

June 16, 2025

*Submitted via regulations.gov*

Dr. Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services

Dr. Thomas Keane  
Assistant Secretary for Technology Policy  
National Coordinator for Health IT  
U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services (CMS)  
Department of Health and Human Services (HHS)  
Attention: CMS-0042-NC, Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

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

Dear Administrator Oz and Assistant Secretary Keane:

As a leading AI-enabled revenue cycle and clinical insights management platform, Smarter Technologies sits at the intersection of clinical and payment data. We appreciate the opportunity to share our thoughts on the health technology ecosystem including opportunities to leverage data to improve outcomes, drive financial sustainability, and enable innovation.

Launched in May 2025, Smarter Technologies is a new automation platform developed for hospitals and health systems. It brings together three companies: revenue cycle management (RCM) services businesses [Access Healthcare](#), AI-powered revenue cycle automation platform [Thoughtful.ai](#) as well as clinical insights AI business [SmarterDx](#). We have more than 27,000 employees serving more than 200 clients, over 60 hospitals and care delivery organizations, supporting more than 500,000 providers, over 70 RCM and EHR systems and industry partners, and we process more than 400 million transactions annually.

Unlike traditional models, Smarter Technologies focuses on enabling in-source teams at provider organizations and our industry partners with modular solutions that are EHR-agnostic. Providers don't need to change anything in their current technology environments. They're not rewriting anything, and they don't have to train their staff on AI tools. We are bringing offerings that complement hospitals and health systems where they are, so they maintain strategic control and pick from a menu of offerings that help them address administrative burdens, rising operational costs, rising claim denials, the pressure to improve cash flow, and the need to keep pace with technological and regulatory changes.

Specific comments on RFI questions are below.

### **Patient Choice**

**PC-12. What are the most valuable operational health data use cases for patients and caregivers that, if addressed, would create more efficient care navigation or eliminate barriers to competition among providers or both? What use cases are possible today? What should be possible in the near future? What would be very valuable but may be very hard to achieve?**

The most valuable operational health data use cases include those that offer: 1) real-time access to provider schedules and the ability to be put on the waiting list digitally for cancellations if the appointment is not currently available; 2) real-time and transparent access to care coordination and quick/easy interoperability to clinical data to support care coordination; and 3) transparent and accurate visibility to patient's out of pocket expenses with a detailed breakdown using real-time apps/digital calculators.

To support transparent and accurate visibility into expenses, pricing information should be queryable via API instead of hidden as an CSV on a provider's website. Some quality information should be made available alongside price information. The same API that returns price data should be able to surface key indicators of quality, for example, STAR ratings, rates of hospital acquired infections, and/or readmissions scores. This would give a holistic picture of a provider's performance and enable better, more informed patient and caregiver decision-making.

Real-time access to accurate scheduling, care coordination, and expense information is valuable from both a clinical and a financial standpoint. More fluid access to schedules would allow those who support patient engagement on behalf of hospitals and health systems to establish appointments with greater efficiency and precision, ultimately allowing for more optimal allocation of provider time and reduced patient no-shows. Care coordination data, such as discharge planning, transition notes, and care plans, often contain critical details that influence coding and billing accuracy, for example, supporting a) diagnosis specificity; b) procedure confirmation; c) place of service accuracy. Access to this data improves real-time eligibility and authorization management and also results in financial clarity that increases treatment adherence. All of this reduces unnecessary administrative costs and promotes efficiency in the health care system.

**PR-2. What are obstacles that prevent development, deployment, or effective utilization of the most useful and innovative applications for physician workflows, such as quality measurement, clinical documentation, and billing tasks? How could these obstacles be mitigated?**

Obstacles preventing development, deployment, or effective utilization of innovative applications for workflow include the following:

### Misaligned Fee-for-Service Incentives

The fee-for-service payment model does not incentivize application developers. Value-based care has more incentives for application developers, and greater adoption of these models would mitigate the challenges presented by fee-for-service.

### Technology Restrictions

Obstacles include monopoly and restrictions created by the dominant inpatient-centric PM systems and EHR systems with each system having its own rules related to integration protocols, arbitrary approval or denials to integration. To mitigate these obstacles, we need standard rules and protocols for bi-directional API integrations and a legal framework to prevent PM/EMR systems from restricting access for third party applications.

### Write-Back Access

Much of what EHRs are required to allow is just read-only functionality. Critical functions such as auto-filling notes, scheduling patients, and adding functionality to the workflow within the EHR require write access, which is not currently required today through the Certified EHR Program. This effectively stifles innovation and prevents technology disrupters from building solutions on top of the EHR itself. Enabling this functionality will be critical to achieving the vision of a truly interoperable health care system, as it would enable real-time charge entry and streamline scheduling and authorization workflows.

