NATIONAL ASSOCIATION OF Community Health Centers

June 16, 2025

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

The Honorable Thomas Keane, MD, MBA
Assistant Secretary for Technology Policy
National Coordinator for Health Information Technology
330 C Street, SW
Washington, DC 20201

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

Dear Administrators Oz and Assistant Secretary Keane:

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers or health centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in America.

Community Health Centers are the best, most innovative, and resilient part of our nation's health system. For nearly sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care. In addition to medical services, CHCs provide dental, behavioral health, pharmacy, vision, and other essential health services to America's most medically underserved communities in urban, rural, suburban, mountain, frontier, and island communities. Today, health centers serve more than 32.5 million people, or at least 1 in 10 Americans, at over 16,000 locations, ensuring patients receive the care they need and pay what they can based on a sliding fee scale.

NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities and preventing chronic conditions. The collective mission and mandate of NACHC and the 1,496 health centers nationwide is to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

NACHC appreciates the opportunity to engage in this Request for Information (RFI) to share our perspective on how the Administration can leverage technology to improve the lives of Medicare beneficiaries. Over the past decade, the number of health center Medicare patients has increased significantly, from 1.5 million in 2010 to over 3.3 million in 2023. Medicaid patients comprise 11% of the patient's health centers.[1] Health centers play an integral role in helping lower out-of-pocket costs for Medicare patients. Costs for health center Medicare patients ($2,370) are 10% lower than physician office patients ($2,667) and 30% lower than outpatient clinics.[2] This could be attributed to the health center model of care that strives to provide Medicare patients with affordable and high-quality care.

1. **What can CMS and its partners do to encourage patient and caregiver interest in these digital health products?**

[1] https://data.hrsa.gov/tools/data-reporting/program-data/national
[2] https://data.hrsa.gov/tools/data-reporting/program-data/national

a. What role, if any, should CMS have in reviewing or approving digital health products on the basis of their efficacy, quality or impact or both on health outcomes (not approving in the sense of a coverage determination)?

NACHC recommends CMS work closely with the Federal Drug Administration (FDA) for all digital health products, with the majority of primary end-users of these products being in the community health space but avoid rigid "approval" processes. This may be outside of the agency's scope, so focusing on "recommended" or "validated" lists will be helpful for health centers that work with these vendors and can utilize these digital health products. As the FDA is the sole federal agency that approves and regulates digital health products that fall under its definition of a "medical device,"[3] CMS has a pivotal role in validation and curation.

What criteria should be used if there is a review process?

NACHC endorses using a tiered system based on existing frameworks, such as the Digital Medicine Society / DiME's Patient-Centered Framework, to assess digital health technologies while adhering to required interoperability standards (e.g., FHIR and related terminology standards). We recommend prioritizing the following criteria regarding their impact on health centers.

1. **Health Parity**: Demonstrated effectiveness across populations, including people with varying levels of digital literacy, language proficiency, and socioeconomic status. Digital health tools should consider that people from any background should benefit from them and be fine-tuned so that effectiveness remains high, regardless of who uses them.
2. **Usability**: Assessment through user-centered or human-centered design principles, which involve patients and end-users in the development process, reflective of the CHC patient populations. As mentioned above, health centers provide care for all types of patients; whether rural or urban, individuals with Limited English Proficiency, young or old, these devices should be easily usable by any patient.
3. **Security & Privacy**: Compliance with HIPAA and emerging data governance standards. Over the past 12 months, excluding the Change Healthcare breach, nearly six million people (5,992,343) have been affected by large healthcare data breaches every month.[4] As more digital health tools come onto the market and become integrated into clinical records, patient privacy, and data protection need to be integral parts of any tool approved by the FDA.
4. **Clinical Validity**: Peer-reviewed publications and evidence suggest that the technology meaningfully addresses a clinical need and improves health outcomes, demonstrating statistical significance.

NACHC recommends CMS look to the Responsible AI Guide published by the Coalition for Health AI (CHAI)**.**[5] Given artificial intelligence's growing usage in all healthcare, if digital health tools draw upon AI, this guide will be useful to ensure that any AI technologies used in healthcare are reliable, safe, and effective. They combine existing standards into a coherent framework and provide practical considerations for applying them in day-to-day operations. The guide emphasizes tangible considerations for all stakeholders involved in the health ecosystem, ensuring that AI implementation is fair, transparent, safe, and beneficial. A significant component of the guide is its lifecycle approach to AI development and deployment in healthcare. This approach begins with defining the problem and planning AI solutions, followed by the ethical and effective design of AI systems. Practical engineering and development phases ensure reliability and safety, which are comprehensively evaluated before deployment. A critical element of the Responsible AI Guide is the emphasis on independent review. This ensures that AI solutions undergo

[3] https://www.fda.gov/medical-devices/products-and-medical-procedures
[4] https://www.hipaajournal.com/april-2025-healthcare-data-breach-report/
[5] https://chai.org/responsible-ai-guide/

rigorous evaluation by external experts to maintain high safety standards, effectiveness, and ethical compliance. The independent review process is designed to build trust and credibility in AI solutions used in healthcare, fostering broader acceptance and adoption. The guide also includes a detailed focus on privacy and cybersecurity. It integrates the NIST Privacy Framework and Cybersecurity Framework to help organizations manage privacy and security risks effectively.

a. What technology solutions, policy changes, or program design changes can increase patient and caregiver adoption of digital health products (for example, enhancements to data access, reimbursement adjustments, or new beneficiary communications)?

