# Health Technology Ecosystem

## CMS Request for Information Response

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-0042-NC

PO Box 8013, Baltimore, MD 21244-8013

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## Introduction

At Moxe, we believe that interoperability's moment is now, but getting it right requires more than compliance checklists and technology mandates. It requires smarter, more intentional collaboration between payers and providers, built on a foundation of shared data that's actually usable and can be trusted.

We've seen firsthand that when clinical data is exchanged efficiently, transparently, and in ways that respect provider workflows and payer goals, the result is better care, reduced administrative burden, and stronger financial outcomes. Yet today's ecosystem remains fragmented. Not just in its infrastructure, but in its incentives. Even the most advanced solutions cannot succeed and thrive if the underlying incentives don't demand, or even support, sustainable alignment.

To truly modernize healthcare, CMS must go beyond policy directives and technical standards and instead foster conditions that reward the exchange and use of high quality clinical data. That means shifting the focus from technical eligibility to measurable impact. Impact on care, collaboration, and cost.

While not experts in all aspects of health tech, our perspective is grounded in experience. By securely connecting with more than 100 health systems, the largest national and regional US health plans, and third-party requestors across the country, Moxe's technology-first approach is fundamentally changing the way clinical data is shared for Payment and Operations use cases. We know what works and what it takes to improve the burdensome, fragmented, and costly state of healthcare data exchange for smarter interoperability grounded in real payer/provider collaboration.

We appreciate CMS's commitment to advancing technology within the healthcare ecosystem and hope our responses offer practical insight into what it takes to make meaningful progress.

## Patients and Caregivers

**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)?**

No, patients and caregivers generally do not have easy access to their complete health information in a single location. Access typically requires reconciling data across multiple patient portals, paper records, and personal notes. For individuals receiving care from multiple providers – especially those using different EHR systems – information is often fragmented. Even when providers use the same EHR vendor, interoperability between patient portals can be limited, making it difficult to maintain a consolidated, comprehensive view of one's health.

## Providers

**PR-5. 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.**

At Moxe, we use numerous FHIR resources connected to over 1000 endpoints, processing over 1 Billion FHIR queries to support our provider customers. The use cases that we support require us to ensure the provenance and do not permit manipulation of data. Because of this, we connect directly to provider organizations rather than through an intermediary. Additionally, working with intermediaries to transact with all of our customers would require us to purchase multiple platforms with overlapping or duplicative capabilities.

Today, we support data sharing between payers and providers for Payment and Operations use cases, primarily focused on Risk, Quality, and Payment Integrity. We use individual queries which allow us to apply business rules to small amounts of data before querying for additional information. This supports our desire to only work with the minimum necessary data at all times

**PR-6. Is TEFCA currently helping to advance provider access to health information?**

Yes. TEFCA, when deployed by existing networks (Epic, CommonWell, eHealth Exchange), provides access to more data than has ever been possible for Treatment use cases. This is especially helpful in pre-visit planning for new patients or in the event of a transfer of care following a procedure or hospitalization.

EHR and other networks are alternatives to provide data to providers when and where TEFCA is either not available, or potentially technologically problematic.

In the current state, the standards don't exist in a redundant manner and consolidation is not required. However, the standards are confusing and complicated. We would suggest updating the documentation to ensure it's easy to understand, especially for those who are not interoperability experts.

## Payers

**PA-1. What policy or technical limitations do you see in TEFCA? What changes would you suggest to address those limitations? To what degree do you expect these limitations to hinder participation in TEFCA?**

The primary technical limitation with TEFCA is that each QHIN individually manages where patient data may be found within each of their participants. Because of this, each has developed redundant capabilities such as master patient indices or record locators. To mitigate the risk of insurmountable costs for each individual QHIN, we would suggest the development of a centralized orchestrator to manage traffic. The current state will eventually lead to each EHR vendor serving as the QHIN for all provider organizations in their network, limiting competition from outside the EHR market.

