September 5, 2025

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Submitted electronically to: PTAC@HHS.gov

RE: Using Data and Health Information Technology to Transparently Empower Consumers and Support Providers Request for Input (RFI)

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for information (RFI) on Using Data and Health Information Technology to Transparently Empower Consumers and Support Providers. NAACOS is a member-led and member-governed non-profit of nearly 500 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve quality of care for patients and reduce health care cost. 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 Direct Contracting/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. 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 datasets 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 are not locked away in silos.

We look forward to continued engagement with the PTAC and the Administration on designing thoughtful approaches to unleash data to improve management of chronic conditions, empower patients, and reduce administrative burdens. Our comments below 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

Question #1: How can electronic health vendors work together to improve data interoperability?

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, available in real-time, are critical to care teams that create and monitor care plans for patients and for those same patients to remain invested in their journey to better health. Aggregated data are 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 electronic health records (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. Alternative Payment Models (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 to shift towards digital-forward processes and away from paper- and fax-based reporting. To date, certification of EHRs has not aligned with providers' needs and requirements.

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 specific capability as a requirement of certification, specifically that EHRs must support standardized data sharing (via APIs or other technologies).** Without this capability, ACOs and their providers will continue to encounter challenges in collecting the data needed for individual patient care and population health management.

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. Additionally, the ability to integrate third-party applications is an area that should be explored for additional CEHRT requirements. This would promote innovation and enhance use of patient-generated health data (e.g., from wearables).

Additionally, 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 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.

At the same time, we caution CMS to 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.

NAACOS suggests that the provider requirements for CEHRT should vary based on the model. However, all CEHRT should have the full capabilities to meet the needs and requirements of providers, across models. 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 health information technology (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.

Finally, 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.

Question #2: How can data infrastructure be improved to ensure the availability of patient data?

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. CMS could enable this through cloud-based solutions that allow scalable, secure, and transportable data storage (while maintaining robust privacy and security practices) and investments in health data analytics capabilities for ACOs and APMs to derive actionable insights from patient data.

However, 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 other opportunities for reporting with these patients. 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 timely interventions. 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. Health information exchanges (HIEs) charge a flat connection fee and then an additional

fee 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 often lack diagnosis information and other critical details 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. Given the vast inconsistencies, this type of data transformation is particularly burdensome for ACOs with multiple HIE connections.
        - 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 health care. 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.

Question #3: What are solutions to transferring data from mobile and wearable apps into EHRs and vice versa?

CMS should use FHIR-based APIs for seamless data transfer between devices/applications and EHRs, including standardized data fields to minimize churn and friction, patient-directed data sharing mechanisms, and ensuring validation processes for accuracy and reliability of patient-generated health data.

Question #4: What funding mechanisms can be used to promote improvements in patient data?

ACOs and providers in accountable care currently use tools and technologies, such as AI, population health analytics, and patient engagement tools, and see opportunities for improved use. However, as we discussed above, barriers of cost, education, return on investment (ROI), and compatibility with EHRs are major obstacles to overcome. Removing these barriers will improve adoption of tools 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 would 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 of digital technologies, rather than requirements, would be a better approach so that APMs can tailor their solutions based on their needs and patients.

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. Upfront incentives (i.e., pre-paid shared savings and capitation options) have enabled providers to make more timely investments in technology. **Accordingly, CMS must consider an incentive framework within the broader context of the financial challenges facing ACOs to ensure ACOs can sustain continued investments in health technology. For example, the expiration of the Advanced APM incentives, combined with pressures from the benchmark ratchet, will make it increasingly difficult for ACOs to support these investments. We urge CMS to work with stakeholders to address these underlying financial challenges.** Potential opportunities to incent adoption include higher shared savings percentages for ACOs demonstrating effective digital tool implementation or bonus payments tied to patient engagement metrics via digital platforms.

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 and care teams so that they receive information that is most relevant for clinical decision-making.
- *Need for upfront incentive framework:* Upfront incentives (i.e., pre-paid shared savings and capitation options) have enabled providers to make more timely investments in technology.

The Administration should also 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. Finally, CMS and ASTP/ONC should ensure that vendors do not place undue costs on providers. For example, vendors should be prohibited from charging for producing files that are

required for quality reporting and tracking, such as QRDA files, a standard document format for the exchange of electronic clinical quality measure (eCQM) data between provider practices and CMS. These should not come at an additional cost to ACOs.

Question #5: How can patients be empowered to:

a) **Better understand the health care data they can access through tools such as patient portals (e.g., to make data meaningful and actionable).**
b) **Make better decisions regarding their health?**

Question #6: How can patient outcomes (e.g., quality, patient experience, clinical outcomes, total cost of care) be improved by empowering patients through the use of health data and digital health tools?
Question #7: What are effective approaches for using patient navigators to support patients in managing their health care?

