EHR instances and versions and particularly those used by small and rural providers.
- Integration with health information exchanges (HIEs) or state data to provide better overall population data for APMs to use.

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

The key focus for most value-based care (VBC) arrangements is the aggregation of digital data across providers to track patient behaviors and outcomes. Individual patient data is as critical to care teams that create and monitor care plans for patients. Aggregated data is needed to share among providers working to improve care coordination and the overall health of the population. These data include

claims, eligibility, administrative and clinical data across multiple EHRs, and patient self-reported data. It should be reiterated that the lack of interoperable data from EHRs is a major barrier to successful data aggregation.

The development of feedback loops, using timely and actionable data within the ACO and with patients, is another important capability. ACOs see the need to share recommendations and resources to patients on their behaviors and clinical indicators and suggest actions to better their health. Feedback to providers on the success of their treatments and areas for improvement is also valuable.

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

Full patient clinical and claims data, eligibility and attribution to providers, outcomes tied to quality measures, real-time patient actions and conditions, and individual provider capabilities are essential data needed in accountable care arrangements. Additionally, full and complete access to data is vital . ACOs have struggled to access complete information in the following areas:

- Patients Opt-Out of Data Sharing: Beneficiaries in ACOs have the option to opt-out of data sharing, which creates challenges for ACOs to manage the care of patients. Some ACOs report that up to 8% of beneficiaries opt out of data sharing. CMS should exclude patients who opt out of data sharing from quality measurement requirements and explore opportunities. Additionally, CMS should better educate patients on the importance of data sharing as part of the opt-out process.
- Admission, Discharge, and Transfer (ADT) Data: Many ACOs find that real-time notifications to providers on patient actions (e.g., emergency department admissions) provide critical information that activates a timely intervention. While CMS requires hospitals to notify providers through ADT alerts, that information is not always accessible by ACOs. A prior survey of NAACOS members highlighted that more than a third (38%) of ACOs do not have agreements in place with hospitals or third-party vendors. For the 62% of ACOs that receive alerts, the majority (66%) state that the alerts are “extremely useful” and 23% said they are “somewhat useful." Ongoing barriers to receiving this information include:
    - Costs: Nearly half of ACOs that receive alerts pay upwards of $50,000 a year for them. HIEs charge a flat connection fee and then for each transaction thereafter. When there are hundreds of thousands of transactions, fees can be costly.
    - Lack of Access to HIEs or Vendors: CMS encourages use of an intermediary, such as an HIE, to route notifications to the appropriate provider. But some states and locales lack a functional HIE. Additionally, not all third-party vendors or HIEs cover an entire market or have access to all hospitals in a region. In these cases, the ACO must go to multiple sources, raising the complexity and cost.
    - Inconsistent Data: Several known challenges with HIEs and broader interoperability also impact the usefulness of the ADT alerts.
        - Missing providers: Smaller providers have a harder time joining an HIE because of the cost. In many states, rehab facilities and nursing homes are also not included.
        - Missing patients: Some states require patients to opt-in to HIEs, limiting the data that ACOs could receive so that it is not useful or cost-effective to maintain systems to receive ADT alerts.
        - Lack of vital information: Alerts are lack diagnosis information and other critical detail about the encounter making the information not actionable.

    - Unusable format: Data from HIEs do not have an ideal or consistent format, which requires additional programming and manipulation before it can be used. This type of data transformation is particularly burdensome for ACOs with multiple HIE connections given the vast inconsistencies.
    - Patient matching: Hospitals struggle to match incoming patients with their historical records, especially in cases where patients have common names or name changes.
- Substance Use Data: CMS currently excludes these data from the Claim and Claim Line Feed (CCLF) files that ACOs receive, which creates barriers to providing coordinated, integrated behavioral healthcare. Despite Congress' efforts to align 42 CFR Part 2 with Health Insurance Portability and Accountability Act (HIPAA) through Section 3221 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), CMS' regulation still restricts secure sharing of substance use disorder (SUD) claims data.

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

While the current criteria and standards provide a broad foundation, they do not focus on the needs for accountable care and population health management. Specifically, current criteria and standards do not consider cross-setting and cross-provider outcome reporting. To date, APMs must rely on collecting information from their participating providers. This approach meets the bare minimum needs but is costly, complex, and burdensome. Essentially, ACOs are left to verify that each instance of each version of an EHR used by their participating practices meets these criteria.

As we note above, accountable care and APMs should be a test case for uses of CEHRT, as providers in these models have advanced data needs. Because they often work with providers of varying sizes, geography, and vendor systems, APMs can provide valuable, real-time information on how vendors are (or are not) meeting the criteria and standards.

VB-6. What specific health information technology capabilities that could benefit APMs are not currently addressed by existing certification criteria and standards that should be included under the ONC Health IT Certification Program?