NACHC recommends CMS and ASTP/ONC prioritize enhancing communication to Medicare patients using trusted messengers, such as health centers and community-based organizations (CBOs), that offer digital health literacy training. Health centers are integrated into their communities; their boards are majority patient governed and commonly employ members straight from the communities they serve. They are well-positioned to help enhance the use of digital health products. Health centers do need to be recognized and reimbursed adequately to help finance the effort involved in supporting patient onboarding and ongoing technical assistance. We ask CMS to explore reimbursement adjustments to encourage patient engagement in programs, potentially through virtual care codes or covered digital therapeutic benefits. For instance, this reimbursement could be time-based, such as 10-15 minutes to cover the provider's time explaining how to use the technology. Reimbursement would enable an appropriate staff member, like a medical assistant, community health worker (CHWs), or a similar role, to spend the necessary time with the patient, assessing barriers to utilization, ensuring access, and training on how to use the technology and tools available to improve health care communication. This will result in more efficient, effective care that improves access and reduces the likelihood of inappropriate utilization of costly hospital and emergency services. Additionally, we recommend that the agencies highly consider communication mediums utilized by beneficiaries outside of required internet access. The U.S. Department of Agriculture estimates that 22.3% of Americans in rural areas and over 27% of Americans living in Tribal lands lack adequate internet coverage.[6] NACHC believes the availability of low-bandwidth health devices is crucial to ensure that rural Americans can successfully use them.

b. What changes would enable timely access to high quality CMS and provider generated data on patients?

NACHC sees timely data access requiring a multi-pronged approach. We recommend that standardized APIs, particularly FHIR, be foundational, but must be accompanied by:

1. **Harmonized Patient Identifiers**: Addressing patient matching across systems remains a critical barrier. Investment in a robust Master Patient Index (MPI) strategy across HIEs and providers is essential while utilizing technologies that protect patient information through privacy-preserving record linkage (PPRL) and others. This will ensure that a health center has a fuller picture of its patients, as they are able to access all the patients' records through the directory[7], which will lead to more comprehensive care.

2. **Robust Data Quality Governance**: CMS should incentivize and potentially audit data quality within submitting organizations. Poor data quality undermines the value of data access.

[6] https://www.usda.gov/sustainability/infrastructure/broadband#:~:text=Unfortunately%2C%2022.3%20percent%20of%20Americans,by%20the%20Federal%20Communications%20Commission.
[7] https://www.4medica.com/blog_insights/what-is-a-master-patient-index/#:~:text=Consider%20the%20long%2Dterm%20benefits%20and%20cost%2Dsaving%20opportunities,reduced%20duplicate%20records%2C%20and%20enhanced%20patient%20safety.

3. **Integration of Non-Clinical Social Factors (NCSF)**: Even with FHIR, current data sharing often lacks comprehensive NCSF data. CMS needs to actively promote and audit the required adoption of standard terminologies for NCSF data elements (e.g., ICD-10-CM Z-codes, SNOMED-CT, LOINC, value sets from the Gravity Project FHIR accelerator) and incentivize their inclusion in NCSF data exchange workflows with CBOs.

4. **Consent Management Technologies**: Implement robust and patient-friendly mechanisms for data sharing consent aligned with TEFCA principles.

c. What features are most important to make digital health products accessible and easy to use for Medicare beneficiaries and caregivers, particularly those with limited prior experience using digital tools and services?

Health centers serve a large number of individuals with multiple risk factors impacting digital literacy: age, lower education levels, language barriers, and cognitive impairments. NACHC recommends that digital health products should include certain features to best serve the medically underserved patients health centers see, including:

- **Multi-Lingual Support**: By law, health centers are required to provide translation services to serve our patients and meet community needs. Out of the 32.5 million patients served by health centers, 8.64 million are best served in a language other than English.[8] In order for health center patients to use digital health tools, we recommend that CMS look beyond basic translation and consider contextual competency interfaces and support materials to meet all patients' levels of understanding. All products could leverage data captured on "preferred language" and utilize language standards (e.g., RFC 5646 and ISO 639-3).

- **Simplified Interfaces**: Health center patients often have lower digital literacy and lower health literacy. To best serve patients, we recommend digital health product designs that avoid complex navigation, jargon, and excessive features. We also recommend that CMS ensure any digital health tool has been validated through a user interface (UI)/user experience (UX) assessment framework, as that will evaluate the UI/UX quality said tool. This includes gathering user feedback and analyses to identify usability issues, enhance design, and lead to a positive user experience.[9]

- **Low-Bandwidth Compatibility**: Recognizing that many medically underserved populations served by health centers lack reliable high-speed internet, in urban and rural areas, we recommend that "lightweight" versions of applications be available, meaning they take up less bandwidth, or SMS-based options, are essential. Broadband is considered a superdeterminant of health due to its significant impact on education and employment opportunities.

- **Accessibility for patients with disabilities**: Adherence to Web Content Accessibility Guidelines (WCAG version 2.2) guidelines is crucial, including screen reader compatibility, adjustable font sizes, and alternative input methods. This will ensure easier access to digital health products for patients and their caregivers.

[8] HRSA 2023 UDS Data

[9] https://reloadux.com/blog/ui-ux-design-evaluation-methods-for-usability-testing/#:~:text=What%20is%20UI/UX%20Testing,user%20experience%20of%20a%20design.

- **Integrated support**: Health centers want to partner with the government in increasing the use of these digital health technologies to enhance access to care. In that pursuit, health centers must be equipped to provide on-site technical support and training to address individual patient needs. This necessitates dedicated staffing and resources. We recommend reimbursement outside the health center's bundled encounter rate to work with the patient to access their data. We expand upon this rationale further below.

Remote Patient Monitoring (RPM) uses digital health tools to monitor a patient's condition; NACHC recommends CMS continue to invest in patients' ability to utilize RPM. Both health centers and their patients continue to report positive experiences with RPM. It has helped increase patient self-sufficiency and allowed patients to gain confidence using these self-measurement tools. Many health centers have shifted to incorporating this model and using remote monitoring technology in general to streamline communication and access for patients. Furthermore, health centers have been able to reimagine preventive care and chronic disease management with at-home care utilizing remote patient monitoring. With many U.S. adults delaying preventive care and 6 in 10 having at least one chronic condition, including heart disease and diabetes,[10] regular health management can be a matter of life and death. Health centers serve a large population of high-risk patients who are more likely to suffer from a disproportionate array of chronic conditions.

Additionally, a recent 2025 report showcased the benefits of RPM in helping manage a variety of disease states. For instance, RPM blood pressure monitoring during periods of active medication management led to better blood pressure control because the providers could quickly change patients' hypertension medications. For diabetes treatment, RPM appeared to be most effective when used by patients with the highest starting HbA1c levels and those at critical transition points in their care plan. Over 3.2 million health center patients have diabetes and could benefit from this service.[11] Currently, only one percent of Medicare beneficiaries use RPM today, with the demographic skewing older, nonwhite, urban, more medically complex, and dually eligible for Medicare and Medicaid. Among the report's recommendations for policymaker consideration is improving access to high-remote monitoring tools.[12] NACHC believes this can happen through multiple avenues: investing in more training for medical staff and patients and making it more affordable for patients and providers.