### USCDI Requirements

USCDI requirements are not very fulsome in terms of what data is required. As a result, in practice, the FHIR endpoints for the APIs required to satisfy criteria with USCDI are standardized, but other APIs are more variable. As AI improves in accuracy and can use a wider variety of data to help with various revenue cycle management tasks, including clinical tasks, those gaps in the data become correspondingly more important.

### Non-Standard Quality Reporting

Non-standard quality reporting is an obstacle. This includes defining what quality reporting means, the elements of quality reporting and how it needs to be measured. Today, this is very subjective and different payers have different, ever-changing frameworks, which makes it very difficult for third party applications to keep pace. To mitigate this, CMS should make reporting requirements a standard set of rules, data elements and values.

### Vendor Fees

Even when an API is available, the fees charged by the EHR may be exorbitant and far above the marginal costs to service the request. We strongly urge CMS and ONC to mandate cost-based pricing for APIs tied exclusively to documented technical expenses, explicitly prohibiting fees based on opportunity cost, data control, or data monetization. Furthermore, the publication of standardized, easily comparable pricing schedules must be mandated.

**PR-4. What changes or improvements to standards or policies might be needed for patients' third-party digital products to have access to administrative workflows, such as auto-**

### **populating intake forms, viewing provider information and schedules, and making and modifying an appointment?**

We recommend the following changes or improvements for patients' third party digital products to have access to administrative workflows:

- Data standardization is needed because different health systems/providers have different formats/forms. It is increasingly difficult for third party digital products to standardize across health systems.
- HL7 is the standard data interchange protocol, but it does not focus on non-clinical data interchange. HL7 coverage can be expanded beyond clinical data so third party digital products can easily access and transfer non-clinical data such as viewing provider info, schedules, intake information, etc.
- Regulatory frameworks should enable/require third-party digital products to be able to access administrative workflows in the EHR. The in-patient EHR market is monopolized by one or two vendors and they do not provide easy access to any third party products.
- There should be standard APIs for every type of data, whether it is scheduling or intake. Non-standard APIs are a big hurdle for third party digital products to exchange data bi-directionally and seamlessly.
- Consent management should be streamlined. Today, for the most part, hospitals manage machine consents for use of their data. This can create perverse incentives for information sharing.

### **PR-7. What strategies can CMS implement to support providers in making high-quality, timely, and comprehensive healthcare data available for interoperability in the digital product ecosystem? How can the burden of increasing data availability and sharing be mitigated for providers? Are there ways that workflows or metrics that providers are already motivated to optimize that could be reused for, or combined with, efforts needed to support interoperability?**

Most of the restrictions on making high-quality, timely and comprehensive healthcare data available for interoperability are put in place by EHR systems. We offer the following recommendations:

- CMS should have stick and carrot policy. EHR systems and providers should be incentivized to make interoperability of data seamless and should be penalized for undue restrictions.
- HIPAA regulations should be made more practical while maintaining confidentiality. HIPAA limitations should not be used as an excuse for denying interoperability of data.
- Data availability and interoperability should be in real-time. Currently, it's mostly in batch format.

With respect to metrics that providers are already motivated to optimize, we suggest the following metrics related to payment:

- % of denials related to incomplete documentation

- % of claims submitted with structured diagnosis/procedure coding sourced from interoperable feeds
- API-response time and uptime metrics for critical workflows like eligibility authorization status or claims status

**TD-9(a). Regarding certification of health IT, what are the benefits of redefining certification to prioritize API-enabled capabilities over software functionality?**

We recommend that ASTP redefine certification to focus on API capabilities. This will increase competitiveness in the EHR market. Defining certification based on functionality defaults to a landscape where only large players can deliver on all the functionality. An API-first approach to certification increases competitiveness by allowing smaller players to compete.

**TD-19. Regarding price transparency implementation: What are current shortcomings in content, format, delivery, and timeliness? Which workflows would benefit most from functional price transparency? What improvements would be most valuable for patients, providers, or payers, including CMS? What would further motivate solution development?**

See comments above. As we move from agent software to agent AI, user interfaces are proportionally less critical and data is proportionally more critical. Defining criteria in terms of FHIR-based APIs, read and write availability, uptime, speed and cost of reply as opposed to specific features of the EHR will create additional value for patients, providers, and payers including CMS.

\*\*\*\*\*

Thank you for the opportunity to comment. Please do not hesitate to reach out to me if we can be a resource to you.

Sincerely,

Travis Smith  
Senior Vice President, Strategy and Corporate Development