APMs must be able to merge and deduplicate patient information across multiple different EHRs – and multiple instances and versions of those EHRs. Currently, this challenge causes difficulties in quality reporting and other data analysis capabilities. We urge CMS/ASTP to include this capability as a requirement of certification, specifically that EHRs must support standardized data sharing (via APIs or other technologies). Without this capability, APMs and their providers will continue to encounter challenges in collecting the data needed for individual patient care and population health management.

To better support APMs, CMS should focus on advancing interoperability for all providers along the continuum of care. For example, CMS' pilot testing of proposed skilled nursing facility (SNF) measures confirmed that paper continues to be the most common mode of information sharing with patients and providers. This long-standing reliance on paper-based transmission of information presents a significant barrier for post-acute care (PAC) providers to implement EHR systems and participate in value-based care arrangements.

Compliance and Certification:

- **VB-7. How can technology requirements for APMs, established through CEHRT or other pathways, reduce complexity while preserving necessary flexibility?**
- **VB-8. How can other HHS policies supplement CEHRT requirements to better optimize the use of digital health products in APMs? As an example, requirements under the Conditions of Participation for hospitals (42 CFR 482.24(d)) require hospitals to transmit electronic patient event notifications to community providers. What barriers are in place preventing APM participants from receiving the same notifications?**
- **VB-9. What technology requirements should be different for APM organizations when comparing to non-APM organizations (for example, quality reporting, and interoperability)?**

CMS should avoid being overly prescriptive in its CEHRT requirements for APMs and providers in APMs. A better approach would be to create broad, total cost of care incentives and allow APMs to determine how to adopt technologies based on their unique needs, providers, and patient populations. Current approaches measure the functionality of providers' EHRs in a "check box" fashion of whether a functionality exists. This approach is best suited for ASTP assessment and certification of technologies.

Any CEHRT requirement for APMs should consider the specific model purposes and goals and avoid simply adopting requirements from other programs. For example, the current CEHRT and quality reporting requirements for APMs seek alignment with individual and group clinician requirements set forth in the Merit-based Incentive Payment System (MIPS). This approach ignores the overall population health goals of APMs. A stronger approach would be to set requirements for clinicians in MIPS to encourage adoption of APMs. NAACOS and other stakeholders have recommended approaches for improving CEHRT and quality requirements for APMs.

NAACOS suggests different CEHRT requirements for different APM models, based on specific purposes and goals of the model. Some APM models may not need to leverage all certified EHR requirements, allowing for model-specific flexibility. In some cases, individual provider reporting rather than APM-level reporting may be used to avoid the complexity of managing the extraction and combination of data from many independent sites with different EHRs into an aggregate report. The one-size-fits-all approach does not work given the variety of APM models and organizational structures. CMS/ASTP should work with HIT vendors and APMs during model development to ensure these tailored requirements can be implemented in vendor products and by the providers participating within a specific model without undue cost or burden.

However, sharing and collection of data from multiple providers of all types, and the ability to analyze that data is a key requirement and should be considered an essential vendor CEHRT requirement. We also suggest that the ability to produce consolidated patient reports for the care teams, in addition to the provider, be a CEHRT requirement.

Modifications to Current CEHRT Approach for MSSP. CMS finalized a requirement that all MSSP participants, regardless of QP status or track, report MIPS Promoting Interoperability (PI) data starting with the 2025 performance year. CMS also increased the Advanced APM CEHRT criteria from requiring 75 percent of all eligible clinicians to use CEHRT to all eligible clinicians, starting in 2025. We remain opposed to the changes in this requirement:

- Requiring all MSSP ACOs to report PI is counter to the Medicare Access and CHIP Reauthorization Act (MACRA) intent to relieve burden from MIPS for Advanced APMs. Congress clearly established a two-track system that exempts MIPS clinicians who participate in Advanced APMs and meet QP thresholds. Requiring Advanced APM MSSP ACOs to now report PI goes

against this intent and now subjects these Advanced APM ACOs to MIPS. This will serve as a disincentive to participate in an Advanced APM at a time when other financial incentives to participate in these models are dwindling.

- ACOs still lack clarity regarding how these policies will be implemented and to what extent they will impact ACOs' ability to share in savings generated. While we were pleased to see CMS recently issue new frequently asked questions (FAQs) to MSSP ACOs, there are still several significant implementation questions that remain unanswered. This uncertainty is causing ACOs to drop practices from their participant lists.
- Reporting PI does not equate to more meaningful use of CEHRT in an ACO. ACOs by design must be committed to robust information and data sharing practices to be successful in the program. Reporting PI measures and meeting required objectives for this program are extremely burdensome and will serve only as a check-the-box exercise and not add any value to patients.

