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Advancing Health in America

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June 16, 2025

The Honorable Thomas Keane, M.D.
Assistant Secretary for Technology Policy
National Coordinator for Health Information Technology
Department of Health and Human Services
Attention: CMS-0042-NC
P.O. Box 8013
Baltimore, MD 21244-8013

The Honorable Stephanie Carlton
Deputy Administrator and Chief of Staff
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0042-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted Electronically

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

Dear Assistant Secretary Keane and Deputy Administrator Carlton,

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comment on the Centers for Medicare & Medicaid Services (CMS) and Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) Request for Information (RFI) regarding the Health Technology Ecosystem.

We support the agencies' goals of reducing barriers for data interoperability and fostering innovation to support better health outcomes. The AHA recognizes the pivotal role that health technology plays in care delivery today and its potential to transform the patient and provider experience in the future. From artificial intelligence (AI) to mobile apps, medical devices to electronic health records (EHRs) — technology supports

improvements in quality and efficiency for patients, caregivers and providers. Moreover, we believe that technology and data interoperability have the potential to address some of the prevalent challenges confronting the health care ecosystem today, including provider burnout and staffing shortages driven by administrative burdens. We also recognize that the innovative applications of health information technology (IT) must be balanced with reasonable guardrails to protect sensitive patient data and ensure security and privacy. In addition, while health technology can make care more efficient, implementing new tools and standards often requires significant financial investment and workflow changes for health care providers. This makes it critical for policymakers to ensure that policy changes intended to spur adoption are scoped and paced sustainably.

The AHA has several recommendations to improve health IT standards and infrastructure, increase beneficiary access to effective digital health tools, and advance data availability to improve health outcomes. Specifically, we recommend that CMS and ASTP/ONC:

- Foster a sustainable pace of standards implementation by continuing to develop ASTP/ONC's United States Core Data for Interoperability vocabulary standards (USCDI), and extending the timeline to transition from USCDI version 3 to USCDI version 4 by an additional year (through calendar year (CY) 2028).
- Collaborate across agencies to address broader infrastructure challenges associated with health IT adoption, such as lack of broadband, digital literacy training and reliable Wi-Fi access for rural and underserved communities.
- Support reimbursement for the use of health technology by clarifying guidance on digital health and interprofessional consultation billing codes, and develop pathways to provide provisional payment for new technologies.
- Promote accountability and engagement from payers on interoperability by requiring that impacted payers adopt and use certified payer application programming interfaces (APIs) and developing safety and security requirements for the Provider Directory APIs.
- Repeal provider disincentives in the June 2024 final rule "21st Century Cures Act: Establishment of Disincentives for Healthcare Providers That Have Committed Information Blocking." Under the final rule, hospitals and providers found to engage in information blocking may face excessive reductions in payment, which threatens access to services (particularly in rural and underserved areas).
- Build additional infrastructure to provide oversight for Trusted Exchange Framework and Common Agreement (TEFCA), including establishing an attestation schedule for all qualified health information networks (QHINs)
- Provide protections to ensure hospitals or health systems that have a QHIN that is suspended or terminated are not held liable for information blocking claims.

- Advance administrative simplification efforts by establishing a standard transaction for clinical attachments to support claims.
- Streamline current price transparency policies to remove complexity from the patient experience by focusing on options for patient estimates and other pricing information. Rely on No Surprises Act good faith estimates (GFEs) and advanced explanation of benefits (AEOBs) to provide patients with the most accurate estimates for their courses of care.
- Provide incentives for technology investment to enable providers to transition to value-based arrangements.
- Revert to previous thresholds (i.e., percentage threshold for the number of clinicians meeting certified electronic health record requirements) for the Medicare Shared Savings Program promoting interoperability measures.

