

June 16, 2025

Mehmet Oz, MD

Administrator

Centers for Medicare & Medicaid Services

Steven Posnack

Acting Assistant Secretary for Technology Policy, Acting National

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Department of Health and Human Services,

Attention: CMS-0042-NC

P.O. Box 8013,

Baltimore, MD 21244-8013

Submitted Via: <http://www.regulations.gov>

Re: [RIN 0938-AV68; CMS-0042-NC] Request for Information: Health Technology Ecosystem

Dear Dr. Oz,

The Post-Acute and Long-Term Care Medical Association (PALTmed) thanks you for the opportunity to submit comments on this important request for information on Health Technology Ecosystem. PALTmed is the only medical specialty society representing the community of medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PALTC) settings. The Society's members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other settings. We are guided by our vision of empowered clinicians providing optimal health care excellence, and our mission to lead the way in empowering compassionate and skilled clinicians to deliver person-centered care in the post-acute, and long-term care continuum.

Below please find our comments:

C. Providers:

Digital Health Apps

As clinicians working in post-acute and long-term care (PALTC), PALTmed strongly supports the advancement and adoption of interoperable health information technology (health IT), including digital health apps and certified electronic health records (EHRs), to improve patient safety, enhance care coordination, and support better clinical outcomes. These tools are

especially vital in PALTC settings, where patients are often medically complex, transitions of care are frequent, and resources are limited

Today's health care environment is defined by a worsening clinician shortage, particularly in PALTC and rural settings. To maintain continuity of care and reduce avoidable hospitalizations, clinicians must be empowered with digital tools that enable them to manage patients across settings efficiently. Interoperable, user-friendly systems can help offset workforce limitations by reducing administrative burdens, streamlining communication, and ensuring timely access to clinical data.

Rural areas face a dual challenge: workforce shortages and inadequate broadband infrastructure. Many facilities and patients in these communities lack reliable internet access, making it nearly impossible to adopt or benefit from digital health innovations. Without robust connectivity, clinicians cannot access critical EHR systems, engage in telehealth, or exchange information during transitions of care, putting rural patients at significant risk. Addressing broadband and IT infrastructure gaps in these areas is not optional; it is foundational to ensuring equity and access in modern health care delivery for our most high risk and complex patients.

Moreover, **the success of value-based care depends on breaking down silos across the care continuum.** A fragmented approach—where hospitals, outpatient providers, and PALTC settings operate at vastly different stages of digital maturity—undermines care coordination and leads to inefficiencies, duplicative testing, medication errors, and poor patient outcomes. **A whole-system approach is required,** one that brings PALTC into full alignment with broader health IT strategies and national interoperability goals.

PALTmed urges CMS and ONC/ASTP to:

- **Develop and fund targeted initiatives** to ensure PALTC settings have access to certified, interoperable health IT tools;
- **Prioritize broadband expansion** in rural and underserved areas, as a prerequisite for health IT adoption;
- **Support PALTC-specific EHR functionality**, including care planning, medication reconciliation, transitional care management, functional assessment, and caregiver communication;
- **Include PALTC clinicians, leaders and stakeholders** in the development of interoperability standards and policy proposals;
- **Incentivize infrastructure investment** in skilled nursing facilities and other long-term care providers, which were excluded from earlier federal EHR funding programs.

Digital health tools, including the HL7 FHIR (Fast Healthcare Interoperability Resources) Standardized Medication Profile (SMP) and eCare Plan frameworks, must be made practical and

accessible for PALTC clinicians. These tools enable accurate medication reconciliation, proactive care planning, and seamless information exchange, especially critical during care transitions and in emergencies.

To succeed in delivering value-based care, we must **treat the health system as an interconnected whole**, ensuring that **PALTC is equipped with the infrastructure, funding, and policy support** it needs to thrive, not just survive, in the digital era.

PR-2 Obstacles

The adoption of approved digital health products by providers in PALTC settings, especially in rural areas, remains limited due to a number of significant obstacles. Chief among them is the lack of adequate infrastructure: outdated hardware, unreliable internet access, and limited interoperability with facility EHR systems. Staff training deficits, high turnover, and workload pressures further complicate adoption. Many clinicians also face uncertainty around how digital health tools will be reimbursed or integrated into current CMS billing frameworks. In addition, both patients and family caregivers in these settings often have limited digital literacy, which impairs the effectiveness of these tools even when available.

