



Health Technology Ecosystem

REQUEST FOR INFORMATION (RFI)

Prepared for: Centers for Medicare & Medicaid Services (CMS) | Department of Health and Human Services (HHS)

Submitted electronically: <https://www.regulations.gov>

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June 16, 2025

Centers for Medicaid & Medicare Services
Submitted via <https://www.regulations.gov>

Re: CMS-0042-NC: Health Technology Ecosystem RFI

To whom it may concern:

Maximus Federal Services, Inc. (Maximus) is pleased to present our responses to the CMS-0042-NC: Health Technology Ecosystem Request for Information (RFI). We have thoroughly reviewed the RFI requirements and have a clear understanding of where CMS is seeking input on the Health Technology Ecosystem.

Our team carefully analyzed each aspect of the RFI to ensure that our responses comprehensively address all specified requirements. We are confident that our proposed solutions will effectively support the consolidation of call center operations, enhancing efficiency and service quality.

Company Information [RFI-5]	Response
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CAGE Code	8AMZ8
UEI Number	TREKW6J3QSF5

As Executive Managing Director for Maximus, I am authorized to submit this response. As such, I certify that all information included and submitted in our response is accurate to the best of my knowledge and belief.

Please contact me with any questions.

Sincerely,

Monica Rosser
Executive Managing Director, Health
Maximus Federal Services, Inc.

Response to CMS-0042-NC: Health Technology Ecosystem RFI

Submitted by

Monica Rosser, Executive Managing Director, Health, Maximus, monicarosser@maximus.com

Introduction

Maximus Federal is pleased to submit our response to the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) Request for Information regarding the Health Technology Ecosystem (CMS-0042-NC). This is a once in a generation opportunity to fully modernize systems and processes within CMS to empower patients and providers. The breadth of this RFI shows a true vision and commitment to changes that Maximus agrees with and wants to support.

Our response is based on extensive experience continuously innovating for immediate impact in our support of millions of beneficiaries and providers nationwide as a long-standing partner with CMS in administering critical aspects of Medicare and Medicaid programs, including the 1-800-MEDICARE Contact Center Operations (CCO). Through our ability to turn data-driven insights from those millions of interactions with beneficiaries and providers into real and immediate solutions, below are four primary themes you can expect from our response to the RFI questions:

- I. How Maximus can empower the individual beneficiary through a Digital Front Door
- II. How Maximus can personalize the customer experience – Nationwide Patient ID & Digital Identity
- III. How Maximus can help facilitate integrated care – Dual Eligible Coordination
- IV. How Maximus can be a key player in building a better ecosystem to prevent fraud

Across these areas, we will demonstrate that Maximus has the vision and technology to be your partner in rapidly building a flexible ecosystem.

I. Digital Front Door

PC-2. Do you have easy access to your own and all your loved ones' health information in one location (for example, in a single patient portal or another software system)?

a. If not, in what contexts or for what workflows would it be most valuable to use one portal or system to access all such health information?

Consistent with the vision of Dr. Oz, and the new team at CMS, better more modernized methods of accessing health data need to be offered to Medicare beneficiaries. Medicare has lagged behind the commercial sector in implementing these technologies.

According to US Census data for 2023:

- 98% of those under the age of 50 own a smart phone

1600 Tysons Blvd | Suite 300 | McLean, VA | 22102

- 89% of 50–64-year-olds own a smart phone
- 76% of 65+ Own a smart phone

Yet according to digital.gov, for the same year, only 55% of Federal websites are mobile friendly. We are not meeting beneficiaries in the modes they find most convenient. Beyond computer-based websites, the digital front door must swing wider to serve the coming generations where they are, with tools and services that meet their methods of access. Granted, there is still a significant population (24%) whose needs must be addressed in methods that meet their accessibility requirements.

Maximus envisions a “digital front door” to complement 1-800 Medicare. We are in a unique position to be your partner in implementing this new tool because our 1-800-Medicare call center associates could be trained to assist seniors on accessing and using the tools. They would ensure seniors know the tools exist, how to download the app(s), and how to use them. Also, we conduct the Medicare appeals process, so we can easily update the app with appeals information.

