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**RE: Request for Information; Health Technology Ecosystem [CMS-2025-0050-0031]**

To Whom It May Concern,

On behalf of Foundation Health, thank you for the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) regarding the future of the health technology ecosystem. Foundation Health is a healthcare technology company focused on modernizing the infrastructure that underpins prior authorization and digital pharmacy services using AI-enabled systems. Our mission is to reduce administrative friction and enable faster, more equitable access to care and medications for all patients.

We commend CMS for undertaking this important initiative to build a more interoperable, efficient, and patient-centered ecosystem. In the sections below, we have provided detailed responses to the RFI questions, grounded in our experiences and the perspectives of a technology vendor actively working to integrate with health systems, manufacturers, direct-to-consumer healthcare companies, and pharmacy networks across the country.

**TD-1. What short term (in the next 2 years) and longer-term steps can CMS take to stimulate developer interest in building digital health products for Medicare beneficiaries and caregivers?**

To meaningfully accelerate innovation and attract a broader range of developers into the Medicare digital health ecosystem, CMS should pursue a dual-track strategy: short-term actions

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to reduce technical and regulatory barriers, and longer-term investments that create sustainable infrastructure for digital health development.

In the short term, CMS can immediately improve developer engagement by expanding access to test environments and regulatory "safe harbors" for early-stage development. Providing low-risk, production-like sandbox environments powered by synthetic or de-identified data would enable developers to build and iterate without fear of noncompliance. In parallel, clearer technical documentation and a unified developer interface across CMS programs such as Blue Button 2.0, Data at the Point of Care, and Prior Authorization APIs would improve usability and lower the learning curve. CMS can further stimulate interest by co-hosting virtual innovation accelerators or public-private challenge programs focused on high-priority areas such as chronic disease management, care navigation, and social determinants of health. These events should offer guided access to CMS resources, hands-on mentorship, and structured feedback loops to help align development with policy objectives.

Over the longer term, CMS should invest in infrastructure and funding mechanisms that enable a broader and more sustainable innovation ecosystem. This includes creating grant programs for developers building FHIR-based applications and other API-enabled tools that address Medicare-specific challenges, particularly those that improve care access, beneficiary understanding, or administrative efficiency. CMS should also consider sponsoring and maintaining open-source tools and libraries that support interoperability and reduce the technical lift for new market entrants. Finally, CMS could establish regional Medicare innovation testbeds or data hubs that allow developers to pilot solutions in real-world environments in collaboration with providers and ACOs. These testbeds would serve as valuable learning grounds for interoperability and digital transformation, while providing CMS with insight into what tools are most effective in improving beneficiary experience and outcomes.

By taking these actions, CMS can send a strong signal that it is committed to fostering an open and innovation-friendly health technology ecosystem. This approach supports not only compliance and standardization, but also creativity, agility, and patient-centered progress.

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

To stimulate greater developer participation in building digital health tools for Medicare beneficiaries, CMS should prioritize the expansion and integration of data assets that enable more personalized and proactive care. One critical opportunity is to make additional datasets available through CMS APIs, including beneficiary risk stratification scores, provider attribution information, and social determinants of health (SDOH) indicators. These data elements would empower developers to build tools that support targeted interventions, more accurate care navigation, and equity-informed decision-making.

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In addition to CMS-owned datasets, pairing claims data with complementary third-party data, such as medication adherence data, laboratory results, or visit summaries from Health Information Exchanges (HIEs), would unlock new use cases for continuity of care and population health management. These integrated views could support applications that help beneficiaries better understand their health trajectory and guide providers in making data-driven decisions.

However, several persistent barriers limit access to these valuable data sources. Developers often face unclear API policies, lengthy and opaque credentialing processes, and a fragmented support ecosystem across CMS programs. These challenges make it difficult for smaller innovators or newer market entrants to engage with CMS data efficiently or confidently.

To address this, CMS should consider consolidating APIs into a single, unified developer interface that brings together services such as Blue Button 2.0, Data at the Point of Care (DPC), and Prior Authorization into a cohesive and well-documented platform. Simplifying access, harmonizing standards, and reducing the administrative overhead required to connect with these APIs would go a long way in making the CMS data ecosystem more welcoming and productive for developers committed to improving care for Medicare beneficiaries.