The development and utilization of digital tools that support physician workflows, such as clinical documentation, quality reporting, and billing, are hindered by several structural challenges in PALTC settings. Most EHR systems used in long-term care were not designed with modern interoperability or automation in mind. They often operate in silos and lack integration with hospital systems, labs, or pharmacies, increasing the risk of errors. Furthermore, regulatory requirements in long-term care result in excessive documentation obligations, much of which is performed manually and not easily automated. Very few innovative applications are designed specifically for PALTC workflows, which differ significantly from acute or outpatient care. Limited financial and technical resources in rural or underfunded facilities also slow the deployment of these tools. To mitigate these barriers, CMS could incentivize the development of PALTC-specific digital solutions, support pilot programs, promote FHIR-based interoperability standards, and offer funding to assist facilities in upgrading outdated systems.

When clinicians do utilize digital tools, they have a responsibility to clearly explain to patients the intended use and clinical benefits, data privacy considerations, and the limitations of such tools, especially that they do not replace direct medical evaluation. Patients should be informed of how data will be used and who will have access to it, and providers must offer appropriate instruction and support to ensure the tool is used as intended. Clinicians must also ensure that any recommended app or digital product is evidence-based, HIPAA-compliant, and appropriate for the patient's clinical condition and cognitive capacity.

PR-3. EHR Interoperability in Rural and Urban Areas

Patients in post-acute and long-term care (PALTC) settings frequently arrive when physicians/providers are not on site or during off hours when staffing levels may be critically low. In these moments, frontline clinicians and nurses are required to make quick decisions, often without the benefit of direct handoffs or real-time communication with the discharging hospital. It is therefore essential that the patient information available be **concise, accessible, and clinically actionable**, clearly highlighting the most **recent medication changes, clinical events**, and any **urgent care goals or red flags**. However, what typically occurs is the arrival of **large, disorganized packets of information**, often delivered late and without prioritization, that fail to clarify what happened last, what has changed, and what the goals of care should be moving forward. This lack of clarity at critical junctures leads to confusion, delays in treatment, and suboptimal care decisions.

The ability to access **all relevant patient data within an EHR system—regardless of whether it is structured, free text, scanned, or faxed—is crucial** to ensuring safe, high-quality care across both urban and rural PALTC settings. Clinicians currently face major challenges in retrieving key documents, particularly those sent from hospitals as **non-searchable PDFs or faxed records**, which are often buried in document repositories and are not easily reviewed in real-time. Free-text clinical notes are unstandardized and frequently unsearchable, rendering them practically invisible during urgent assessments. This **fragmented data landscape** contributes directly to **delays in care, duplicative testing, medication errors, and unsafe transitions**.

Technologically, most EHR systems used in PALTC lack the **data processing power or natural language processing (NLP) capabilities** needed to extract relevant clinical information from unstructured or semi-structured data. Small and rural providers, in particular, face significant **financial barriers to upgrading** to systems that offer these advanced functionalities. From a privacy standpoint, expanding interoperability to include all data formats adds complexity to consent management and data protection, yet these challenges must be addressed head-on.

PALTmed considers full data accessibility, across all formats and entry points, to be a high-priority interoperability objective. Timely, complete, and clinically meaningful access to patient data is essential to reduce unnecessary hospital readmissions, enhance safety during care transitions, and enable PALTC clinicians to make informed decisions in real-time. Without these capabilities, the potential of health IT in post-acute care will remain unrealized, and some of the most high risk patients will continue to fall through the cracks in moments that demand precision and clarity the most.