There are other areas relevant to the health technology ecosystem that were not directly addressed in the RFI, including cybersecurity. We included several health IT and cybersecurity-focused recommendations in our recent response to the Office of Management and Budget's RFI on deregulation, including modifying the HIPAA cybersecurity rule of December 2024 to make the requirements voluntary.[1]

Our detailed comments are attached. We look forward to the opportunity to work with CMS, ASTP/ONC and the Department of Health and Human Services (HHS) to help realize technology's full potential for improving health outcomes, fully engaging patients in managing their health and reducing administrative burden. Please contact me if you have questions, or feel free to have a member of your team contact Jennifer Holloman, AHA director of health IT policy, at jholloman@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

[1] https://www.aha.org/system/files/media/file/2025/05/aha-response-to-omb-deregulation-rfi-letter-5-12-2025.pdf

HEALTH TECHNOLOGY ECOSYSTEM
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DATA ACCESS AND INTEGRATION

United States Core Data for Interoperability Version 4

The United States Core Data for Interoperability (USCDI) was first established in 2020 to replace the Common Clinical Data Set (CCDS). USCDI establishes standardized classes and elements of data to provide consistent health information exchange across the various parties that engage in a patient's health care journey. It also supports quality measurement reporting since it provides standardized data elements across care settings. It has been updated multiple times to integrate new data elements.

The AHA is supportive of standardizing data classes and elements through USCDI. Standardized data can help ensure that patients and providers have consistent, comprehensive information across settings. While we support the standardization of data, we do have recommendations pertaining to USCDI v4 standards.

First, as we commented previously, we encourage ASTP to continue building out vocabulary standards for all USCDI v4 elements in instances where they are missing or limited.[2] Vocabulary standards provide the baseline definitions and units of measure for data elements, and as such are foundational building blocks for interoperability. This ensures that providers are communicating in the same manner when exchanging relevant health data and tracking longitudinally over time. For example, for body weight, USCDI v4 vocabulary standards include use of Logical Observation Identifiers Names and Codes (LOINC®) version 2.67 and the unit of measure is the Unified Code of Units for Measure (UCUM), Revision 2.1. Continuing to expand vocabulary standards across elements will ensure that the USCDI continues to evolve from a collection of narrow data points into a more holistic and complete picture of the patient's health.

Second, we remain concerned with the aggressive timeline for transitioning to USCDI v4 requirements. In the Health, Technology and Interoperability (HTI-2) rule last year, the agencies proposed that USCDI v3 will expire by Dec. 31, 2027. However, many organizations are still working to meet requirements for USCDI v3. Indeed, based on HTI-1, USCDI v3 will be required beginning Jan. 1, 2026. That only leaves one year to transition to the next version. We are particularly concerned that this may put smaller hospitals at risk for noncompliance given that some of the technology vendors supporting these organizations have been challenged to keep up with USCDI updates. **We request that ASTP extend the expiration date of USCDI v3 for an additional year (through CY 2028), and continue to monitor progress on readiness for transition.**

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[2] https://www.aha.org/2024-10-04-aha-comment-letter-hhs-hti-2-interoperability-proposed-rule

PROVIDERS

Digital Health Apps

The RFI requests feedback on barriers or obstacles for providers in leveraging digital health products (particularly those providers in rural areas).

One barrier to expanding digital health products to rural and underserved populations has been a lack of access to enabling technologies (like broadband, reliable Wi-Fi or smartphones), as well as education to support digital literacy. Indeed, the Federal Communications Commission (FCC) reports that over 22% of Americans in rural areas lack access to appropriate broadband (fixed terrestrial 25/3 Mbps) compared to 1.5% of urban areas.[3] Furthermore, according to a recent report from the Assistant Secretary for Planning and Evaluation (ASPE), over 26% of Medicare beneficiaries reported not having computer or smartphone access at home.[4] These data points suggest that investment in foundational infrastructure and educational resources may increase patients' access to telehealth and digital health applications. **We encourage cross-agency collaboration to develop training and potential grant funding opportunities to support patient educational efforts on digital health tools. This could include coordination across agencies like HHS, the FCC, the Department of Commerce, the Department of Agriculture and the Department of Education.**

Other barriers to the adoption of digital health tools include insufficient payment. We have supported the establishment of new billing codes for digital treatment, including the digital mental health treatment (DMHT) codes and interprofessional consultation codes that were finalized as part of the CY 2025 Physician Fee Schedule, as well as the historical remote physiological monitoring codes. However, **we continue to urge the agencies to provide clarifying guidance and technical assistance for these codes.**

For example, in the CY 2025 Physician Fee Schedule, CMS designated DMHT technologies as software devices requiring Food and Drug Administration (FDA) certification. CMS finalized that devices "must be cleared under 510(k) or granted De Novo authorization by the FDA and in each case must be classified under 21 CFR 882.5801 for mental or behavioral health treatment." This narrow definition may limit the types of devices available and deviate from standards for Remote Therapeutic Monitoring (RTM) services, which only require that a device meet the definition of an FDA device. We urge CMS to provide clarifying guidance on the definition.