We recommend that CMS employ the following approaches to better understand ACOs' use of CEHRT:

- Require ACOs to attest to use of CEHRT: This is the approach previously employed in MSSP and currently used for REACH. CMS should align requirements between similar models (i.e., ACOs) rather than align MSSP with MIPS. Doing so would better support clinicians who move between models, and APM entities that participate in both programs. The REACH attestation approach is preferred as it places less burden on providers and does not require providers to report on the meaningless data points collected in PI for MIPS.
- Leverage data reported to ASTP from health IT developers through the new Insights Condition and Maintenance of Certification finalized in the Health Data, Technology and Interoperability (HTI-1) final rule to reduce redundant data collection.
- Gradually increase the Advanced APM CEHRT criteria: Expecting 100 percent of clinicians across an ACO to comply with burdensome PI requirements and/or meet CEHRT criteria is not reasonable. If one practice or clinician fails to meet these criteria, it could jeopardize the entire ACO's ability to satisfy program/model requirements. This is unrealistic. At a minimum, CMS should employ practice enforcement discretion to give ACOs more time to work with practices to comply with these new requirements.

VB-10. In the Calendar Year (CY) 2024 Physician Fee Schedule final rule (88 FR 79413), 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? Are there specific flexibilities or alternatives to consider for smaller or resource-constrained (such as rural) providers in meeting CEHRT requirements without compromising quality of care or availability of performance data?

Flexibility should be based not only on the clinical practice area or practice size, but also on the specific goals of the APM. We recommend that CMS/ASTP allow smaller or resource-constrained providers to select EHRs that better reflect their goals – which may not necessarily be certified products.

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

The time and cost to implement these products, burden of implementation, and knowledge gaps in interoperability standards remain major barriers to implementing standards like HL7 and FHIR. We recommend that CMS/ASTP provide additional education to help the industry, APMs, and their

participating providers understand the requirements, potential implementation timeline, and costs and benefits to implementing FHIR. For example, the prior authorization interoperability requirements took one NAACOS member 2.5 years to fully implement, yet it allowed FHIR-based quality reporting at half the price of web interface reporting.

Our members also report that the ability to exchange large amounts of data through the Bulk FHIR functionality continues to be a major challenge. Most EHRs are unable to support bulk operations needed by ACOs. CMS/ASTP must continue to promote its use as it is a critical component to enable effective and efficient reporting.

VB-12. What technology standardization would preserve program-specific flexibility while promoting innovation in APM technology implementation?

Standardizing the output and reporting technology will promote innovation, and efforts such as the DaVinci Project serve a critical role in this process. We recognize that the DaVinci Project has made significant progress in developing FHIR implementation guides for exchange of data between and among plans and providers. However, implementation still need to be finalized and proven through real-world testing. We encourage CMS/ASTP to continue these efforts but also recommend that testing capabilities be standardized to facilitate new implementation of these technologies by APMs.

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

As noted above, better standards to exchange large sets of data that can be used for population health management by APMs are needed and should include a wide range of digital data, including health plan data. Payers are not subject to information blocking, which is a barrier to advancing provider-led accountable care across all populations.

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

We appreciate and acknowledge the potential benefits of digital identity credentials but note that this requirement would be burdensome to implement. While this is a worthy goal, it requires significant advance planning, coordination, and support during implementation since it would require health systems and provider groups to map their current internal patient IDs to the new ID. Incomplete upfront planning and support from all players including federal agencies could result in an undue and costly burden to providers as well as delays in successful implementation.

As part of the planning and support for digital identity credentials, CMS/ASTP should provide technical guidance for an API-based approach for integrating these digital identity systems into clinicians' internal enterprise master patient index (eMPI). Since provider groups' and health systems' eMPI are typically managed through their EHR vendors, CMS and EHR vendors should partner to determine an optimal mapping process that can occur via EHRs and include the necessary specifications in future CEHRT criteria.

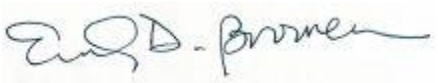
VB-15. How could a nationwide provider directory of FHIR endpoints help improve access to patient data and understanding of claims data sources? What key data elements would be necessary in a nationwide FHIR endpoints directory to maximize its effectiveness?

If correctly implemented, this directory would allow providers to more easily obtain patient data through FHIR APIs, but we believe that it would need to include other data beyond just FHIR endpoints. For example, the directory should include provider APM participation and information on the digital technology capabilities of each provider. Guidance and a process to address how to resolve multiple provider endpoints will be needed as these would be necessary to be identified for their specific purpose.

Conclusion

Thank you for the opportunity to provide feedback on the Health Technology System RFI. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement in the use of technology to improve patient care and experience. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,



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