Data Exchange

PR-5. FHIR APIs

PALTmed supports all the FHIR APIs (Fast Healthcare Interoperability Resources Application Programming Interfaces) listed in PR-5 (a–i). As an advocate for clinicians practicing across the continuum of post-acute care, PALTmed recognizes the importance of these APIs in enabling seamless data exchange, improving clinical workflows, and supporting real-time decision-making. PALTmed also actively monitors developments within Health Level Seven International (HL7), the developer of FHIR standards, and engages in the feedback process to ensure that the needs of our clinicians are reflected in evolving interoperability frameworks. We are particularly interested in the practical applications of tools such as CDS Hooks, which hold promise for enhancing clinical decision support at the point of care, especially in resource-constrained and high-acuity environments.

PR-6. TEFCA (Trusted Exchange Framework and Common Agreement)

PALTmed supports and believes that the Trusted Exchange Framework and Common Agreement (TEFCA) will significantly advance provider access to health information, including for those practicing in post-acute and long-term care. Through ongoing engagement with ASTP/ONC, PALTmed has provided feedback to ensure that TEFCA implementation reflects the needs of clinicians working in diverse care settings. Although TEFCA only became operational in December 2023, nine Qualified Health Information Networks (QHINs) had been designated as of April 2025. According to the Sequoia Project and the Recognized Coordinating Entity (RCE), 1,633 organizations including QHINs, participants, and sub participants, were live on TEFCA and had signed the framework agreement as of January 2025. The RCE, in coordination with ASTP/ONC, continues to oversee the development and implementation of the Common Agreement to support secure and scalable nationwide data exchange.

PALTmed also supports the proposed exchange requirements for QHINs outlined in § 172.201(b), which are essential to ensuring that the data sharing infrastructure remains private, secure, and trusted. We are closely following the developments related to the Health Data, Technology, and Interoperability (HTI-2) proposed rule, issued by ASTP/ONC on September 12, 2024, and are committed to advocating for the inclusion of post-acute clinicians in future interoperability frameworks.

PR-7. Data Availability

Providers in the post-acute and long-term care (PALTC) sector face unique challenges that must be acknowledged in any national interoperability strategy. These include fragmented health IT systems, limited technical resources, staffing constraints, and high administrative burden. To ensure PALTC providers can meaningfully participate in the digital health ecosystem, CMS should consider the following strategies:

a) **Align Interoperability with Existing Quality and Payment Programs**

Strategy: Integrate interoperability objectives with familiar, existing programs such as the Merit-Based Incentive Payment System (MIPS), Minimum Data Set (MDS), Quality Reporting Programs (QRP), and Value-Based Purchasing (VBP).

Example: Allow data already collected for MDS assessments to be reused for interoperability reporting or quality dashboards through FHIR APIs.

Benefit: Reduces duplication and leverages workflows already optimized by PALTC providers.

b) **Fund and Incentivize EHR Modernization for PALTC Providers**

Strategy: Provide financial incentives or grants (akin to the original Meaningful Use program) specifically tailored to PALTC EHR upgrades that support standardized data exchange (FHIR, SMART on FHIR, TEFCA connectivity).

Benefit: Many EHRs used in nursing homes and assisted living communities lack modern APIs. Without targeted funding, these facilities will remain on the sidelines of national interoperability efforts that will directly impact the patients residing there.

c) **Simplify and Standardize Interoperability Requirements**

Strategy: CMS should work with ONC to streamline standards and reduce fragmentation (e.g., reduce reliance on legacy document-based exchange and promote transition to FHIR-based data).

Benefit: Reduces the learning curve for providers and vendors, promotes adoption, and avoids duplicative compliance efforts.

d) **Provide Scalable Technical Assistance and Centralized Resources**

Strategy: Establish a dedicated CMS technical support program or regional interoperability resource centers to help PALTC providers onboard to interoperability networks (e.g., TEFCA, QHINs). Support during these times will be crucial to minimize the risk of errors and to ensure patients still get the care they need.

Benefit: Smaller facilities often lack internal IT staff; hands-on support is essential for participation.

e) **Enable Proxy or Delegated Interoperability Participation**

Strategy: Allow clinically integrated networks, ACOs, or intermediary HIEs to act on behalf of PALTC facilities in meeting interoperability mandates.