**PA-2. How can CMS encourage payers to accelerate the implementation and utilization of APIs for patients, providers, and other payers, similar to the Blue Button 2.0 and Data at the Point of Care APIs released by CMS?**

The best mechanism CMS has available to accelerate implementation and utilization of APIs for patients, providers, and other payers are incentives. CMS is best positioned to create incentive programs that encourage payers to implement APIs for patients, providers, and other payers. To be effective, these incentive programs should include both a benefit for payer participation and a financial consequence for non-participation.Instead of relying on reporting, CMS must use proactive API testing to ensure they are in place and usable at any and all times.

**PA-5. What are ways payers can help with simplifying clinical quality data responsibilities of providers?**

Payers increasingly need access to high quality, precise data in a timely fashion. This growing demand often results in slower turnaround times and frequent provider follow-ups. Once the data is received, it can require significant resource investment to consume and use. By standardizing their data needs, enabling digital exchange, and attempting to reduce administrative friction, payers can meaningfully impact the responsibilities providers face. Other areas of focus could include aligning internally to reduce duplicative requests and addressing provider concerns around data use with greater transparency and shared accountability.

## Technology Vendors, Data Providers, and Networks

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

To stimulate developer interest, CMS should make more data available, in a timely manner, for additional use cases. For example, increasing the quantity of deidentified claims data, similar to the BSA files that are already available, would be very valuable.

The primary obstacle related to CMS data is that it cannot be used for most real-time, or near real-time, data needs. Improving the turnaround time for available data would exponentially increase the number of accessible use cases, and theoretically, the use of CMS data in general.

CMS and ASPT/ONC should consider implementing clinical data in both an identified (for patients and providers) and deidentified manner (for research and technology vendors) to support and drive innovation. For example, CMS is uniquely positioned to help technology vendors with access to near real-world information at scale.

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

The demand for clinical data, especially as it relates to Payment and Operations use cases, is only growing. More and more, payers need access to timely, accurate clinical data that they can actually use. Providers are overburdened responding to the mounting requests with tight deadlines. While TEFCA strives to drive meaningful change as it relates to Treatment, it does not

support Payment and Operations use cases. This is largely due to requirements for bilateral agreement between payers and providers on permissible data use. Because of the potential for operational delays, lack of standardization, and inconsistent participation, TEFCA is not positioned to address the administrative and financial drivers that define Payment and Operations use cases. Existing alternatives that can deliver high quality, relevant clinical data precisely configured for Payment and Operations use cases, while ensuring transparency and compliance are critical. Payers need usable, timely data that providers trust.

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

USCDI has greatly improved both interoperability and data exchange advancement. As a large consumer of data via FHIR, we have found that the quality, consistency, and usability has grown immensely since the first compliance requirement of USCDI v1. In most cases, USCDI has the data required for the use cases we serve (provider/payer). The primary gap is the slight variation in implementations of USCDI by EHRs and providers. If the EHRs can be pushed to truly standardize, then the problems USCDI sought to solve will be.

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

No, CMS should not endorse non-CMS data sources and networks. However, CMS should consider a program for non-CMS data sources and networks that do not fit within TEFCA. Then make that information easy to find for providers, payers, developers, and others interested in health data.

From a privacy and security standpoint, the criteria should match TEFCA, and require a high level (e.g. 90%) of data consistency and quality.

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

EHI can be powerful in circumstances when a patient’s entire medical record is truly necessary. Patients should always have the right to restrict the use and sharing of certain information and technology vendors/developers should always work with only the minimum necessary data they require.

At Moxe, the use cases we serve require a significant volume of data, but we have found FHIR and USCDI to be sufficient. EHI should be reserved for special circumstances and should not become the default simply because working with USCDI or smaller data sets is challenging.

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

Moxe connects the healthcare ecosystem with high quality, efficient clinical data. Our broad network is powered by more than 250,000 providers across the country representing close to 14,000 TINs, including direct connections to over 100 health systems and the largest national

and regional health plans, as well as numerous third party partners. We're compatible with the leading US EHRs, representing more than 75% of the market, and have direct access to the entire athenahealth network. To support our customers, we use numerous FHIR resources connected to over 1,000 endpoints and process over 1 Billion FHIR queries.