Maximus works across other government programs like SNAP and workforce development training and could eventually integrate that data into one app for those who are eligible for multiple programs.

Our vision for a digital front door encompasses technologies like patient portals, mobile apps, chatbots, online appointment scheduling, virtual care platforms, and symptom checkers. The goal of the digital front door is to streamline access to care, enhance patient engagement, and provide a seamless, user-friendly experience across the continuum of care.

Policy Support. The policies are in place, including 1) [The CMS Interoperability and Patient Access Final Rule \(CMS-9115-F\)](#), encourages secure data sharing across payers so beneficiaries can manage their health records via mobile apps or portals; And 2) the 21st Century Cures Act: “Interoperability, Information Blocking, and the ONC Health Information Technology (IT) Certification Program final rule,” (ONC Cures Act final rule), are paving the way for a robust digital front door.

Digital Front Door Components. An AI-driven, multilingual digital front door specifically tailored for CMS, leveraging advanced capabilities:

- **Unified Digital Platform (Web/App-based):** Secure, intuitive self-service interfaces with integrated appointment scheduling, personalized notifications, and streamlined navigation, significantly reducing beneficiary-initiated calls and confusion
- **AI-Driven Multilingual Virtual Assistants & Advanced NLP:** Proactive, multilingual AI chatbots (powered by state-of-the-art NLP) guide beneficiaries seamlessly through eligibility, enrollment, and benefit processes, available 24/7 for immediate resolution of common issues and queries.
- **FedRAMP Infrastructure & Immediate Integration:** Our Mission-Driven Service Management and Modernization (MDSM2) delivery model offers a FedRAMP authorized environment with proven technologies and modernization accelerators to rapidly deploy and seamlessly integrate with existing platforms.

Recommendations for Inclusion in the Digital Front Door

- **Expand Functionality of Medicare.gov:** Integrate telehealth scheduling, AI-powered chat support, and simplified plan comparison tools into a single website or application.
- **Encourage Provider Adoption:** While the 2020 Interoperability and Patient Access Final Rule (CMS-9115-F) requires payers—not only providers—to implement standardized FHIR-based Patient Access APIs to establish a broader API-driven ecosystem, we think CMS could achieve this goal faster by incentivizing providers participating in Medicare to adopt standardized patient portals, remote patient monitoring, and digital therapeutics.
- **Promote Interoperability:** Mandate seamless data exchange across systems, minimizing patient handoffs between multiple platforms.
- **Educate Beneficiaries:** Provide user-friendly tutorials and guided help to ensure seniors and new enrollees can navigate digital tools confidently. As mentioned above, Maximus, through 1-800-Medicare, can assist with seniors' education.
- **Ensure Accessibility:** Incorporate design elements for individuals with visual, hearing, or dexterity challenges, ensuring inclusivity across demographics.

II. Nationwide Unique Patient ID Application & Digital Identity

PC-4: Missing Features in Current Health Applications

PC-4.a: Apps That Should Exist, But Do Not Yet

A most critical application missing from today's health technology ecosystem is a comprehensive Nationwide Unique Patient ID platform that puts control firmly in beneficiaries' hands while solving the fundamental identity challenges plaguing our healthcare system.

Based on our experience operating the 1-800-MEDICARE contact center, we observe that a significant number of all calls involve identity verification challenges or record matching issues. These issues directly impact CMS's ability to manage care effectively, process claims correctly, and prevent fraud, waste, and abuse (FWA).

This unified identity solution does not exist today primarily due to:

1. **Historical Legislative Barriers:** Congressional restrictions on federal funding for the development of a unique patient identifier system have been reconsidered in recent years.
2. **Technical Complexity:** The challenge of securely linking existing fragmented identities across disparate systems while maintaining privacy, and offering the speed and fluidity required between systems.
3. **Stakeholder Alignment:** The need for unprecedented coordination between government, healthcare systems, and technology providers. We believe, based on what we have seen so

far, that the Trump Administration is uniquely capable of achieving the necessary coordination.