Benefit: Reduces the administrative and technical burden on individual providers and promotes collective action.

f) **Leverage Existing Workflows and Data Collection Motivators**

Strategy: Build interoperability use cases around:

- Transitions of care (e.g., hospital-to-SNF admission summaries)
- Advance care planning and POLST forms
- Medication reconciliation

- Infection control reporting
- Quality Measures

Benefit: These are workflows providers are already heavily invested in due to patient safety and regulatory compliance requirements. Aligning interoperability initiatives with these will boost adoption.

g) **Establish Meaningful, Clinician-Driven Metrics**

Strategy: Develop interoperability performance metrics that reflect clinical relevance (e.g., timely receipt of discharge summaries, medication list accuracy), not just technical transactions.

Benefit: Focuses efforts on improving care outcomes, not just meeting data-sharing checkboxes.

h) **Reduce Redundant Reporting Requirements**

Strategy: Streamline and harmonize data reporting across CMS programs (e.g., QRP, VBP, Infection Control) and allow data submitted once (via FHIR or other standardized formats) to be reused across programs.

Benefit: Reduces provider fatigue and encourages participation in interoperability initiatives as a path to reduce reporting burden overall.

The big picture is that while we strongly support advancing interoperable health information exchange, CMS must avoid a cart-before-the-horse approach. Current [ONC reports \(2023–2024\)](#) highlight that over 80% of SNFs have EHRs, but only 17% of hospitals send information to post-acute care (PAC) providers, and only 8% of PACs send information back to hospitals. These data reflect significant gaps that will not be addressed by adding new compliance penalties or checkbox reporting.

We oppose proposals that begin with punitive measures, such as the 2% SNF QRP payment penalty, which would remove funds that could otherwise be used for IT investments. CMS should instead focus on providing incentives and supportive infrastructure to foster bidirectional data exchange.

Moreover, we are strongly against adding further MDS-based process measures (e.g., checkbox attestations of sending data electronically). These are often burdensome, duplicative, and ineffective. A better solution is for CMS to work with certified EHR vendors to automate detection and reporting of actual transactions (e.g., through background data flags, similar to how claims-based measures function). If interoperability reporting becomes necessary, it should be zero-burden, relying on system-level logs and automated reporting mechanisms.

Any interoperability measure must also include clear and reasonable exceptions for providers facing legitimate barriers, such as lack of broadband, natural disasters, or cyber incidents, that temporarily impede participation.

Finally, CMS should reconsider the concept of "data goodness" as it relates to real-time data exchange. Rigid expectations tied to traditional assessment-based processes are not always compatible with the flexibility and speed of real-time interoperability. There is a trade-off between timeliness and data precision. CMS should acknowledge that the value of interoperability lies in better care, not merely the fact that a data exchange occurred.

PR-8. Clinical Data Responsibilities of Providers

PALTmed supports CMS efforts to simplify clinical quality reporting and strongly advocates for interoperability solutions that reduce provider burden—particularly for clinicians practicing in PALTC settings, who often face unique documentation and staffing challenges. One area of high potential is the use of **Bulk FHIR exports** from EHRs directly to CMS, which would streamline quality measurement processes and reduce administrative friction.

a. Bulk FHIR for Clinical Quality Submission

CMS could meaningfully reduce provider burden by leveraging Bulk FHIR data exports for quality measurement purposes. This would eliminate the need for duplicative reporting systems and manual data entry—allowing CMS to calculate quality measures directly from structured EHR data captured at the point of care. Such an approach aligns with the principle of “no new burden” interoperability and would be especially impactful in PALTC environments, where staffing shortages and resource limitations make redundant documentation particularly unsustainable.

b. Consolidation of Quality and Interoperability Functions

PALTmed encourages CMS to explore ways to consolidate quality reporting and interoperability requirements. Data captured through automated, real-time interoperability processes—such as discharge summaries, medication reconciliation, and clinical assessments—can and should serve dual purposes: supporting both immediate clinical decision-making and downstream quality reporting. This would reduce documentation redundancies and better align reporting systems with actual patient care workflows.

c. Real-Time Quality and Registry Support

Quality registries and digital quality infrastructure must support **real-time access to clinically relevant data**. CMS should set baseline interoperability expectations for registries, ensuring that data submissions can simultaneously support regulatory compliance and enhance clinical care. This dual use would encourage the adoption of interoperable tools within routine workflows, helping providers improve patient outcomes while avoiding unnecessary administrative overhead. Some basic artificial intelligence programs could be utilized here and will only become more helpful in searching large amounts of data for clinically relevant information, further improving the efficiency of care for patients in PALTC facilities, but also leading to quicker clinical decision making.