NACHC recommends allowing CMS to issue a co-insurance waiver for CHC patients using RPM devices. While most Medicare patients do not have to pay for RPM devices, they are still responsible for a 20% co-insurance payment. Patients should not have to choose between crucial RPM services and necessities such as food, housing, and transportation. Waiving RPM co-insurance costs for CHC patients alleviates potential financial barriers to care and increases affordability for this vital service.

NACHC advocates that CMS classify Self-Monitoring Blood Pressure (SMBP) devices as Durable Medical Equipment (DME) to allow any health center patient who needs one to self-manage their blood pressure information in partnership with their care team via telehealth. From 2022 to 2023, the overall Health Center patient population grew by 3%, while the number of individuals with hypertension increased by 5%, afflicting over 5.8 million Health Center patients.[13] SMBP devices allow health center care teams to reach more people more quickly. Furthermore, cost and coverage should not be barriers to accessing a SMBP device, especially given the unique patient population health centers serve. Hypertension is the most

[10] https://www.cdc.gov/chronic-disease/about/index.html#:~:text=Definition%E2%80%8E,of%20daily%20living%20or%20both.&text=Six%20in%2010%20Americans%20have,two%20or%20more%20chronic%20diseases
[11] 2023 UDS HRSA data
[12] https://petersonhealthcare.org/news/evolving-remote-monitoring-report/
[13] UDS HRSA Data 2023

common chronic condition of Medicare beneficiaries and the leading modifiable risk factor for coronary heart disease, stroke, and congestive heart failure, also contributing to chronic kidney disease and dementia. Given this reality and the growing shift towards keeping individuals in their homes and communities as they age and receive care, health centers will need to utilize SMBP devices to better care for patients. NACHC strongly urges CMS to allow SMBP devices to be covered and billable under Medicare as a critical patient care tool.

Furthermore, NACHC advocates for more federal support of the Protocol for Responding and Assessing Patients' Assets, Risks and Experiences (PRAPARE) tool. NACHC helped create this tool to enable health centers and other providers to collect the data they need to understand better and address their patients' non-clinical social factors. In 2023, over 700 health centers used the PRAPARE tool. There is currently a lack of federal funding to assist health centers in covering the cost of integrating PRAPARE into their Electronic Health Records (EHRs), which could cost anywhere from $6,000 to over $49,000. Health centers operate on thin financial margins, and while many health centers already screen for non-clinical social factors, there are smaller health centers whose budgets cannot absorb the cost of integrating PRAPARE into EHRs. NACHC supports additional federal funding to help health centers cover the administrative costs of integrating PRAPARE into their clinics and the costs to cover the services needed for patients after PRAPARE identifies them.

3. In your experience, what health data is readily available and valuable to patients or their caregivers or both?

Health centers establish trusted relationships between their providers and patients, as well as caregivers or personnel on the patient care team. Part of that trust is built on having easily accessible, understandable health data so all parties can play active roles in their healthcare journey. The following items are some of the most important data health centers share with their patients and/or caregivers:

- **Problem List**: Clear summary of formally diagnosed (and billed) conditions, comprehensively coded in International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and SNOMED-CT[14] as required by USCDIv1 and USCDIv3.

- **Lab Results**: Easily understandable test results, with historical trends, and represented in platform databases using Logical Observation Identifiers Names and Codes (LOINC) codes. This universal code used by the U.S. Federal Government systems allows the exchange and aggregation of clinical results for care delivery, outcomes management, and research.[15] Using these standardized codes instead of proprietary codes from diagnostic companies helps improve interoperability, provide more precise and quality data,[16] which will benefit health center patients as it enhances provider ease with clinical decision-making.

- **Medication Lists**: Accurate and up-to-date prescriptions, with start/end dates, clear explanations for how to take each medication, and which condition it is for. Depending on the capabilities of the health center and its pharmacy, there is also potential integration with medication adherence tools.

- **Appointment Schedules**: Reminder and scheduling tools accessible in multiple formats, especially those used by patients with low digital literacy, such as via text message, paper-based, and portals

[14] A comprehensive, international, and multilingual clinical terminology system used in EHRs
[15] https://mmshub.cms.gov/measure-lifecycle/measure-specification/specify-code/LOINC
[16] https://pmc.ncbi.nlm.nih.gov/articles/PMC5636728/#:~:text=Improved%20interoperability%20of%20laboratory%20test,borders%20%5B19%2C%2021%5D.

that can work on low-bandwidth internet. This option will help bridge gaps in digital health literacy or limited broadband access and help decrease the instances of no-shows.

- **Care Plans:** Individualized and accessible documentation for all parties involved in patient care so that shared goals and action steps are developed collaboratively between patients and providers. Health centers have advanced care coordination teams to approach a patient's health condition(s) from multiple angles, creating a care plan to provide the most comprehensive care possible. Part of this, too, is inclusion and closing the loop on non-clinical social factors (NCSF); health centers have been at the forefront of screening NCSF needs and connecting patients to local CBOs such as food banks, housing departments or others to address the need flagged in their needs assessment.

- **Non-Clinical Social Factor Data:** Screening results & referrals to community-based organizations (CBOs). As discussed above, over two-thirds of health centers screen patients for social needs, gathering this data through screening tools such as PRAPARE.

- **Cost Sharing Information**: Clear and transparent billing information, including estimated out-of-pocket costs. Health centers serve some of the most financially and medically underserved populations. They work with their patients to pay what they can for services; they establish a sliding fee discount program, which reduces or waives the amount that the patient pays based on their income relative to the federal poverty level and the patient's family size.

4. How is the Trusted Exchange Framework and Common Agreement™ (TEFCA™) currently helping to advance patient access to health information in the real world?