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

Similar to EHI, bulk FHIR is powerful and promising for specific use cases. The primary benefits being fewer total transactions to acquire data, while allowing source systems to schedule or 'batch' the processing. However, bulk FHIR as an export function should be used only when a full export is needed. For example, if a provider organization is implementing a population health management software that requires a new data warehouse, this would be a good scenario for bulk FHIR APIs. At Moxe, we have engineered our products to work without bulk FHIR while maintaining access to large quantities of data for specific use cases. We purposely only extract the minimum data needed and that complies with all privacy requirements, including those elected by the patient.

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

The primary benefits of point-to-point models is that data transaction provenance is clear. Transactions are fulfilled out of a true source system versus aggregation, and data sharing can be controlled by trading partners with existing reasons to exchange information. The obvious tradeoffs are the associated cost and effort required to set up and maintain point-to-point connections.

Shared network infrastructure largely has the opposite tradeoffs and benefits. Where shared networks can largely help cut the costs and maintenance on many parties sharing data, the networks will truly have one customer to serve (whomever pays). The economics of shared networks must be controlled to see the major benefits of scale (i.e. no parties should pay to be on every shared network to get the data they need).

**TD-17. Given operational costs, what role should CMS or ASTP/ONC or both have in ensuring viability of healthcare data sharing networks, including enough supply and demand, that results in usage and outcomes?**

Shared network infrastructure shows significant promise in improving data access for key healthcare parties involved. With each shared network's requirement to provide capabilities that function independently of other shared networks, CMS and/or ASPT/ONC can help ensure that costs are contained and remain reasonable. Network participants should not need to subsidize the costs of multiple networks.

Also important to note, each network must operate as an independent company and provide services with both technological and operational parity to the other networks. Therefore, as networks develop or as requirements from the federal government evolve, consideration should be made to subsidize portions or provisions of central features by CMS or ASTP/ONC. This

ensures that from both a business model and requirements standpoint the networks can succeed economically.

## Value Based Care Organizations

**VB-3. What are essential health IT capabilities for value-based care arrangements?**

Value-based care arrangements require all parties participating in the arrangement to have similar access to the same data. This builds trust and ensures 'apples-to-apples' conversations around the outcomes and value provided.

Technologically, the capabilities required to work together on the same data set and/or share the data all exist today. In our experience, the capabilities can be implemented and used, but there is no standard. The development of capability-specific implementation guides that require specific data transactions and expected outcomes from those transactions would be a helpful addition.

For example, the VBC IG could require that an A01 or FHIR subscription with specific data elements (date, time, diagnosis, admitting MD, event token) be sent to a health plan whenever an attributed patient is admitted to the hospital. The health plan could then ensure that the admission meets their utilization requirements and that any additional data needed can be retrieved using the event token.

**VB-4. What are the essential data types needed for successful participation in value-based care arrangements?**

In a value-based care arrangement, all data is needed at some point in time. However, not all data is required at all times and should not be used at all times. At Moxe, we have found that implementing privacy and use-case specific data filtering effectively addresses this problem. Providers can control and see the data that's shared, while other participants in value-based arrangements get the precise data they need, when and where they need it.

## Conclusion

Moxe Health thanks CMS for its continued leadership in advancing interoperability, improving clinical data exchange, and reducing administrative waste across the healthcare ecosystem. These efforts are essential to creating a more connected, transparent, and efficient system. One that better serves patients, providers, and payers alike.

Moxe is driven by a similar purpose: to transform the complex, outdated, and costly processes that continue to hinder healthcare operations. We are committed to enabling smarter, more collaborative interoperability that empowers stakeholders with the precise data they need, when and how they need it, to improve outcomes and reduce burden.

We appreciate the opportunity to contribute to this dialogue and welcome continued collaboration with CMS and its partners as we work toward shared goals.

Sincerely,
The Moxe Health Team
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