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[3] https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2020-broadband-deployment-report
[4] https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf

Other examples of billing codes requiring clarification can be found in the remote patient monitoring codes. In prior rulemaking, CMS established a set of codes for Remote Physiologic Monitoring (RPM) and RTM services. In CY 2021, CMS established that following the end of the COVID-19 public health emergency, RPM services may only be furnished to established patients. As such, in CY 2024, CMS returned to the CY 2021 guidance and pre-COVID-19 pandemic rules to require that RPM and RTM services only be administered to established patients. We disagree that RPM and RTM services should be limited to just established patients. RPM and RTM have been critical capabilities to safely discharge patients with chronic conditions from the hospital, transition patients to better self-manage conditions and reduce readmissions. During the COVID-19 pandemic, the flexibility to provide these services to both new and established patients meant that patients were able to start monitoring services earlier (in many cases enrolling prior to discharge), which provided critical support in the immediate timeframe after discharge. There is concern that requiring an established relationship will create a barrier for patients to access services in a timely manner. Furthermore, there is precedent within evaluation and management (E/M) coding structure for new vs. established relationships (E/M codes are separated based on new vs. established). **As such, we urge CMS to reinstate flexibilities to allow for both new and established patients to access RPM and RTM services.**

Finally, we encourage CMS to develop pathways for billing of new non-face-to-face provider services that are facilitated by technology. CMS has already permanently adopted, on a case-by-case basis, certain non-face-to-face codes for remote physiological monitoring, remote therapeutic monitoring, AI, e-visits and virtual check-ins. As technology advances, applications of digital care delivery will expand. For telehealth services, CMS created two categories: one for permanent telehealth-eligible codes (approved permanently) and another for provisional codes, which allow for billing of certain services while the agency completes evaluation of feasibility for permanent adoption. We would encourage the agency to create a similar status for other non-face-to-face provider services to foster incentives for technology adoption while the agency reviews these applications for permanent adoption.

Data Exchange — Prior Authorization API

The AHA commends the agencies for seeking input on the development and use of the Prior Authorization API as well as on effective certification criteria and standards under the ONC Health IT Certification Program. The Prior Authorization API required in the Interoperability and Prior Authorization final rule (CMS-0057-F) will remove barriers to patient care by streamlining the prior authorization process. With the final rule, CMS addressed a practice that too often leads to dangerous delays in patient treatment and clinician burnout in the health care system.

The Interoperability and Prior Authorization final rule requires the creation of Fast Healthcare Interoperability Resource (FHIR)-based APIs to facilitate the exchange of

information necessary to streamline prior authorization processes directly from a provider's EHR system. The AHA has long advocated for the creation of electronic prior authorization standards that integrate with provider clinical information systems to eliminate time spent transposing clinical data from one system to another. We continue to strongly support an end-to-end automated prior authorization process that integrates with clinicians' EHR workflow.

However, realizing the goal of automated prior authorization and interoperability requires many health information technology (HIT) products and module systems to function as an integrated whole, including some products not under ONC certification. These include practice management systems and systems operated by entities not directly under CMS authority, such as clearinghouses and intermediaries. Additionally, variance in API usage and FHIR transaction implementation specifics could require significantly more vendor services to navigate, which would increase provider costs, thus undermining savings and process improvements. Streamlining API usage would allow providers to access and share prior authorization data with payers more efficiently, thereby reducing the burden and enhancing patient care.

To date, the Prior Authorization API requirements have not been finalized as part of health IT certification. This inaction creates concern that providers will be required to comply with a CMS requirement without certainty that, in turn, their EHRs will support the electronic prior authorization transaction. In its HTI-2 proposed rule, ASTP/ONC proposed to establish HIT certification criteria that align with the CMS API requirements and recommendations in the Interoperability and Prior Authorization final rule. **We strongly support this proposal, which would ensure that the APIs developed to meet the CMS regulation adhere to relevant interoperability standards and support effective information sharing.** Importantly, ASTP/ONC proposed to update certification criteria and standards to require vendors to facilitate electronic prior authorization using certified HIT. Specifically, ASTP/ONC proposed adopting two "Prior Authorization APIs" certification criteria, which specify requirements for certified HIT that providers and payers can leverage to conduct electronic prior authorization. We reiterate our support for adding these API requirements into the base EHR criteria.