Since 1965, CHCs have utilized strategic partnerships to improve community health and advance patient access. In recent years, CHCs have continued to be innovators as the environment changes with new health technology. NACHC acknowledges the utility of the Trusted Exchange Framework and Common Agreement (TEFCA) and supports CMS in assessing ways to improve CHC adoption to ultimately improve patient access to health information.

a. Please provide specific examples.

TEFCA holds immense potential, but adoption within the CHC ecosystem is nascent. Current adoption is limited primarily to larger, better-resourced Health Information Exchanges (HIEs) participating as Qualified Health Information Networks (QHINs). NACHC sees the potential use cases around referral management and care coordination, and we encourage CMS to evaluate the complexity of onboarding, cost of integration, effectiveness, and lack of informatics staffing in organizations that act as barriers to widespread TEFCA adoption in CHCs. See additional details below.

b. What changes would you suggest?

NACHC recommends that CMS evaluate the following to increase TEFCA adoption in CHCs:

- **Onboarding:** Reduce the administrative burden for smaller HIEs and CHCs to connect to QHINs. Health centers use a variety of Electronic Health Record (EHR) systems that don't necessarily "talk" to each other. To participate in and integrate with TEFCA's exchange model, health centers and smaller HIEs would need to complete substantive technical upgrades or even complete system replacements.
- **Financial Support:** Capital is necessary to invest in the future of technology, especially as health centers provide millions of dollars in uncompensated care, and general care costs are

rising. Providing grants or subsidies to assist CHCs and smaller HIEs with TEFCA implementation costs would help significantly.

- **Technical Assistance:** Offer dedicated technical support and training tailored to the needs of CHCs in participating in a QHIN. Becoming part of this advanced network of organizations to ensure a secure and standardized exchange of electronic health information means bolstering a health center's technology systems and training staff to correctly participate. Health centers do not have the capital to pursue this and ask CMS/ONC to support efforts in this space.
- **Data Governance Clarity:** Develop clearer guidance on data governance and consent management within the TEFCA framework. States may have different requirements regarding consent management, and participants in TEFCA could have different policies and procedures for data governance. Having a more streamlined approach to both data governance and consent management will help enhance health centers' adoption of TEFCA.

c. What use cases could have a significant impact if implemented through TEFCA?

The implementation of TEFCA could significantly impact CHCs and their patients. For example, TEFCA could facilitate seamless access to patient records across state lines for individuals receiving care at multiple CHCs. Additionally, the framework could provide CHC clinicians with real-time access to patient information in emergency situations, regardless of location.

Lastly, the framework could offer a standardized approach for sharing non-clinical social factor data across organizations to enable more holistic care coordination. This is especially important for CHCs, as over 3 million CHC patients in both rural and urban environments were screened positively for social risk factors in 2023, including financial strain, food insecurity, housing insecurity, and a lack of transportation.[17]

d. What standards are you aware of that are currently working well to advance access and existing exchange purposes?

While Fast Healthcare Interoperability Resources (FHIR) are the cornerstone to advancing access to health information, NACHC encourages CMS to look to 'adherence to terminology' standards through the terminology module as they provide a way to define and use mandatory code systems/terminology (ICD-10-CM, SNOMED-CT, LOINC, RxNorm, etc.), value sets, and concept maps. We also encourage CMS to look to HL7 v2 for legacy system compatibility (while transitioning to FHIR), and CDA for document sharing.

f. Are there redundant standards, protocols, or channels that should be consolidated?

NACHC encourages CMS/ASTP to review ongoing duplication of effort around unique patient identification. CMS/ASTP should consider adopting a national framework managed by a neutral party while respecting patient privacy concerns. CMS/ASTP should consider adopting Privacy-Preserving Record Linkage (PPRL) through free open-source options such as Anonlink and PPRL package, combined with a commercial product (e.g., Colorado University Record Linkage / CURL).

5. How are health information exchanges (HIEs) currently helping to advance patient access to health information in the real world?

a. How valuable, available, and accurate do you find the data they share to be?

[17] UDS 2023 HRSA Data

Data quality and availability vary significantly depending on which states are covered by the HIE and state laws/regulations. HIE data is often valuable for acute care referrals and hospital transitions, but less comprehensive regarding primary care, behavioral health, and non-clinical social factor data. Accuracy can be compromised by data entry errors and inconsistent coding practices, negatively impacting health center patients and hindering providers' care efforts.

b. What changes would you suggest?

- **Incentivize Data Completeness:** Reward HIEs for actively soliciting and integrating comprehensive data from participating providers, particularly primary care practices such as health centers, adhering to a common data model, USCDIv3, and others. Data is power, and the benefits will trickle down to health centers and their patients.

- **Standardized Data Quality Audits:** Implement regular data quality audits to identify and address inaccuracies and the lack of utilization of required standard terminologies. To reiterate, standardizing data makes comparing patient data apples to apples easier, helping alleviate provider burden and ensure accuracy.

- **Promote Non-Clinical Social Factors (NCSF) Data Integration:** Encourage HIEs to adopt and implement standardized NCSF data elements through the Gravity Project value sets. The Gravity Project looks to identify data elements and associated value sets to represent NCSF information documented in EHRs across four clinical activities: screening, diagnosis, goal setting, and intervention activities. The Gravity Project will develop a consensus-based set of recommendations on how best to capture and group these data elements for interoperable electronic exchange and aggregation and collaborate with coding and terminology organizations to address coding gaps identified and apply for new codes (e.g., CPT codes for interventions). Collecting non-clinical social factors through the Gravity Project value sets will help better understand the patient as a whole, given their strong impact on the patient's general health, well-being, and quality of life.[18] Compared to the national population, more health center patients screened positive for financial strain, food insecurity, housing insecurity, and lack of transportation,[19] making integration of these NCSF into HIEs crucial.

c. Are there particular examples of high-performing HIE models that you believe should be propagated across markets?

Regional HIEs with strong provider engagement (e.g., those led by State Primary Care Associations) often demonstrate greater success. Models focused on data normalization through proper use of standard terminologies and value sets, with strict conformance to USCDI, combined with analytics, are valuable and should be propagated. Furthermore, while HIEs excel in HL7 ADT exchanges, some HIEs often lack discrete lab data (non-ELR interfaces).

d. What is the ongoing role of HIEs amidst other entities facilitating data exchange and broader frameworks for data exchange (for example, vendor health information networks, TEFCA, private exchange networks, etc.)?