**TD-3. Regarding digital identity implementation:**

Digital identity is a critical enabler of secure, scalable, and interoperable healthcare systems. However, the implementation of digital identity solutions in the Medicare ecosystem comes with both significant opportunities and important challenges. From a developer and user experience standpoint, one of the primary challenges is the risk of user friction. Solutions that require new logins or unfamiliar authentication processes may be confusing or burdensome for older beneficiaries, caregivers, or providers. Additionally, adoption among providers has historically been limited due to inconsistent standards and fragmented identity solutions across systems.

Despite these challenges, the benefits of digital identity implementation are substantial. Stronger authentication protocols can help ensure secure access to sensitive health data and support the creation of more accurate and complete longitudinal patient records. Digital identity also enables more seamless data exchange across providers, payers, and applications, thus advancing interoperability and trust in the ecosystem.

Requiring identity credentials that meet NIST 800-63-3 IAL2 and AAL2 standards, such as those provided by Login.gov or ID.me, could increase security and create consistency in user verification. However, CMS must be mindful of the risk that such requirements could inadvertently exclude underserved populations or individuals with limited digital access. Maintaining alternative pathways for identity verification and access will be essential to promoting equity and usability.

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The mandatory adoption of the OpenID Connect identity protocol would provide a clear technical standard to streamline authentication and reduce the proliferation of redundant login systems. Standardization around this protocol would simplify integration for developers and reduce complexity for users, ultimately improving both security and user experience across CMS digital health tools.

**TD-4. How can CMS better encourage use of open, standards-based, publicly available APIs over proprietary APIs?**

CMS can play a pivotal role in promoting interoperability and reducing vendor lock-in by mandating the use of open, standards-based APIs across all CMS-certified systems. Requiring public FHIR-based APIs for data exchange, prior authorization, and patient access would create a level playing field for developers and reduce the dominance of proprietary interfaces that limit innovation. In addition to mandates, CMS should introduce meaningful disincentives for closed systems by incorporating openness and interoperability as evaluation criteria in vendor certification processes and value-based contracting models, including those for ACOs and other alternative payment entities. Prioritizing vendors that adopt open standards will not only expand developer participation but also ensure that Medicare beneficiaries and providers benefit from a more connected, responsive, and transparent digital health ecosystem.

**TD-5. How could a nationwide provider directory of FHIR endpoints improve access to health information for patients, providers, and payers? Who should publish such a directory, and should users bear a cost?**

A nationwide provider directory of FHIR endpoints would significantly improve the ease and reliability of health information exchange by centralizing endpoint discovery for developers, providers, and payers. Currently, locating and validating endpoints is a manual and error-prone process that hinders timely data exchange, especially across organizational boundaries. A standardized directory would reduce this friction and enable faster, more scalable patient data sharing, helping to fulfill the promise of nationwide interoperability. This would be particularly beneficial for smaller or under-resourced providers that may lack the infrastructure to maintain endpoint directories or participate in proprietary networks. CMS or a designated Qualified Health Information Network (QHIN) should be responsible for publishing and maintaining such a directory, ensuring it is accurate, up to date, and publicly accessible. To maximize adoption and equity, access to the directory should be provided at no cost to users, including developers and care delivery organizations.

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**TD-6. What unique interoperability functions does TEFCA perform?**

The Trusted Exchange Framework and Common Agreement (TEFCA) introduces structured governance and identity assurance across disparate health networks, helping to facilitate nationwide trust and streamlined onboarding. By defining clear rules for data sharing, authentication, and participant engagement, TEFCA creates a cohesive framework that simplifies cross-network interoperability. That said, private entities such as Carequality and CommonWell already offer functional data exchange capabilities and are effectively meeting many real-world use cases. To reduce duplication and friction, CMS should focus on consolidating similar functions, use cases, and technical endpoints across these frameworks. Harmonizing governance, directory services, and endpoint standards under a coherent, unified model would enhance interoperability, minimize administrative burden, and avoid redundant infrastructure investment.