As noted, for providers to realize the benefits of electronic prior authorization, their EHR developers must provide and support this technology as part of their base product offering. However, for each end of the electronic prior authorization exchange to function properly and for provider and payer systems to successfully interplay, payer APIs must be able to connect with the EHR APIs used by providers. Without bridging the gap between provider and payer systems, providers cannot be certain that their EHRs will communicate successfully with payer systems in a standardized, efficient

manner. **Accordingly, the AHA urges that ASTP/ONC and CMS collaborate to require that impacted payers adopt and use certified payer APIs**.[5]

Data Exchange — Provider Access API

The AHA appreciates the agencies' commitment to promoting the seamless and secure flow of health information between payers, providers and patients. **As such, the AHA supports the Provider Access API, a FHIR-based platform that allows a provider to access patients' claims and encounter data, clinical data maintained by the plan, and information on pending and active prior authorization decisions. We strongly support CMS' efforts to increase provider access to data held by payers.** Providers benefit from increased data exchange with payers, since payers often have information about preventative care and other services furnished by other providers. Access to this information can help providers better manage a patient's care, enable more informed decision making and potentially prevent the ordering or provision of duplicative services.

In its HTI-2 proposed rule, ASTP/ONC proposed the addition of criteria to the base EHR definition to include a Provider Access API. The AHA supports ASTP/ONC adding new API requirements. We see the Provider Access API as a vehicle to allow impacted payers to build upon their existing systems and processes to enhance access to patient data, while continuing to protect patient privacy and data security.

Data Exchange — Patient Access API

The AHA has consistently supported the Patient Access API, and we commend CMS' action in the Interoperability and Prior Authorization final rule to expand the information in the patient access API to include information about a patient's pending, active, denied and expired prior authorization decisions. We agree that increasing the transparency surrounding the prior authorization process is beneficial for patients, as these utilization management policies frequently have a significant impact on their care. The AHA supports patients utilizing the Patient Access API to access supporting documentation for a specific prior authorization request so they can gain visibility into what the payer is evaluating and better understand the payer's clinical criteria.

We strongly agree with CMS that one of the most important aspects of making health data accessible to patients is to protect the privacy and security of patient health information. This is particularly important once a patient's data is received by a third-party application administered by a non-covered entity under the Health Insurance Portability and Accountability Act (HIPAA). We applaud CMS' commitment to ensuring

[5] https://www.aha.org/2024-10-04-aha-comment-letter-hhs-hti-2-interoperability-proposed-rule

that patient privacy and security are protected, and we encourage CMS to continue exploring ways to promote interoperability while protecting patient privacy.

Furthermore, we support the agencies' ongoing efforts to educate patients about the potential benefits and risks of accessing their health information via APIs using third-party applications that often do not have the same privacy obligations as HIPAA-regulated entities. We encourage the agencies to collaboratively identify the best ways to communicate privacy policies and practices deployed by third-party health apps. It is critical that patients understand in plain language the ways in which data protections may change as their data moves from HIPAA-regulated entities, such as their providers and payers, to third-party apps.

Data Exchange — Provider Directory API

The AHA shares the agencies' goals of improving patient access to provider information and facilitating health information exchange and data reporting. **In particular, we are supportive of the Provider Directory API that allows patients to discover in-network providers with the most accurate and up-to-date lists. However, we have several concerns relating to operationalizing the Provider Directory API.** For example, some Provider Directory APIs do not fully and accurately represent plan details and networks. For these APIs to be useful to patients, they must be reliable.

Moreover, the AHA urges ONC/ASTP and CMS to ensure that the Provider Directory API replaces other existing provider information data sets. Steps must be taken to ensure that the Provider Directory API does not simply become an additional data source available to patients without sufficiently addressing how or why it differs from the myriad provider directories already in existence, and to ensure that it does not complicate patients' abilities to access accurate information. Further, **work on provider directories must reduce — not contribute to — provider reporting burden and ensure adequate testing and standardization of health information and data transmission**. Finally, we encourage ONC/ASTP and CMS to collaborate to ensure that there are clear safety and security requirements in place for the Provider Directory API.