HIEs remain vital, even with TEFCA. They offer regional expertise and established provider relationships and can serve as key connectors between QHINs and providers. However, HIEs need to evolve from simply being data "pipes" to offering value-added services like analytics and care coordination support.

[18] https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health
[19] 2023 UDS HRSA Data

6. What can CMS and its partners do to encourage providers, including those in rural areas, to leverage approved (see description in PC-5) digital health products for their patients?

a. What are the current obstacles?

Health centers face many obstacles in utilizing approved digital health products for their patients. A key challenge is workflow integration; integrating new digital health products into existing EHR workflows is particularly difficult for CHCs with limited informatics staff. While CHCs maintain a dedicated staff, these IT teams are small and usually wear multiple hats, meaning health centers rely on third-party vendors and organizations to assist them with their informatics. For digital health products, the cost related to both licensing and implementation makes uptake prohibitive. Additionally, there are costs related to training; providers need adequate training and support to effectively use new technologies. Provider burnout is still high – 48.2% of physicians reported experiencing at least one symptom of burnout[20] – and lack of clear reimbursement pathways discourages adoption.

NACHC harbors concerns about patient access to technology and digital literacy and a general lack of broadband access in rural and urban areas. To address both transportation barriers that health center patients may face and the lack of access to broadband, which could impact telehealth access, many health centers have implemented mobile units to meet community needs.

NACHC recommends that CMS invest in mobile health care units operated by health centers to reach medically underserved communities. One health center in Missouri partnered with its county's mobile healthcare network to meet patient needs. The program utilizes paramedics and CHWs to conduct house calls to high-risk and chronically ill patients lacking access to primary care. At the patient's home, these providers conduct home assessments, medication reconciliation, physical assessments, capture vital signs, in-home lab draws, point-of-care lab testing, IVs, perform electrocardiograms, ultrasounds, and other preventative and post-discharge needs.

Paramedics and CHWs can also support patients with their telehealth visits by liaising with their clinicians and bringing mobile hotspots to rural areas that lack reliable internet access. This innovative model has also established strategies to support and strengthen the workforce by working with local colleges to train locally and has demonstrated significant healthcare savings. In the first year of this program, 21 patients were served, and there was a 100% decrease in emergency transport to hospitals. Patients served by this program frequently needed emergency transportation for basic primary care needs. In 2020, before enrolling in the program, a patient was transported at least 44 times, and their health care totaled more than $118,000. After enrolling in the program, the year-to-date costs were approximately $5,000. This partnership approach can be replicated in other rural and underserved communities as it provides the flexibility to include other services like managing chronic conditions that are prevalent in the community, access to vaccination, and addressing social drivers of health like access to healthy food and increasing health literacy. NACHC recommends CMS consider leveraging these lessons learned by supporting health centers to expand these models to more rural and underserved communities. It is important to note that while mobile health care can expand access to care, insurance for drivers and the units can become cost-prohibitive, creating another barrier for safety net providers. Oversight of these insurance costs would help safety net providers to grow these innovative models.

b. What information should providers share with patients when using digital products in the provision of their care?

[20] https://www.ama-assn.org/practice-management/physician-health/measuring-and-addressing-physician-burnout#:~:text=The%20most%20recent%20study%20in,2014%20and%2045.5%25%20in%202011.

All data requested by patients should be provided per ASTP/ONC's information blocking rule.

- **Clinical Evidence:** Explain the evidence base and peer-reviewed data supporting the product's use. This will help increase the health center patients' trust regarding the product and enhance the likelihood of usage.

- **Workflow Integration Details:** Clearly outline how the product will integrate into existing workflows. Explaining to the health center patient how this digital product will enhance care coordination and positively impact their health will help them further understand the device/product.

- **Patient Support Resources:** Information about available patient training and support materials. With proper funding, the health center could provide this directly to boost patient confidence in utilizing this device.

- **Privacy & Security Information:** Transparency about data security measures. In an age where data breaches happen weekly, outlining the policies and procedures of how both the health center and the company manufacturing the device strive to keep the patient's data safe and secure will boost trust between the provider and patient.

- **Potential Costs and Benefits:** Outlining impacts on both patients and practice budgets. Health center patients are some of the most medically and financially underserved in the country; 56% of health center patients are at or below 150% FPL. These products need to be made available at affordable prices to enhance patient access.

c. What responsibilities do providers have when recommending use of a digital product by a patient?

- **Appropriate Selection:** Choosing products based on clinical evidence and patient needs. Health center providers use the best information possible, coupled with their deep knowledge of their patients' medical needs, to recommend the right product to help address their patients' health concerns.

- **Proper Training:** Ensuring adequate training for staff. As previously mentioned, staff need to comprehensively understand the uses of digital products whenever they use them.

- **Patient Education**: Clearly explaining the product's purpose and benefits to patients.

- **Monitoring & Evaluation:** Monitor patient outcomes and adjust the use of the product as needed. Health center providers currently do this when reading Self-Monitoring Blood Pressure devices (SMBP) or remote blood glucose monitors when they transmit results straight back to the provider via Bluetooth. The provider can use those results to make the right care decision for their patient.

7. Which of the following FHIR APIs and capabilities do you already support or utilize in your provider organization's systems, directly or through an intermediary? For each, describe the transaction model, use case, whether you use individual queries or bulk transactions, and any constraints:

As we previously commented on in the 2024 Interoperability and Prior Authorization Rule,[21] NACHC supports ways to improve the efficiency of the prior authorization process through a patient access application program interface (API). See below for descriptions of how each API is used and beneficial to CHCs and their patients:

a. Patient Access API: For patient access to health information through third-party apps that address their clinical and patient use cases. A constraint for the Patient Access API is a lack of access for out-of-network providers. Given varying network adequacy standards, a patient may need to seek care from an out-of-network provider. For instance, Medicaid managed care plans have wide discretion when measuring provider network adequacy. States currently calculate these standards quantitatively, given that the 2020 CMS Medicaid managed care final rule removed the state requirement of using time and distance standards.[22] These changes do not consider geographic and distance barriers that health center patients may face in getting access to timely care. The nearest provider who accepts Medicaid may not be in the patient's insurance network. Health center patients should be able to access prior authorization information via the Patient Access API, regardless of their provider, and their provider should be able to offer the same services for prior authorization, regardless of their network status with the patient.