By fully integrating interoperability into the core functions of clinical care and quality reporting, simplifying standards, and focusing on tools that reflect actual practice conditions—**especially in under-resourced and rural PALTC settings**—CMS can drive meaningful digital transformation. This approach will help ensure PALTC clinicians are equipped to succeed in a value-based care system and that no segment of the care continuum is left behind in our nation’s health IT modernization efforts.

3. Technical Standards and Certification

TD-5: How could a nationwide provider directory of FHIR endpoints improve access to health information for patients, providers, and payers?

A nationwide directory of FHIR endpoints has the potential to significantly improve access to health information for patients, providers, and payers by offering a centralized, reliable resource for identifying verified health IT connections across care settings.

For **patients**, especially those receiving care in PALTC settings, this directory could enable timely retrieval of their health records from multiple providers and health systems, helping improve care continuity and empowering patients and their caregivers to better understand treatment options, track changes in condition, and comply with care plans. This is particularly important for individuals transitioning between hospitals, nursing homes, and home-based care, often during nights or weekends when clinicians must make urgent decisions with limited information.

For **clinicians**, the ability to quickly locate and connect to FHIR endpoints across settings would dramatically improve access to actionable patient information. This can reduce delays in care, minimize duplication of tests, and enhance real-time clinical decision-making. In the PALTC environment—especially in rural areas facing broadband gaps, cognitive impairment among the patient population, and weekend staffing shortages—access to up-to-date, relevant information (e.g., latest medication changes or care goals) must be easily retrievable and clearly presented. Too often, clinicians receive disorganized, late-arriving packets of unsearchable PDFs or scanned records with no indication of recent changes or priorities for care. FHIR-based directories would facilitate more concise, targeted information sharing that supports safe and efficient transitions of care.

For **payers**, a national FHIR endpoint directory would streamline claims processing, reduce reporting burden, and support network management by keeping provider connections current. It would also facilitate better coordination in value-based care models, which depend on real-time data exchange and alignment across care settings. PALTC providers cannot be excluded from this digital transformation, or the entire system risks breakdowns in communication and continuity of care.

PALTmed supports HL7's **National Directory of Healthcare Providers & Services (NDH) Implementation Guide**, which lays out a standards-based foundation for a national directory infrastructure. Local and regional directories, including those that serve long-term and post-acute settings, should also be able to leverage FHIR APIs to integrate seamlessly with national systems. However, progress remains uneven across federal agencies. PALTmed urges greater coordination, funding, and prioritization of this foundational infrastructure to support all care settings equitably.

TD-7: United States Core Data for Interoperability (USCDI)

PALTmed supports the continued development of the **United States Core Data for Interoperability (USCDI)** as a baseline standard for nationwide electronic health information exchange. As the clinical complexity of PALTC patients increases, and as care transitions continue to accelerate in both frequency and acuity, it is essential that the core dataset reflects the specific needs of clinicians in these environments.

USCDI provides a standardized set of health data classes and elements, many of which are foundational for safe and effective care coordination in PALTC settings—including medications, problems, goals, care team members, and advance directives. However, alignment between USCDI and FHIR US Core is still incomplete. Many data elements that are critical to post-acute care—such as functional status, behavioral health indicators, and facility-based observations—may not yet be fully represented or mapped between standards.

PALTmed actively reviews and provides feedback to ASTP/ONC on proposed updates to USCDI and will continue to advocate for inclusion of data elements that reflect the realities of PALTC clinical practice. A robust, complete, and interoperable core dataset is essential to enabling the longitudinal, team-based, and often asynchronous care that defines our field.

Thank you for the opportunity to submit these comments. Should you have any questions please reach out to Alex Bardakh, MPP, CAE, Senior Director Advocacy, at abardakh@paltmed.org

Sincerely,



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President
Post-Acute and Long-Term Care Medical Association (PALTmed)