- 4. Privacy Concerns:** Public hesitation about centralized identity systems without robust protection.

Maximus proposes that the time is right for CMS to lead the development of this critical infrastructure with proper safeguards. Our frontline experience with Medicare beneficiaries informs our opinion that the absence of a unified identity system results in millions of dollars in annual improper payments, administrative burden, and beneficiary frustration for Medicare.

Maximus as a Leader in Technical Customer Experience Delivery

Maximus is exploring innovative technologies that could support a secure patient identity system, including an encryption wrapper for digital health assets. This approach would allow a patient's health records to be tracked wherever they go while maintaining a "smart contract" that governs approved uses.

When handling over 42 million calls annually through the 1-800-MEDICARE line, our agents often focus solely on identity verification. With a secure, unified ID system:

- 1. Beneficiary Control:** Patients would authorize precisely who can access their information and for what purpose.
- 2. Transparent Audit Trail:** Every access attempt would be recorded and viewable by the patient.
- 3. Seamless Integration:** Identity verification would happen instantly, reducing call handling time and beneficiary frustration.
- 4. Fraud Prevention:** Enhanced ability to detect and prevent improper claims before payment.

This solution would directly address the pain points we observe daily in the CCO contract, where callers frequently express frustration with having to repeatedly provide the same identifying information to different parts of the Medicare system.

PC-14.f: Encouraging Digital Identity Credential Adoption

Response: Based on direct interactions with millions of Medicare beneficiaries, Maximus recommends that CMS consider:

- 1. Streamlined Authentication Process:** Our 1-800-MEDICARE agents report callers expressing frustration with current authentication requirements. A simplified and standardized process would significantly improve the beneficiary experience.
- 2. Education and Outreach:** Currently, callers to the CCO line are unaware of digital identity options. CMS should launch targeted campaigns during enrollment periods.
- 3. Incentive Structure:** Offer meaningful incentives for beneficiaries who adopt secure digital identity credentials, such as expedited service or enhanced digital capabilities.

4. **Trusted Provider Network:** Leverage existing trusted relationships with providers to encourage adoption during in-person visits.
5. **Multi-Channel Support:** Based on our CCO operations, we see the generational differences among Medicare beneficiaries requiring assistance with digital tools. CMS must employ a solid change-management strategy and maintain robust phone and in-person support for credential identity enrollment.

Financial Impact of Identity Solutions on Medicare FWA

Based on our Maximus Program Integrity services and analysis of publicly available CMS data, we estimate:

1. **Improper Payments Reduction:** A comprehensive identity solution could lead to significant cost savings, reducing improper payments through better beneficiary-provider matching and claim verification.
2. **Administrative Savings:** Processing time can be reduced for claims requiring manual review, translating to millions in annual administrative cost savings.
3. **Provider Burden Reduction:** Healthcare providers could save significant time per day currently spent on identity verification, allowing more time for patient care.
4. **Beneficiary Experience Improvement:** Based on our CCO data, call handling times would decrease per call, representing millions of hours saved annually for Medicare beneficiaries.

III. Dual Eligible Coordination

PC-8.a. What data is valuable, but hard for patients and caregivers, or app developers and other technical vendors, to access for appropriate and valuable use?

a. What are specific sources, other than claims and clinical data, that would be of highest value, and why? Real-Time Dual-Eligible Program Coordination Intelligence

For the 12.8 million Americans eligible for both Medicare and Medicaid, the most valuable yet inaccessible data involves real-time program coordination intelligence that determines which Federal or state program covers specific services, providers, and circumstances. This coordination data represents the difference between seamless care delivery and the systematic failures documented in Medicare Rights Center case studies, where dual-eligible beneficiaries face unexpected bills, lose access to established providers, and navigate byzantine appeals processes.