b. Standardized API for Patient and Population Services: For querying health information for individuals or populations (bulk data transactions for public health reporting), which is critical for policy advocacy backed by real-world evidence.

c. Provider Directory API: For discovery of healthcare providers' details for care coordination, which is critical for closing care gaps in patients with non-clinical social risk factors of health, and linkages to CBOs.

d. Provider Access API: For providers to query patient health information from others involved in a patient's care, which is critical for care coordination across the biopsychosocial issues of patients in CHCs.

e. Payer-to-Payer API: For exchange of beneficiaries' data when a beneficiary changes payers, which is critical for correct and timely community health center reimbursement.

f. Prior Authorization API: For streamlining the prior authorization process, which is critical for both patients and providers, who can strengthen initial prior authorization requests and ease re-submissions or address denials.

NACHC supports requiring healthcare items and services to be subject to the electronic prior authorization process for both the Patient Access API and the Provider Access API. NACHC recommends CMS work with different agencies, such as ONC and SAMHSA, along with states, to make prescription drugs subject to these prior authorization requirements and include them in these APIs. In the final 2024 Interoperability and Prior Authorization final rule, CMS stated it would "consider options in future rulemaking to address improvements to the prior authorization processes for drugs."[23] While we understand that the processes and standards for prior authorization differ for prescription drugs, patients deserve the same transparency in the process regarding their prescriptions.

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[21] https://www.regulations.gov/comment/CMS-2022-0190-0222

[22] https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care

[23] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

According to 84% of physicians in a 2021 survey, the number of required prior authorizations for prescription drugs has increased over the years.[24] This trend has been consistent at health centers, which have seen an increase in prior authorization for higher-cost brand drugs versus generic drugs. This becomes an issue for patients who cannot take the generic alternative or if the generic is unavailable due to pharmaceutical storage. Furthermore, chronic medications constantly trigger prior authorization when a patient requires a refill. Instances like these showcase the need for prescription drugs to be subject to these same provisions to enhance and improve the prior authorization process.

Health centers take pride in offering pharmacy services and contract with community pharmacies to expand patient access to affordable prescription drugs. Many health center pharmacies employ clinical pharmacists who ensure that providers are kept up to date with the latest prescriptions on the formulary so providers can make an informed choice on what is best for the patient's condition. Clinical pharmacists also ensure patients understand their medication and lend themselves as a resource for any patient follow-up questions. NACHC encourages CMS to include prior authorizations for prescription drugs within the scope of this proposed rule to improve care coordination for patients by improving interoperability between providers and pharmacists. It is crucial to include prescription drug prior authorization in the Patient Access API.

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

Health centers are well-positioned to be leaders in the value-based care space and help CMS reach its goal of having all traditional Medicare beneficiaries participating in value-based care models by 2030. In partnership with their state Primary Care Associations (PCAs) and Health Center Controlled Networks (HCCNs), health centers across the country have already been actively engaged in ACOs and the Medicare Shared Savings Program (MSSP). For decades, health centers have provided comprehensive primary care by screening for non-clinical social risk factors and used this information to build patient-centric models of care. However, challenges related to restrictive reimbursement models have stifled health centers' ability to employ the right workforce and provide the unique services their patient populations need. The transition to alternative payment models (APMs) must work for all providers, improve health access, and be sustainable for participating providers. Safety-net and small community providers face unique barriers to implementing new value-based payment models. Many of these models require significant upfront investments that safety net providers may be unable to make. NACHC urges CMS to consider the complexities related to health center patients, providing care in rural and medically underserved areas, and common barriers for safety-net providers. Below are key considerations to support health centers growing into the MSSP and strengthening their ability to take on risk.

APMs should also account for the higher costs associated with caring for underserved populations and must not penalize ACOs that spend more to invest in primary care, target historical and ongoing health outcomes, and address non-clinical social risk factors. The current glide path presents a challenge and is a deterrent for new ACOs to join the program, particularly for CHC ACOs and those serving medically underserved populations. Data consistently show that physician-led ACOs earn a bonus and generate higher savings than hospital and integrated ACOs.[25] It's also been demonstrated that ACOs generate more savings over time –

[24] https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf
[25] https://www.healthaffairs.org/content/forefront/medicare-shared-savings-program-2020-positive-movement-and-uncertainty-during-pandemic#:~:text=Trends%20In%20Shared%20Savings%20For,percent%20and%2085%20percent%2C%20respectively.

with savings increasing by the third year of participation.[26] The rapid transition to downside risk accelerates the speed with which ACOs must develop and hone the skills and capabilities required to succeed in value-based payment arrangements, leading to ACOs dropping out of the program after the first three years. This is even more prominent in the CHC space, as health centers incur unique risks by providing care to all patients regardless of their ability to pay and being strategically placed in medically underserved areas. CMS should consider health centers' "risks" when evaluating how and when they transition into models that assume more downside risk. NACHC appreciates that CMS recognizes that low-revenue ACOs may need additional time to participate in upside-only and provides ACOs the opportunity to remain in Level A for the full agreement period. NACHC supports policies acknowledging that the rapid assumption of downside financial risk has prevented many practices and ACOs serving medically underserved populations from transitioning to value-based payment. Providing practices with additional opportunities to participate in value-based payment arrangements, including non-ACO models, is an important step in advancing health access. Additionally, CMS must consider health center-specific challenges with maintaining required attribution rates for safety-net providers. If an ACO is not ready to transition to the next level, CMS should provide technical assistance to help ACOs evaluate their programs to understand barriers to transition and provide resources to support a successful transition.

Furthermore, timely claims data ensures health centers can better assess patient needs and care metrics requiring more attention. Health centers can then engage with community partners who can assist with the care gaps, implement technology/services to close care gaps, and provide the necessary training to support patient utilization of digital products. Delays in this information pose a risk to health centers' ability to meet performance metrics within downside risk contracts, a financial risk many cannot afford to take. When payers and other partners are timely with their data transfer, it ensures success for all health centers to provide timely, relevant, and adequate care to prevent unnecessary illness. This enables payers to ultimately save money and reduce costs by having healthier patients.