**TD-7. To what degree has USCDI improved interoperability and exchange and what are its limitations?**

The United States Core Data for Interoperability (USCDI) has been an important step forward in improving the consistency and semantic alignment of clinical data across systems. It has helped standardize key data elements, which in turn supports more reliable data exchange and broader interoperability across platforms. However, the current scope of USCDI does not fully meet the data needs of developers and care teams. In particular, it lacks sufficient granularity in areas such as behavioral health, social services, and pharmacy-related data, all of which are increasingly important for holistic, patient-centered care.

These gaps stem from both the limitations in the current USCDI definitions and the way in which the standard is implemented across the ecosystem. Expanding USCDI to include these critical domains could provide significant value, but doing so without careful planning could introduce complexity and burden. To address this, CMS and ONC should consider adopting an incremental, use-case-driven release cycle that includes pilot testing with real-world implementers. This would allow for iterative improvement while preserving the usability and clarity of the core dataset.

Looking ahead, the emergence of advanced language models and natural language processing (NLP) capabilities presents an opportunity to rethink how structured and unstructured data can coexist. A hybrid model that includes both structured fields and free-text notes—augmented by NLP tools—could enable more comprehensive data coverage without overwhelming the standard. Ensuring that this model remains non-proprietary and openly accessible would further support innovation and equitable access to high-value data for all stakeholders.

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**TD-8. What are the most effective certification criteria and standards under the ONC Health IT Certification Program?**

The most effective certification criteria under the ONC Health IT Certification Program are those that directly enable real-time, bi-directional data exchange and integration across systems. Standards such as Bulk FHIR, CDS Hooks, and scheduling APIs are particularly valuable because they support high-volume data retrieval, clinical decision support, and workflow integration in a scalable and developer-friendly way. These capabilities are essential for enabling smart automation, care coordination, and data-driven decision-making across both payer and provider systems.

To further enhance the value of certification, CMS and ONC should incorporate requirements for usability and system performance. Specifically, certified systems should be evaluated on measurable criteria such as API response times, uptime reliability, and ease of implementation. Including these metrics would help ensure that certification reflects not only conformance to technical standards but also real-world utility for developers and end users. This approach would better align certification with the practical demands of a modern, patient-centered digital health infrastructure.

**TD-9. Regarding certification of health IT:**

Redefining health IT certification to prioritize API-enabled capabilities over general software functionality would align certification more closely with real-world interoperability outcomes. By emphasizing dynamic data exchange and standards-based integration, certification can better support the needs of developers, providers, and patients alike. This shift would accelerate innovation, reduce manual workflows, and enable the creation of more intelligent digital health tools.

However, this approach is not without risks. One key drawback is the potential for superficial compliance—where vendors technically meet API specifications without ensuring meaningful data quality, completeness, or usability. To avoid this, certification should include not just technical conformance but also performance metrics and real-world testing that reflect end-to-end data utility.

ASTP and ONC can further strengthen certification criteria by requiring APIs to support both structured and unstructured data elements, including free-text clinical notes and scanned or faxed documents. Comprehensive data exchange must go beyond discrete fields and reflect the complexity of the full patient record. Certification processes should validate that APIs can support these mixed data types and surface them in ways that are accessible and actionable to downstream systems.

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To encourage high-quality data exchange in practice, CMS should establish incentives that reward providers for responding to API-based queries with complete, timely, and well-structured information. This could include integrating API responsiveness into value-based care models or quality programs. Positive reinforcement for high-performing organizations will help establish a culture of data stewardship that extends beyond compliance.

Finally, bulk data transfer capabilities in EHRs—especially those that conform to the FHIR Bulk Data Access (Flat FHIR) standard—present a significant opportunity to streamline quality reporting. These exports can reduce provider burden by automating data submission to CMS, provided that vendors support the capability and that guidance is clear regarding the granularity and structure of required data. While this model holds great promise, concerns remain about variability in implementation, the readiness of smaller vendors, and the potential for data gaps if underlying systems are not harmonized. CMS should ensure that bulk data use for quality reporting is phased in thoughtfully, with adequate support and oversight to safeguard accuracy and completeness.