Unlike traditional claims and clinical data, **dual-eligible coordination data is dynamic, policy-dependent, and exists at the intersection of federal Medicare rules and 50 different state Medicaid programs.** This creates a complex matrix of coverage determinations that changes based on beneficiary location, enrollment status, provider networks, service types, and evolving state policies—information currently scattered across multiple systems, making it impossible for patients, caregivers, or technology vendors to access in a usable and actionable format.

Specific High-Value Data Sources Beyond Claims and Clinical Data

1. Real-Time Eligibility and Benefits Coordination Matrices

What it is: Dynamic databases showing which program (Medicare Part A/B/C/D or state Medicaid) provides primary coverage for specific services based on beneficiary characteristics, location, enrollment status, and provider networks.

Why it is valuable: Prevents coordination failures, such as an unexpectedly large dental bill, where D-SNP dental coverage was minimal, despite a patient having comprehensive Medicaid dental benefits. The cause is unavailable information at the point of care scheduling.

Current access barriers: This data is fragmented across Medicare systems, state Medicaid databases, and health plan platforms, with no unified API or real-time access mechanism for patients or technology vendors.

2. State-Specific Medicaid Policy and Coverage Determination Rules

What it is: Detailed state-by-state variations in Medicaid coverage policies, prior authorization requirements, provider enrollment criteria, and coordination of benefits rules that interact with federal Medicare coverage.

Why it's valuable: Essential for determining coverage responsibility before service delivery, for example, orthotic shoe inserts are only covered by Medicare for diabetes-related conditions, requiring Medicaid coverage for all other conditions, but this nuanced coverage determination data is not readily accessible.

Current access barriers: State Medicaid policies are often found in PDF documents, provider manuals, and administrative systems that lack standardized formats or Application Programming Interfaces (APIs) for technology integration.

3. Provider Network Participation Status Across Dual Programs

What it is: Real-time data showing which providers accept Medicare, Medicaid, or both programs, including network adequacy metrics, appointment availability, and geographic access patterns specific to dual-eligible populations.

Why it's valuable: Prevents network coordination failures where beneficiaries receive care from providers who participate in one program but not the other, creating unexpected financial liability.

Current access barriers: Provider directories are notoriously inaccurate (CMS compliance reviews reveal problems in all examined directories), while dual-program participation status isn't consistently tracked or reported.

4. Appeals and Prior Authorization Decision Patterns

What it is: Historical data on appeals outcomes, prior authorization approval rates, and coverage determination patterns across Medicare Advantage plans, traditional Medicare, and state Medicaid programs for dual-eligible services.

Why it's valuable: Enables predictive analytics to identify likely coverage determinations before submitting requests, reducing the administrative burden that generates 50 million Medicare Advantage prior authorization requests annually.

Current access barriers: Appeals data is considered proprietary by health plans and isn't aggregated or made available for technology development purposes.

5. Non-medical Drivers of Health and Support Services Mapping

What it is: Comprehensive databases linking dual-eligible beneficiaries to available social services, housing assistance, transportation programs, nutrition support, and community-based services that complement medical coverage.

Why it's valuable: Dual-eligible beneficiaries often require coordinated medical and social services; however, current systems don't effectively map these relationships or provide integrated access to available resources.

Current access barriers: Social services data are stored in local government databases, non-profit systems, and community organizations that lack interoperability standards or data-sharing agreements.

6. Quality Metrics and Outcomes Data for Dual-Eligible Populations

What it is: Specific quality measures, health outcomes, and care coordination metrics for dual-eligible beneficiaries across different delivery models (traditional Medicare/Medicaid, D-SNPs, FIDE SNPs, etc.).

Why it's valuable: Enables comparative effectiveness research, helping beneficiaries choose optimal coverage arrangements based on measurable outcomes for their specific conditions and circumstances.

Current access barriers: Quality data is reported separately for Medicare and Medicaid programs, with limited integration or dual-eligible-specific metrics available for public access.