Digital Identity

As mentioned previously, the AHA supports reasonable guardrails to ensure the safe exchange of sensitive health data and the privacy of patients. One key component of this is digital identity verification to ensure that patients, providers, caregivers and other stakeholders are, in fact, who they claim to be when requesting or sending sensitive health information. **We support the establishment of reasonable, flexible standards for digital identity credentials. We look forward to working with the agencies on potential solutions.**

Information Blocking

The AHA has long supported transparency of critical health data for patients and the clinicians treating them. Timely access to data can help patients make more informed decisions about their health. However, we are concerned about certain aspects of information blocking policies. **As we cited in our recent response to the Office of Management and Budget's deregulation RFI, we request that ASTP repeal the provider disincentives in the June 2024 final rule "21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking" (RIN 0955-AA05).**[6]

The 2024 rule establishing disincentives for providers found to have committed information blocking is excessive, confusing and imbalanced. Under the final rule, hospitals and providers found to engage in information blocking may face reductions in Medicare payment updates, adjustments to reimbursement rates, lower performance scores and potential ineligibility for certain incentive programs. Specifically, hospitals under the Medicare Promoting Interoperability Program found to have committed information blocking would experience a reduction of the market basket update by 75%. Critical access hospitals (CAHs) would see a reduction from 101% to 100% of reasonable costs, while clinicians in Medicare's Merit-based Incentive Payment System would receive a score of zero in the MIPS Promoting Interoperability performance category. Providers in accountable care organizations (ACOs) that commit information blocking would be ineligible to participate in the Medicare Shared Savings program for at least one year and may not receive revenue they may have earned through the program.

The disincentive structure in this rule is excessive, so much so that it may threaten the financial viability of economically fragile hospitals, including many small and rural hospitals. In addition, the processes by which the Office of the Inspector General will determine if information blocking has occurred are unclear, including the appeals process, giving this rule the appearance of being arbitrary and capricious. **We therefore urge the agencies to repeal these disincentives.**

Trusted Exchange Framework and Common Agreement (TEFCA)

The AHA has supported the objective of TEFCA to create a common national framework that provides a universal technical foundation for interoperability. The establishment of such a framework has the potential to provide the connective tissue for providers, patients, payers and public health agencies to share information securely across health information networks. While we are encouraged by the potential for

[6] https://www.aha.org/lettercomment/2025-05-12-aha-response-omb-deregulation-rfi

TEFCA to support the transferability of data, there are gaps in the current framework. We have several recommended changes to address these gaps.

For example, the AHA remains concerned that there are no detailed specifications related to suspension and termination processes for QHINs. While there is a process to terminate QHINs from TEFCA for cause, it's unclear what happens to the hospitals and health systems that relied on that QHIN once it is terminated. We ask that CMS provide clarification on the rights and obligations of hospitals or health systems that are using a QHIN that gets suspended or terminated from TEFCA. **Specifically, we ask that the agencies provide appropriate protections to ensure that hospitals and health systems that have a QHIN that is suspended or terminated not be held liable for information blocking claims.**

Another example of gaps in the current framework is related to the governance structure of TEFCA, which gives QHINs the primary responsibility for ensuring that their participants abide by TEFCA's requirements. This governance structure runs the risk of quickly exceeding the capabilities of both QHINs and the Recognized Coordinating Entity (the organization responsible for TEFCA's oversight) to effectively manage oversight for TEFCA. And this also limits the scalability of TEFCA. **We recommend that ASTP build additional internal capacity to oversee and ensure adherence to TEFCA's stipulations, including establishing an attestation schedule for all QHINs. ASTP should also publish the "designation" documentation publicly on its website.**

Quality Measure Reporting

The RFI seeks feedback on ways to continue advancing the adoption of FHIR standards to support the reporting of quality measures. The AHA agrees that a digital and interoperable quality measurement enterprise is a laudable long-term goal that could have positive and far-reaching impacts on quality of care and the provider experience. The AHA also sees significant potential in expanding the use of FHIR, as this standard is more flexible than many other available frameworks. At the same time, transitioning to only FHIR-based digital quality measures (dQMs) in federal programs will prove to be a staggeringly complex task.