NACHC supports CMS revising the regulatory requirement that an RHC or CHC medical visit must be a face-to-face encounter between a beneficiary and an RHC or CHC practitioner, including encounters furnished through interactive, real-time, audio, and video telecommunications technology. CMS should amend the definition of a CHC medical visit to ensure health centers receive their full PPS rate. Currently, health centers are receiving around $96 for services that generate the same costs related to workforce and technology. Being able to bill PPS for medical visits will bolster financial stability, improve cash flow, and ensure fairer compensation for telehealth services. By simplifying the billing process and increasing revenue, health centers can expand telehealth access to underserved populations. NACHC strongly supports amending the definition of a medical visit, which would help provide more congruent payment for telehealth visits, no matter if they are medical or behavioral health visits.

As mentioned previously, the cost is a large barrier to new endeavors; this is no different for digital health adoption in MSSP and ACO environments. The cost of many digital products (such as Self-Measured Blood Pressure (SMBP) home devices and technology to sync SMBP data via Bluetooth) requires upfront cost and maintenance. CMS should consider upfront incentives to provide health centers with the financial capability to implement technologies that benefit patients and fund the staff time to provide the necessary training to patients and the care team to make it successful.

Telehealth has been crucial in bridging gaps in the care of health center patients. In 2023, 99% of health centers nationwide offered telehealth services compared to just 43% in 2019.[27] Fifty-four percent of telehealth visits were for medical services, 34% for behavioral health services, 9% for enabling services,

[26] https://www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024
[27] 2023 UDS HRSA Data

and 3% for other services. By offering telehealth services for medical and behavioral health care, health centers can expand access to comprehensive care and better serve Medicare beneficiaries facing socioeconomic, mobility, or transportation challenges. Telehealth is also popular among health center patients. Results from a NACHC survey show that almost 90% of patients surveyed agreed that telehealth addressed their needs, was suitable for interaction with their clinician, and they were generally comfortable and satisfied with care via telehealth. A quarter of the patients surveyed had a visit for behavioral health – 52.55% via audio-only and 65.7% via video (and some were both).[28] This adds to the growing body of research about the strength of telehealth in providing clinically equivalent care, besides eliciting strong satisfaction from patients. Further expansion of telehealth continues to connect more providers to patients and break down barriers to care for patients.

Changing the definition of a medical visit to include virtual encounters allows health centers to provide patients with services through the modality of their choice and to best address their medical needs. Health centers strive to meet patients where they are and to enhance access to care; telehealth helps health centers fulfill their purpose of providing high-quality, affordable, and accessible care to all their patients.

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

Value-based care arrangements require a diverse and robust set of health IT capabilities, including care planning tools, patient event notifications, data extraction and normalization, quality performance measurements, access to claims data, attribution and patient ID matching, remote device interoperability, patient portals, and applications for patient self-monitoring and reporting.

a. Examples (not comprehensive) may include:

In addition to the IT capabilities listed above, there are other IT-related barriers to the adoption of value-based care arrangements. For example, CHCs struggle to successfully target patients to schedule their Annual Wellness Visits (AWVs) if there is incorrect patient attribution. AWVs are a vital opportunity for patients and their providers to discuss preventive strategies collaboratively and for the provider to recommend clinical preventive services, leading to a diagnosis.[29] These can help improve patient health as well as establish and develop a deeper, trusted relationship with their provider. Health centers have stressed the need for a timelier way to accurately identify eligible patients on their rosters for AWVs. While they are switching to newer technologies in many elements of their practices, health centers currently rely on outdated payor reporting. NACHC requests that CMS require Medicare plans to allow providers, like health centers, access to updated patient attribution lists via the plan's portal. Access to a Medicare portal would allow health centers to verify the eligibility of the entire attribution list, improving efforts in identifying and reaching out to patients to schedule their AWV. The linkage between patient attribution and provider care creates better alignment between providers and plans, reduces the administrative burden on both entities, streamlines payer-provider coordination, and improves patient outcomes.

b. What other health IT capabilities have proven valuable to succeeding in value-based care arrangements?

CHCs could benefit from expanded health IT capabilities to succeed in value-based care arrangements. For example, the ability to extract positive non-clinical social factors concepts in free-text or unstructured provider notes would improve CHCs' ability to participate, as they can offer more detailed and nuanced

[28] https://www.nachc.org/resource/assessing-patient-satisfaction-with-telehealth-at-community-health-centers-a-policy-brief/
[29] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8455445/.

outlooks of the patient visit that more structured data, such as limited diagnosis codes, could miss.[30] NACHC recommends CMS/ASTP consider the appropriate ICD-10-CM Z-code or SNOMED-CT code and evaluate the work on this topic by the Gravity Project. As previously mentioned, the Gravity Project looks to identify data elements and associated value sets to represent NCSF information documented in EHRs across four clinical activities: screening, diagnosis, goal setting, and intervention activities. The Gravity Project will develop a consensus-based set of recommendations on how best to capture and group these data elements for interoperable electronic exchange and aggregation and collaborate with coding and terminology organizations to address coding gaps identified and apply for new codes (e.g., CPT codes for interventions). Collecting non-clinical social risk factors through the Gravity Project value sets will help better understand the patient, given their strong impact on patients' general health, well-being, and quality of life.[31]

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

NACHC recommends that CMS promote interoperability with the Health Resources and Services Administration (HRSA) to streamline reporting requirements. Health centers use a standardized reporting system known as the HRSA Uniform Data System (UDS) that captures a core set of data that includes patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues. This data set does not always align with quality metrics often used by CMS's value-based payment models, or there is duplication. For instance, many CHCs must report nearly identical quality measures, such as blood pressure control or depression screening, multiple times to multiple entities, with only minor variations in specifications. The promotion of interoperability between HRSA and CMS reporting processes would greatly improve health center participation by decreasing the data reporting burden and ensuring that patient outcomes are correctly attributed to the health center where these patients get their primary care services.