The Technology Solution Opportunity

With advances in Health Information Exchanges (HIEs), artificial intelligence, and large language models, creating a comprehensive dual-eligible coordination platform is now technically feasible. This platform could:

- **Determine coverage responsibility in real-time** before service delivery using AI-powered decision engines trained on federal Medicare rules and state-specific Medicaid policies
- **Provide predictive analytics** for prior authorization and appeals outcomes based on historical patterns and beneficiary characteristics
- **Offer unified provider directory services** showing dual-program participation status and real-time appointment availability

- **Enable seamless care coordination** across federal and state programs through standardized APIs and data sharing protocols

Expected Impact on System Efficiency

Implementation of comprehensive dual-eligible coordination data access could dramatically reduce system inefficiencies:

- **Eliminate thousands of preventable appeals** by ensuring correct program billing from the outset
- **Reduce administrative costs** for providers, health plans, and government programs through automated coordination
- **Improve beneficiary experience** by preventing unexpected bills and coverage gaps
- **Enable value-based care models** designed explicitly for dual-eligible populations
- **Support state innovation** in dual-eligible integration while maintaining federal oversight

Data Standardization and Interoperability Requirements

Success requires establishing standardized data formats and APIs that enable:

- **Real-time queries** across Medicare and Medicaid systems for coverage determinations
- **Automated data updates** when policies, provider networks, or beneficiary status changes
- **Privacy-compliant data sharing** that protects beneficiary information while enabling coordination
- **Scalable cloud infrastructure** capable of handling queries for 12.8 million dual-eligible beneficiaries
- **State flexibility** within the federal framework standards for Medicaid program variations

Conclusion: Transformational Potential Through Data Access

Dual-eligible program coordination data represents the missing link in achieving truly integrated care for America's most vulnerable and **expensive** healthcare population. While claims and clinical data provide essential insights, **coordination data enables the prevention of system failures before they harm beneficiaries**, as well as the opportunity for a measurable return on investment (ROI) through reduced administrative costs, improved outcomes, and enhanced beneficiary satisfaction.

Technology solutions that successfully aggregate, standardize, and provide real-time access to dual-eligible coordination data will transform care delivery for approximately 12.8 million Americans, generating significant value for healthcare stakeholders. The combination of regulatory mandates, market concentration, and technology advancement creates an unprecedented opportunity for innovative data platforms that bridge the persistent gap between federal Medicare and state Medicaid programs.

The time for incremental improvements has passed—comprehensive dual-eligible coordination data access represents the foundation for systematic transformation of America's most complex healthcare integration challenge.

Improving the 1-800-MEDICARE Contact Center Operations with Dual-Eligible Coordination Technology

A comprehensive dual-eligible coordination system would revolutionize 1-800-MEDICARE Contact Center Operations (CCO) by eliminating the most time-consuming and error-prone aspects of supporting dual-eligible beneficiaries. Currently, dual-eligible calls require extensive manual research across multiple systems, with agents spending 3-5 minutes per call solely on identity verification and another 5-10 minutes navigating disconnected Medicare and Medicaid databases to determine coverage responsibility. **With real-time access to integrated dual-eligible coordination data, CCO agents could instantly verify beneficiary status, identify coverage responsibility, and provide definitive answers about provider networks, prior authorization requirements, and appeals processes.**

The system would enable CCO agents to proactively prevent coordination failures by alerting beneficiaries to potential network mismatches before enrollment decisions, identifying when Medicare Advantage plans may not align with existing Medicaid providers and state-specific guidance on coverage variations. **For the estimated 25-30% of CCO calls involving dual-eligible coordination issues, resolution times could decrease by 50-70%,** while accuracy would improve significantly through the use of automated decision support tools. **This transformation would not only enhance beneficiary experience but also reduce CCO operational costs and support CMS' implementation of new coordination requirements through 2027.**

PC-8.c. What specific opportunities and challenges exist to improve accessibility

With newer technologies, advances in the federal and state government focusing on HIE's, today, the promise of creating a dual eligibles platform, combining information, and policies across states is possible using AI and LLMs to offer a tool which can determine where a provider/beneficiary should submit a claim, prior to submission. This will reduce the thousands of annual appeals and increase the speed to payment and service delivery to beneficiaries.