As CMS and ASTP/ONC continue their digital quality measurement work, the AHA offers several overarching recommendations. **First, while FHIR-based reporting holds promise, the overarching goal for its quality measurement programs should remain as measuring the highest priority opportunities to improve care.** In other words, the pursuit of adopting particular reporting standards should not come at the expense of ensuring the measures are a meaningful reflection of quality and providing usable information to hospitals to improve care.

Second, we urge the agencies not to set arbitrary dates for standards adoption. As CMS and ASTP/ONC have previously articulated, dQMs could integrate data from a wide range of sources, including hospital administrative systems, clinical assessment data, case management systems, EHRs, instruments (e.g., wearable medical devices), patient portals, health information exchanges (HIEs) and registries, and "other sources." Hospitals do not manage some of these sources themselves; yet, their performance on a dQM could be linked to such data. We are concerned that the accuracy and reliability of dQMs could be compromised by poor data quality from outside sources. For this reason, the pace of conversion should be based on the results of field testing and feasibility studies rather than an arbitrary deadline.

Lastly, the AHA encourages the agencies to advance efforts to align digital quality measurement across the public and private sectors. Hospitals have long aspired to an approach to quality measurement that enables them to report data only once and have it used for multiple purposes. Unfortunately, hospitals have long faced discordant reporting requirements among Federal, state and private sector quality reporting and value programs. Even when the measure topics are the same, often there are differences in measure design across programs that result in the need for duplicative data collection, excess costs and confusion. As CMS and ASTP/ONC advances a plan for dQMs, we encourage the agencies to prioritize the development of dQMs that are usable across the public and private sectors.

PAYERS

Establishing a Claims Attachment Standard

The AHA urges the administration to establish a standard transaction for clinical attachments to support claims, the lack of which has been a significant source of administrative complexity and burden for hospitals and other providers. Specifically, the AHA is largely supportive of the proposal to standardize claims attachments under HIPAA.

Since the initial creation of the HIPAA administrative simplification standards, Congress and HHS have recognized the need for standardized attachments to reduce industry burden associated with sharing clinical information needed to process claims. This standardization remains of critical importance for providers and their patients, given the increasingly complex benefit structures of health plans that progressively require substantial information to supplement claims for adjudication. Too frequently today, provider payments are often delayed by weeks or months as plans request and providers submit additional information necessary for adjudication in nonstandard ways. Creating a consistent method for a plan to request the specific documentation necessary to "clean" a claim would exponentially reduce these processes, thereby enabling plans to issue payments to providers much sooner. This would not only help alleviate some financial stress by improving time to payment, but also would prevent

delayed bills from surprising patients when receiving their cost-sharing amount after insurance payment is complete.

In December 2022, CMS released a notice of proposed rulemaking recommending standardization using the X12N 275—Additional Information to Support a Health Care Claim or Encounter Version and X12N 277—Health Care Claim Request for Additional Information to facilitate the request for and attachment of claims information. Since this time, additional methods, such as HL7 FHIR APIs, have been identified as potential mechanisms to standardize this interchange. The AHA does not endorse a specific method, but rather supports that the standard utilized is available and applied consistently across all their payer partners, which should eliminate the inefficiencies caused by plan-specific attachment requirements. Furthermore, we urge the administration not to delay the establishment of a standard as a result of additional emerging methodology, as the need for this transaction is long overdue. Instead, we encourage the administration to ensure that new technologies can be adequately incorporated as they are properly developed and shown to offer increased efficiencies.

TECHNOLOGY VENDORS/DATA PROVIDERS/NETWORKS

Price Transparency

The AHA appreciates the agencies' focus on improving the price transparency policies to make them most valuable to patients and other health care stakeholders. Hospitals and health systems are dedicated to improving price transparency for patients. We remain concerned, however, that the numerous and sometimes conflicting requirements at both the state and federal levels create an overwhelming landscape of pricing information that not only is challenging for patients to navigate but also adds excessive costs and workforce burden to the health care system.[7,8,9] **We strongly recommend that CMS focus on streamlining current policies to remove complexity from the patient experience by focusing on the options for patient estimates and other pricing information and ensuring those estimates are as accurate as possible.** This will allow the policies to achieve their intended purpose — to help patients understand and compare their expected costs prior to care — while also minimizing duplication and excess burden on the health care system. Our specific recommendations for aligning the policies are as follows:

First, we recommend streamlining the hospital machine-readable file requirements to minimize duplication of effort and the potential for conflicting

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[7] https://www.aha.org/fact-sheets/2023-02-24-fact-sheet-hospital-price-transparency
[8] https://www.aha.org/system/files/media/file/2023/09/aha-comments-on-cms-outpatient-and-ambulatory-surgery-prospective-payment-system-proposed-rule-for-cy-2024-letter-9-8-23.pdf
[9] https://www.aha.org/system/files/media/file/2021/03/aha-comments-on-no-surprises-act-price-transparency-provisions-letter-3-16-21.pdf

information, while preserving public access to negotiated rates. Specifically, we recommend that CMS maintain the requirement that insurers post all negotiated rates with providers while allowing hospitals to focus solely on chargemaster rates and cash prices. In doing so, consumers, third-party vendors, researchers and other interested parties would retain access to negotiated rate information while the risk of potentially conflicting information would be reduced. This also would eliminate duplication of effort and therefore reduce unnecessary costs and burden in the health care system.

Second, we recommend relying on the No Surprises Act GFE and AEOB requirements to provide patients with the most accurate estimates for their course of care. We believe that once fully implemented, the No Surprises Act GFE and AEOB policies will have the greatest impact on patients. These estimates will be tailored to the patients' unique characteristics and expected care pathways and, in the case of insured patients, take into account their health care coverage, including where they are in their deductible. In addition, patients will automatically receive these estimates as part of their pre-care paperwork without additional effort on their part. We are deeply engaged with CMS and other stakeholders in workgroups to ensure that the insured GFEs and AEOBs will be implemented in a way that will create meaningful estimates in an efficient manner, and we look forward to continuing this work with the new administration.

There are, however, still several issues that are slowing down the process, including determining which entity is responsible for collecting and collating estimates from various providers involved in a patient's episode of care. The AHA strongly encourages CMS to require each provider to submit its own preservice estimate to the insurer, which would collate them and apply its coverage rules to generate the AEOB, consistent with how the post-service claim explanation of benefit (EOB) process works today.

The AEOB process is intended to essentially provide patients with an EOB in advance of care. AEOBs, like EOBs, are not simply a compilation of claims from unique providers. They are the result of the insurer processing the individual claims and applying its coverage rules, including considering where the individual is within their deductible and maximum out-of-pocket cost limits. These coverage rules — such as whether the insurer bundles some set of services into a single reimbursement or even covers certain items in a given circumstance — are all elements that must be known to generate the AEOB. Insurance companies already have the workflows and technology to not only collect and collate claims from different providers but also to apply their coverage rules and adjustments.

As we previously expressed jointly with the American Medical Association and Medical Group Management Association, the alternative of requiring a single convening provider for AEOBs would create enormous administrative burdens for providers, utilize a process that diverges from the claims process used to create patient bills, and could

potentially lead to delays in care.[10] To ensure that the estimates are most reflective of a patient's final bill and do not create unnecessary burdens on the care delivery process, the AHA urges CMS not to require a single provider to compile preservice estimates before they are sent to the insurer.

Finally, we recommend CMS only require GFEs and AEOBs for scheduled services, while relying on the shoppable service/price estimator requirements of the Hospital Price Transparency and Transparency in Coverage rules to provide preservice information to shopping patients. Generating GFEs and AEOBs is labor- and time-intensive and their usability is often dependent on clinical information and other personal information that is not known for nonscheduled patients. Therefore, we recommend the agency consider applying these requirements where they will provide the most value and rely on the more scalable shoppable service/price estimator tool requirements to meet the needs of patients who are evaluating different options (i.e., shopping).

In addition, we recommend that CMS engage with Congress to preserve hospitals' abilities to meet the shoppable service requirement with a price estimator tool. These tools are currently the best mechanism for patients to access price estimates. Changing this policy would move the field in the wrong direction, requiring patients to navigate machine-readable files that can be confusing and cumbersome.