While the number of Medicare patients in health centers is rapidly growing, they currently represent a smaller portion of the overall Medicare population. This ultimately creates a barrier to meeting the minimum Medicare participation requirements in many value-based models, resulting in health centers often being unable to participate in CMS's alternative payment models.[32] Health centers need transparent, continuous, and accurate attribution numbers and a simple methodology to enter value-based care arrangements. CMS and payers need to share this information, which should include how patients are transferred into and out of a provider's attributed population.

NACHC urges CMS to align patient attribution requirements and processes among the same payer and work with other agencies, such as the Center for Medicare and Medicaid Innovation (CMMI), to evaluate how patient attribution strategies can be better streamlined across payers. Successful patient attribution is a key component to achieving success in value-based care (VBC) arrangements.[33] CMS has strongly encouraged healthcare providers, including CHCs, to increase their participation in these arrangements. In partnership with their state PCAs and Health Center Controlled Networks (HCCNs), health centers across the country have already been actively engaged in Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program (MSSP). In 2021, 15 states had CHCs that led ACOs.[34] Some health centers participating in these VBC arrangements have reported issues with the patient attribution system. If

[30] https://pmc.ncbi.nlm.nih.gov/articles/PMC10938158/
[31] https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health
[32] e F et al. If Medicare builds it, can CHCs come? Medical Care. American Public Health Association. 2023. https://www.themedicalcareblog.com/CHCs-medicare-primary-care-model/.
[33] https://www.soa.org/493462/globalassets/assets/files/resources/research-report/2018/patient-attribution.pdf
[34] NACHC 2021 PCA Policy Survey Assessment

not correctly attributed, CHCs face an undue administrative burden on providers who cannot access crucial data for their patients, such as prior authorization data, ultimately hurting the patient's access to care. Furthermore, incorrect attribution can hurt overall care coordination efforts and the health center's ability to maintain VBC arrangements.

NACHC has heard from health centers that it is challenging to track patients, given the existing limitations of accessing updated Medicare Advantage (MA) patient attribution panels. Furthermore, many patients are automatically attributed to a specific CHC when their primary care provider is at another facility. This auto attribution has a negative impact because the CHC is responsible for a patient they are not providing care to, and the system provides the CHC with limited options to remove that patient from their panel. Incorrect attribution does not accurately reflect the patient's care, which impacts the CHC's financial success when participating in VBC arrangements. NACHC continues to urge CMS to recognize the importance of correct patient-provider attribution.

Currently, CHCs are responsible for submitting overlapping quality data to multiple payers often reporting the same data in different formats, through different portals, and on different timelines. CMS should conduct a comprehensive review of its current portfolio of value-based care (VBC) initiatives—including ACOs, Patient-Centered Medical Homes (PCMHs), MIPS Value Pathways, Innovation Center models, bundled payment programs, and advanced primary care models. Many of these models pursue similar goals (cost control and improved quality) and focus on the same beneficiaries and conditions, yet they differ in design, reporting, and payment mechanics. This proliferation creates unnecessary complexity, particularly for safety-net providers like CHCs, who must assess eligibility, track participation, and report performance across multiple, partially redundant initiatives. These parallel reporting obligations require additional staffing, IT system adaptations, and manual reconciliation efforts that do not improve care quality. CMS should explore opportunities to consolidate, align, or sunset overlapping programs and standardize core value-based care components (e.g., risk adjustment, attribution, and quality measures) to create a unified national framework. By streamlining the value-based care landscape, CMS can improve program transparency and ensure that fraud prevention and oversight resources are concentrated on meaningful system reform.

NACHC also recommends that CMS encourage payers to provide participants in VBC arrangements, including CHCs, timely access to claims data. Access to timely, relevant claims data sets up health centers and their patients for success in providing high-quality care. One of the biggest benefits is a heightened ability to engage in population health management. By seeing a comprehensive view of patient care across the health care system, whether through office visits, prescriptions ordered, or procedures completed, having access to this data allows health centers to better understand health trends and tailor their interventions, medical or otherwise, to the needs of their patients. Additionally, timely claims data helps health centers review patient risk and elevate opportunities to bridge gaps in care. Access to timely data can also help identify underlying chronic conditions, allowing the health center to identify and diagnose conditions earlier to prevent costlier interventions in the future.

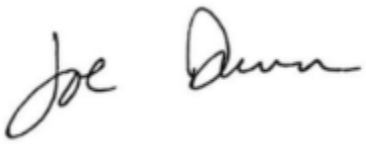
11. What specific interoperability challenges have you encountered in implementing value-based care programs?

To reiterate previous answers, health centers face challenges related to data fragmentation across providers and payers, a general lack of data standardization, varying health IT infrastructure capabilities, patient matching and attribution issues, and security and privacy concerns. We reiterate the importance of CMS aligning patient attribution requirements and processes among the same payer and working with other agencies, such as the Center for Medicare and Medicaid Innovation (CMMI), to evaluate how patient attribution strategies can be better streamlined across payers. Successful patient attribution is a key

component to helping achieve success in value-based care (VBC) arrangements.[35] CMS has strongly encouraged healthcare providers, including CHCs, to increase their participation in these arrangements. In partnership with their state PCAs and Health Center Controlled Networks (HCCNs), health centers across the country have already been actively engaged in Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program (MSSP). In 2021, 15 states had CHCs that led ACOs.[36] Some health centers participating in these VBC arrangements have reported issues with the patient attribution system. If not correctly attributed, CHCs face an undue administrative burden on providers who cannot access crucial data for their patients, such as prior authorization data, ultimately hurting the patient's access to care. Furthermore, incorrect attribution can hurt overall care coordination efforts and the health center's ability to maintain VBC arrangements.

We greatly appreciate the opportunity to respond to this request for information and share how technology can greatly benefit health center Medicare patients. NACHC looks forward to continuing to collaborate with this Administration on leveraging technology to help advance the Make America Healthy Again agenda, in which health centers play a vital role. We appreciate your consideration of our feedback. Please feel free to contact Elizabeth Linderbaum, Deputy Director of Regulatory Affairs, at elinderbaum@nachc.org if you have any questions about our comments.

Sincerely,



Joe Dunn
Chief Policy Officer

[35] https://www.soa.org/493462/globalassets/assets/files/resources/research-report/2018/patient-attribution.pdf
[36] NACHC 2021 PCA Policy Survey Assessment