PC-8.b: High-Value Data Sources Beyond Claims and Clinical Data

Response: Beyond traditional data, we recommend prioritizing:

Administrative and Geographic Data

Based on our experience supporting CMS, Maximus recognizes the critical value of administrative information, including:

- 1. Beneficiary Geographic Distribution:** Enabling better resource planning and identifying access disparities.
- 2. Provider Service Capacity:** Understanding the actual availability of services by location.
- 3. Claim Submission Patterns:** Geographic and provider-specific patterns that can indicate potential FWA hotspots.

At the 1-800-MEDICARE call center, we frequently receive calls from beneficiaries who are unable to find certain specialists within a reasonable distance. A comprehensive data layer that combines unique patient IDs with geographic service information would enable CMS to predict better and address these access issues.

PC-8.c: Improving Interoperability of Clinical Data

Response: Opportunities and Challenges for Improving Data Integration

A Nationwide Unique Patient ID system would address fundamental challenges in data interoperability by:

- 1. Eliminating Record Duplication:** Our analysis of Medicare databases suggests an estimated 8-12% duplication rate in beneficiary records, leading to fragmented care views.
- 2. Enabling Accurate Record Matching:** Currently, our 1-800-MEDICARE agents report many calls involving difficulty accurately matching beneficiaries to their complete records.
- 3. Supporting Longitudinal Care Analysis:** Facilitating research and care improvement through reliable data connections across the care continuum.
- 4. Enhancing Security:** Ironically, the current fragmented system creates more security vulnerabilities than a well-designed unified system would.

The primary challenges we must address include:

- 1. Privacy Framework Development:** Creating clear rules for consent, access, and use.
- 2. Technical Standards Implementation:** Establishing universal requirements for identity verification and matching.
- 3. Legacy System Integration:** Developing reliable crosswalks between existing identifiers to ensure seamless data integration.

IV. Building An Ecosystem to Prevent Fraud

TD-2. – Ecosystem

There are several parts of the overall ecosystem that need to be addressed, which form the underpinnings of any new technology, system or processes as they are introduced into the CMS ecosystem, which include Change Management, fast knowledge platforms, and fraud, waste and abuse.

Change Management in CMS Programs

Change management is a critical component in the successful implementation of health technology initiatives within CMS programs. Effective change management ensures that stakeholders are engaged, communication is clear, and beneficiaries and the workforce are prepared for new processes and technologies.

In the context of CMS programs, change management involves:

- Engaging beneficiaries and providers to understand their needs and concerns.
- Communicating the benefits and impact of new technologies.
- Providing training and support to ensure smooth transitions.
- Monitoring and evaluating the effectiveness of implemented changes.

By incorporating change management principles, CMS can enhance program integrity, improve service delivery, and ultimately achieve better health outcomes for beneficiaries.

TD-2. Regarding CMS Data, to stimulate developer interest

c. What obstacles prevent accessing these data sources today?

Fraud, Waste & Abuse Delays Critical Development

Maximus has new technologies that can capture fraudulent payments in-flow, and invoke proactive measures for fighting fraud, instead of increasing more roadblocks for legitimate beneficiaries.

Although not specifically called out in the request for information, a significant dark cloud hangs over all health IT solution development, and that is the challenge of compensating for bad-actors defrauding the Medicaid & Medicare systems, waste caused by multiple billings for tests for patients, because their information is locked in another system, and abuse by those that may bill for services for which patients are not legally entitled. This cloud causes excessive burden on the patients, who must go through a proving ground of security “checks” on their identity, the validity of their medical needs, and the challenge of managing and understanding excessive paperwork – resulting not from their own bad behaviors, but as a result of fraudsters impersonating patients, and impersonating legitimate providers.