Value-based, person-centered care would be greatly enhanced if providers can leverage data and tools to engage patients in managing their health. This can be achieved with EHRs that are dynamic tools used by patients or other portals/applications that can integrate data into the EHR. Opportunities include:

- Prioritizing user-friendly design in EHRs and other tools, as well as ensuring they are not inundated with medical jargon or uncomprehensible recommendations.
- Embedding personalized insights and tailored recommendations that transform raw data into actionable guidance.
- Embedding resources to support shared decision making, such as explanations of potential outcomes, personalized health coaching, and secure messaging to communicate with care teams.
- Incorporating predictive analytics and remote monitoring to allow for providers to conduct real-time oversight of patient progress

Question #8: What are best practices for encouraging shared decision-making between clinicians and patients?

a) What role can health system level incentives and organizational culture play in influencing shared decision-making?

Best practices for encouraging shared decision-making between clinicians and patients include aligning financial incentives with shared decision-making and developing performance-based metrics to track patient engagement and empowerment. Health system-level incentives and organizational culture can influence shared decision-making in a positive way through the cultivation of a culture that values collaboration and trust. Recognizing and awarding clinicians and care team members who excel in patient engagement alongside the deployment of a shared decision-making model is crucial in the development of baseline expectations.

Patient Empowerment and Chronic Disease Management

- **Question #9: How can providers help to engage patients and promote patient empowerment?**
- **Question #10: What are the most effective approaches for empowering patients with multiple chronic diseases to help improve quality, outcomes, and TCOC?**
- **Question #11: What are effective care delivery models to increase the engagement of patients with chronic conditions?**

- **Question #12: What role can ancillary providers (e.g., nurses, nutritionists, community health workers, pharmacists, behavioral health providers) play in promoting shared decision-making and patient empowerment?**
- **Questions #13: How can patients with chronic diseases be empowered to make healthy choices about nutrition and other factors that affect their health?**
- **Question #14: What kinds of benefit design changes can help to incentivize patient empowerment?**
- **Question #15: How can payment and performance measurement for population based, total cost of care models such as ACOs be designed to incentivize patient empowerment?**

Patient Empowerment

ACOs employ a team-based approach that goes beyond the traditional doctor-patient relationship and include a multidisciplinary set of stakeholders. Ancillary providers (e.g., pharmacist, nutritionist) are an extension of the core medical team and help to create a collaborative care team. This enables trust to be built with the care team and adds support for navigating a complex and burdensome health care ecosystem. Effective models leverage digital support tools, including patient apps or portals, to actively manage their condition through tracking of health data and real-time communication with care team members. Approaches include:

- Access to complete health records and test results
- Personalized educational materials for patients and caregivers
- Human-centered design that meets patients where and when they most need support
- Access to digital-forward tools, such as remote monitoring devices
- Telehealth alongside peer support and mentoring groups
- Personalized nutrition and lifestyle coaching to identify strategies that promote healthy behaviors.

Engaging Patients with Chronic Conditions

NAACOS has previously provided comments to the PTAC on Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC). Many of the barriers highlighted are still present today and former recommendations are more important now than ever. Patients with complex chronic conditions or serious illnesses have some of the highest health care costs and some of the greatest opportunities to benefit from the care coordination and wraparound services that value-based care can provide. However, program policies are often not designed with these populations in mind, making it difficult for them to be attributed to and benefit from these models. Similarly, this makes it challenging for health care provider organizations that predominantly serve complex and high-needs patients to participate and succeed in value models. For example, program elements of the MSSP have been designed based on the traditional Medicare population writ large. When organizations serving a high proportion of patients with complex chronic conditions or serious illnesses participate, challenges with financial benchmarks, attribution methodologies, and performance measurement arise.

Complex and seriously ill populations are significantly different than the average traditional Medicare population. Attempting to fit these high-needs populations into APMs designed for standard populations will always fall short of accounting for their unique needs and circumstances. Due to this, these beneficiaries have historically had limited participation in APMs.

Lessons from organizations serving complex or seriously ill populations in the High Needs Track of ACO REACH and in the MSSP can help inform future model design appropriately tailored to these populations. Future APM design should enable and incentivize participation of organizations providing care to these populations by appropriately accounting for these considerations. Services that can be made available for patients include personalized nutrition and lifestyle coaching to identify strategies that promote healthy behaviors, access to remote monitoring tools to track key health metrics, and partnerships with community-based organizations to address SDOH.

NAACOS recommends the following considerations for the development of effective TCOC model design to further engage patients and promote patient empowerment:

- Design alternative program policies to account for high-cost, high-needs beneficiaries who are significantly different from the average traditional Medicare beneficiary.
- Ensure participation criteria do not exclude high-needs beneficiaries from benefitting from value-based care models.
- Account for the care settings and care delivery models through which these populations are often receiving care in attribution models.
- Design financial methodologies specifically for these populations to ensure sustainability and predictability for the participating organizations that serve them.