VALUE-BASED CARE

HIT and digital health tools are vital for the implementation of value-based care models, including those implemented by the Center for Medicare and Medicaid Innovation (CMMI). From patient-facing technologies (like remote monitoring equipment) to provider tools to capture and track quality measure performance, health IT is critical to hospitals and health systems being successful in these types of models. At the same time, these tools require significant time and resources to implement. Oftentimes, the cost and complexity of technology can be a rate-limiting step for many hospitals seeking to make the transition to value-based models. To ensure that technology is an enabler rather than a barrier to value-based care, the AHA makes the following recommendations:

Aligning Incentives

As mentioned above, hospitals and health systems are critical stakeholders in the journey to value. However, specific policies have hampered their ability to participate in

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[10] https://www.aha.org/lettercomment/2022-09-27-cms-urged-not-create-advanced-explanation-benefits-burdens

certain models. For example, CMS has used captured revenue to distinguish ACOs as "low-revenue" or "high-revenue," and by proxy, to identify ACOs as either physician-led (low-revenue) or hospital-led (high-revenue). The agency has then limited participation in certain alternative payment models (APMs) or qualification for advanced investment payments (AIPs) to only physician-led or low-revenue ACOs. The advanced investment payments provide needed resources for organizations to build health IT infrastructure to support outcomes tracking, patient digital health tools, and quality reporting requirements. The arbitrary threshold for qualification for advanced investment payments means that many hospitals, including rural and CAHs, are not able to receive the necessary resources to invest in these models. **We urge the removal of problematic high/low revenue thresholds that preclude rural and CAHs from obtaining necessary resources for infrastructure investment.**

The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was also intended to support the transition to value-based care. MACRA provided advanced incentive payments (5%) for providers participating in advanced APMs through 2024. These payments were designed to assist with the provision of non-fee-for-service programs, including digital tools and care coordinators. However, MACRA statute only provided the advanced APM bonuses through the CY 2024 payment period. Because participation in the advanced APM program has fallen short of initial projections, spending on advanced APM bonuses has fallen well short of the amount the Congressional Budget Office projected when MACRA was originally scored. Repurposing the spending shortfall for APM bonuses in future years will serve to accelerate our shared goal of increasing APM adoption. **We urge the agencies to work with Congress to extend APM incentive payments, which have helped support technology investment costs.**

Promoting Interoperability

Historically, the Medicare Shared Savings Program (MSSP) policy required ACOs participating in the MSSP BASIC track levels A through D to certify annually that at least half of their eligible clinicians used certified EHR technology to document and communicate clinical care to patients or other health providers. ACOs participating in the BASIC track level E or the ENHANCED track were required to meet a higher threshold of 75% of eligible clinicians using certified EHR technology. However, in the CY 2024 PFS final rule, CMS adopted a policy requiring all clinicians in an ACO to use certified EHR technology that meets either the 2015 Edition base EHR definition or any subsequent base EHR definition promulgated by ASTP/ONC.

The AHA continues to believe that widespread adoption of certified EHR technology is an important enabler to innovative care approaches. **However, we remain deeply concerned that eliminating the percentage threshold for the number of clinicians meeting certified EHR requirements may inadvertently disqualify too many clinicians from participating in ACOs.** The AHA urges CMS to revert to its prior policy

and focus on advancing policy approaches that can more broadly support the wider clinician adoption of EHRs. For example, the AHA has recommended that CMS consider expanding Safe Harbor protections (i.e., Stark and Anti-Kickback) for hospitals and health systems to extend access to their EHRs to others, including clinicians, who also fill patient care needs in an episode-based payment model.

Streamlining Quality Measures

CMS value-based models usually require hospitals and other providers to report quality measure data to CMS. To meet these requirements, providers rely on technology platforms — e.g., EHRs, administrative systems, clinical registries — to collect measure data and track their performance. Each new reporting requirement requires resources — personnel time, vendor costs for needed upgrades, workflow changes, to name a few. This makes it imperative that CMS strike a balance of value and burden in adopting measures for its programs.

As CMS continues its value-based care, we urge the agency to continue maximizing the use of its existing quality measures and reporting requirements to reduce provider administrative burden and duplicative uses of limited hospital technology resources. For example, in several recent CMMI models, CMS has used the measures, data submission requirements and timeframes from its hospital quality reporting and value programs. While not every existing CMS measure is ideally suited to a value-based care arrangement, making use of existing measures when possible helps hospitals focus less on changing their processes to accommodate new reporting requirements and more on improving outcomes.