Why is this happening? An indicator of why it is happening can be found in the Dark Web. On the Dark Web, a stolen credit card number is worth between \$5-\$110, and an EHR is worth \$1-\$1000 depending on its completeness.¹ Indicating that data in an EHR is potentially worth legions more to access potentially larger pools of funds – and where it takes months to find the fraudulent activity compared to credit cards where it takes minutes to days. A large portion of Medicare/Medicaid fraud comes from criminal individuals and syndicates, US and Internationally based, who are abusing the systems, not our grandparents. These criminals are taking advantage of siloed information systems, “after the fact” analytics and trend evaluation, which launches a “pay-first and recover model” of fraud reduction – not prevention. According to a GAO report, published in 2024, there is over \$100 Billion in Medicare payment errors annually. Granted, the velocity of claims was over 1 billion to process \$1T of health claims for 66 million recipients. However, as the old adage goes “An ounce of prevention is worth a pound of cure.”

Maximus’s Approach. Siloed information is no longer an excuse, if CMS enforces data access rules, as there are multiple ways to federate data from multiple sources without re-storing it. The real hang-up today is that widely used technologies to handle the streams of data required to analyze this

¹ Experian, 2025

data for anomalies is costly, thus making this solution out of range, and often done in a “black box” not allowing government agencies the clarity required by law.

Maximus has proactively invested over \$100M in the past 5 years, to bring through our FedRAMP environment leading edge technologies that we believe will address fraud, waste, and abuse at scale. These solutions are available as off-the-shelf solutions to CMS to take advantage and rapidly provide value and are centered around an outcomes driven cost model.

Maximus has a suite of breakthrough technology with (10 patents) that makes it possible to have instant access to fully connected and contextualized data at any scale at a substantially lower cost. This means that data spread throughout the CMS enterprise can be seamlessly integrated into a single, data-centric knowledge infrastructure. As data changes throughout CMS, it can be instantly updated in the knowledge infrastructure and this stream of information can be processed to look for anomalies or tip advanced algorithms (e.g. look for fraud).

With legacy technology, these capabilities would simply be unaffordable and impractical from a return-on-investment perspective, as the cost associated with fully connected and contextualized data at the scale of CMS would erode the margins related to fraud identification and prevention.

This capability could be deployed to support three important capabilities:

1. Provide real-time observability of the CMS enterprise.
2. Knowledge infrastructure to host advanced algorithms to detect fraud and waste.
3. Knowledge infrastructure to provide the data-centric architecture necessary to realize the promise of AI.

Without the seamlessly connected data provided by this knowledge infrastructure, AI models would have to be built to understand each system. Without the accelerated speed of access provided by this knowledge infrastructure, AI models would be delayed due to slow query times similar to how today’s human users are impacted. Since this infrastructure does not replace existing systems, it could rapidly be implemented and proof of value quickly realized by bringing in data from just a few selected systems. In addition, external data for purposes such as benefit eligibility or identifying fraud could also be seamlessly connected with other data across the knowledge infrastructure. It inherently includes zero-trust security and pervasive compartmentalization – to provide very high levels of security and assurance.

Finally, the Maximus team intends to bolt on a proactive AI-led fraud prevention outbound call and notification workflow that engages relevant parties (departments, agencies, and customers). If our system identifies fraud, waste, and abuse issues across the CMS enterprise in near real-time, then the proactive engagement model will also need to be modified.

Conclusion

As CMS and ASTP/ONC consider the future of the health technology ecosystem, we strongly support this administration’s focus on preventing Fraud, Waste & Abuse (FWA). A foundational component to support the elimination of FWA is the Nationwide Unique Patient ID system, which places control in beneficiaries' hands, and enables them to walk through a digital front door with

minimal assistance. Although not the “complete” remedy, this addresses the heart of the challenges in administering and delivering healthcare for CMS programs.

Maximus stands ready to support CMS’s critical initiative through our deep expertise in Medicare and Medicaid operations, beneficiary engagement, and advanced technology solutions. The implementation of such a system can yield significant returns for CMS through reduced FWA, improved administrative efficiency, and enhanced beneficiary experience.

We appreciate the opportunity to provide this feedback and welcome further discussion on how Maximus can partner with CMS to advance this vision.

Respectfully submitted,

Monica Rosser
Maximus Federal