Evaluating patient experience

NAACOS supports efforts to advance performance measurement for population-based total cost of care models to incentivize patient empowerment. Survey measurements to capture patient experiences are a vital tool ACOs can maximize to meet their needs for improvement efforts in a timely and actionably way. We caution against the use of certain web-based tools, such as the CAHPS for MIPS survey, to evaluate patient experience of care provided by ACOs. The timing of surveys results in patients conflating experiences with various providers and having difficulty recalling experiences that took place months ago. The survey itself has not been updated and the questions included are confusing, leading, and can be misinterpreted. Overall, many ACOs report that CAHPS performance does not correlate with whether the patient would recommend the provider or provider group to friends and family. Instead, many ACOs are using their own internal surveys that have a much larger sample size and are more meaningful to patients and providers, using the survey data for improvement purposes.

Question #16: How can providers be incentivized to promote patient empowerment (e.g., through the use of digital tools, patient education)?

Educated patients are empowered patients and providers should seek to encourage that behavior. Beyond achieving intended care goals, there are opportunities to create incentives by incorporating patient empowerment metrics into value-based care payment models, offering financial and non-financial rewards for effective use of digital tools, or implementing pay-for-performance programs tied to patient satisfaction/activation measures.

Question #17: How can patients be incentivized to participate in value-based care?

One of the largest challenges in advancing accountable care is the limited awareness patients and their caregivers have around value-based care models and the benefits it holds for improved care coordination. Effectively communicating these benefits is one strategy providers can implement to better engage patients in their care. NAACOS would like to elevate previously published guidance, co-

developed with the Health Care Transformation Taskforce, on the effective methods to engage people in governance, care planning, and care delivery redesign, primarily in accountable care organizations (ACOs).

Key challenges for beneficiary communications and education include limited the knowledge beneficiaries have about what an ACO is and misconceptions about terms like "accountable care" and "value-based care." CMS regulatory requirements and definitions for "marketing materials and activities" cause ACOs to be more cautious about developing content that could fall under the definition. Additionally, beneficiaries have reported that CMS template-language is confusing and they note that templates are not provided in multiple languages.

Effective utilization of voluntary patient alignment is another challenge. Not all beneficiaries are aware of the importance of having a primary care relationship and many care engagement and delivery tools were not developed in collaboration with patients. Operationally, CMS' factsheet for beneficiaries on how to choose a primary clinician may be misleading. When an individual clinician leaves a particular practice location, the beneficiaries that follow the clinician to a new location will still align to the previous practice location. This results in beneficiaries being attributed to ACOs they are no longer receiving care through, or not being attributed to an ACO provider from which they are receiving primary care services, because voluntary alignment takes precedence over claims-based alignment. Other challenges include varying applications of Medicare fee-for-service requirement waivers across accountable care models.

Additional challenges for beneficiary participation and input in ACO governance include beneficiaries' lack of time, expertise, and background knowledge of health care payment structures and operations necessary for full engagement in board discussions.

Recommendations to better improve beneficiary engagement across all aspects of an ACO include:

1. **Beneficiary communications must be tailored to different patient populations. Current regulations require a one-size-fits-all approach which limits educational and engagement potential to specific audiences.** CMS should transition to approaches that empower ACOs to tailor the timing and information communicated to beneficiaries. As with other programs, CMS could set broader parameters for beneficiary communications and timelines and allow ACOs to customize their approaches. For example, beneficiaries are best served when communicated with in their primary language to build trust and foster a fuller understanding of what is being communicated to them.
2. **ACOs and other APMs can be improved with enhanced beneficiary engagement tools.** ACOs offer freedom from regulatory burden by waiving certain Medicare FFS requirements. Many waivers tested offer a direct benefit to the patient, such as waiving cost-sharing for certain services or allowing a beneficiary to be directly discharged to a skilled nursing facility (SNF) without meeting the minimum nights of a hospital stay. These benefits facilitate improved engagement for patients with the health care they seek. However, waivers are inconsistently applied across the various ACO models. CMS should work to expand and align waivers that provide direct benefits to beneficiaries and support ACOs with understanding parameters for meeting beneficiary-related requirements.
3. **Meaningful input from patients, family caregivers, and communities is critical to the success of accountable care models.** Effective two-way communication promotes person-centeredness and can advance population health goals. CMS should ensure ACOs and other APM participants have adequate guidance to solicit beneficiary input and feedback, establish community

partnerships, and incorporate these perspectives into their work. The focus should be on co-creation of care delivery models where the patient voice is considered and acted upon throughout the care continuum.

Conclusion

Thank you for the opportunity to provide feedback on leveraging data and technology to empower patients. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.