**TD-10. For EHR and other developers subject to the ONC Health IT Certification Program, what further steps should ASTP/ONC consider to implement the 21st Century Cures Act's API condition of certification (42 U.S.C. 300jj-11(c)(5)(D)(iv)) that requires a developer's APIs to allow health information to be accessed, exchanged, and used without special effort, including providing access to all data elements of a patient's electronic health record to the extent permissible under applicable privacy laws?**

To fulfill the intent of the 21st Century Cures Act, ONC should take additional steps to ensure that certified APIs provide truly comprehensive, frictionless access to patient health information. Specifically, API certification should require access to the full breadth of EHR data types, including both structured and unstructured data, through a single, universal API interface. Developers should be prohibited from gating data behind proprietary workflows, paywalls, or custom configurations that limit interoperability or require special technical effort to overcome. In addition, enforcement mechanisms should be strengthened to prevent information blocking and ensure that all data elements defined as part of the EHR are accessible in a standardized, documented, and developer-friendly manner. These measures are critical to advancing the spirit of the law: empowering patients and providers with seamless access to data while supporting innovation across the digital health ecosystem.

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**TD-11. As of January 1, 2024, many health IT developers with products certified through the ONC Health IT Certification Program are required to include the capability to perform an electronic health information export or "EHI export" for a single patient as well as for patient populations (45 CFR 170.315(b)(10)). Such health IT developers are also required to publicly describe the format of the EHI export. Notably, how EHI export was accomplished was left entirely to the health IT developer. Now that this capability has been in production for over a year, CMS and ASTP/ONC seek input on the following:**

Now that the EHI export requirement has been in production for over a year, CMS and ONC have a valuable opportunity to standardize and strengthen this capability to ensure it drives meaningful interoperability. The current variability in implementation limits the utility of EHI exports for many developers, researchers, and care teams. CMS and ONC should revise the requirement to mandate standardized export formats using FHIR, such as the (g)(10) standard or FHIR Bulk Data Access (Flat FHIR). Standardizing the export method will promote consistency across systems, reduce the burden on integrators, and enable more scalable data aggregation.

From a workflow standpoint, there is a clear need for more guidance and consistency in how patient populations and cohorts are defined for export. Developers and providers would benefit from a more uniform approach to cohort construction and export initiation, including clarification of trigger events and user permissions.

To further encourage adoption and utility of this feature, CMS should consider aligning policy levers, such as reporting requirements or value-based care incentives, with the availability and use of robust EHI export functionality. Rewarding vendors and providers who make these capabilities easily accessible and actively used in clinical or administrative workflows will help ensure that EHI export is more than a checkbox exercise and instead becomes a foundational tool for improving patient care and population health outcomes.

**TD-12. Should CMS endorse non-CMS data sources and networks, and if so, what criteria or metrics should CMS consider?**

Yes, CMS should consider endorsing non-CMS data sources and commercial data networks, such as Health Information Exchanges (HIEs) and national interoperability frameworks, when they meet clear standards for performance, access, and data integrity. Endorsement should be contingent on these networks demonstrating high levels of data completeness, low latency in data availability, and strong support for patient access and transparency. CMS's endorsement could help encourage broader adoption of high-performing networks, reduce duplication across systems, and give providers and developers greater confidence in relying on third-party data sources. Establishing transparent evaluation criteria and requiring adherence to industry-

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standard formats (such as FHIR) would ensure that endorsed networks advance CMS's broader goals of interoperability, equity, and patient empowerment.

**TD-13. What new opportunities and advancements could emerge with APIs providing access to the entirety of a patient's electronic health information (EHI)?**

APIs that provide access to the entirety of a patient's electronic health information (EHI) have the potential to unlock significant advancements in care coordination, clinical decision support, and patient engagement. With access to complete records, including scanned documents, clinical notes, and unstructured content, developers could build more intelligent tools for personalized care, automate administrative workflows, and support longitudinal care planning across providers and settings.

However, several key obstacles must be addressed to realize these benefits. Many EHR systems still lack robust support for structured data formats, which limits the ability to extract or process information consistently. Legal and contractual barriers, particularly those related to data ownership and redisclosure, also create uncertainty around full EHI sharing. In addition, some EHR vendors may be resistant to enabling broad data access due to commercial or competitive concerns.

When comparing USCDI with full EHI access, the primary tradeoff lies between standardization and completeness. USCDI offers a tightly defined, structured dataset that supports consistency and ease of implementation. In contrast, full EHI access provides a more comprehensive view of the patient's history but may introduce variability that overwhelms downstream systems or developers. Fortunately, advances in computing power, natural language processing, and flexible data pipelines now allow many organizations to handle hybrid data models that incorporate both structured and unstructured information. CMS and ONC should ensure that developers have the option to access both USCDI-defined elements and full EHI exports, so they can tailor data use to their capabilities and the clinical context.

**TD-14. Regarding networks' use of FHIR APIs:**

Foundation Health's network includes a wide range of patient data exchange endpoints, though the majority of coverage is currently concentrated in urban geographies. Many endpoints are not yet searchable by National Provider Identifier (NPI) or organizational ID, which limits automation and discoverability. Connections are established through a mix of standards, including FHIR (g)(10) endpoints, IHE XCA protocols, and proprietary APIs. We interconnect with vendor networks for broader reach and are actively exploring TEFCA-based exchange frameworks to support secure, governed interoperability at scale.

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**TD-15. Regarding bulk FHIR APIs:**

Expanded use of bulk FHIR APIs would unlock powerful capabilities in population health management, predictive analytics, and automated quality reporting. These APIs enable high-volume data exports that are essential for health systems, payers, and developers working on cohort-based interventions or value-based care models. However, widespread adoption introduces challenges, including significant infrastructure demands on provider systems and risks of data misuse if governance and access controls are not well defined. CMS should consider establishing technical safeguards and accountability measures to ensure that bulk FHIR is used responsibly and effectively.

**TD-16. What are the tradeoffs of maintaining point-to-point models vs. shared network infrastructure?**

Point-to-point integration models are costly, brittle, and difficult to scale, especially as data exchange needs grow more complex and real-time. Shared network infrastructure, by contrast, enables broader scalability, lowers duplication, and supports a more standardized approach to interoperability. Current policy frameworks do not yet go far enough to encourage adoption of scalable models. CMS and ONC could improve alignment by requiring reciprocal data access, enforcing consistent FHIR versioning, and promoting unified API standards across networks and vendor systems.

**TD-17. Given operational costs, what role should CMS or ASTP/ONC or both have in ensuring viability of healthcare data sharing networks?**

To ensure the long-term viability of healthcare data sharing networks, CMS and ONC should take a more active role in underwriting innovation and removing barriers to adoption. This includes funding QHIN pilot projects, standardizing sustainable cost-sharing models, and embedding participation in these networks within CMS rulemaking and value-based care initiatives. By aligning incentives and reducing risk, CMS can help ensure that both supply and demand for data exchange networks grow in parallel, leading to greater participation and more impactful outcomes.

**TD-18. Information blocking:**

As a technology vendor, we have encountered information blocking practices such as vendors delaying the release of interface specifications or imposing excessive fees for API access, both of which inhibit timely interoperability. CMS and ONC should establish clearer expectations around timeliness and completeness of responses, with penalties for non-cooperation or low-quality data access. While providers face some oversight under existing rules, other key

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stakeholders—particularly payers and pharmacies—often lack strong disincentives. CMS should consider expanding the regulatory framework to include these entities to ensure consistent accountability across the ecosystem.

**TD-19. Regarding price transparency implementation:**

Current price transparency efforts are hampered by inconsistent file formats, missing data elements, and outdated or difficult-to-access pricing information. These shortcomings reduce trust in pricing tools and limit their impact on patient decision-making. Functional price transparency would be most beneficial in patient-facing shopping workflows and in provider decision support tools used during treatment planning. To improve utility, CMS should promote adoption of real-time pricing APIs and require a uniform data schema that supports accurate, comparable pricing. Further motivation for innovation could come from linking price transparency capabilities to eligibility for alternative payment models or other CMS incentive programs.

Foundation Health appreciates the opportunity to contribute to this RFI and commends CMS and ONC for their leadership in shaping the future of digital health. We strongly support a vision for a connected, standards-based health technology ecosystem that empowers patients, supports providers, and fosters innovation. We look forward to continued collaboration as these initiatives evolve.

Sincerely,
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