Netsmart

June 16, 2025

U.S. Department of Health and Human Services (HHS)
Center for Medicare and Medicaid Services (CMS)
Attention: Secretary Robert F. Kennedy Jr.

RE: Health Technology Ecosystem Request For Information (RFI); Docket No. CMS-0042-NC

Secretary Kennedy,

Netsmart Technologies, Inc. ("Netsmart") appreciates the opportunity to respond to the Health Technology Ecosystem Request for Information (RFI) issued by the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Technology Policy (ASTP). As a leading provider of integrated clinical and administrative technology solutions, Netsmart serves a broad spectrum of healthcare organizations nationwide—including behavioral health, substance use treatment, home and community-based services, and senior living providers.

Our extensive experience across these sectors, combined with our commitment to interoperability and innovation, equips us with a grounded, real-world perspective on the opportunities and challenges facing the health technology ecosystem. We welcome the opportunity to contribute insights that reflect the needs of our clients and the communities they serve, and we commend CMS and ASTP for engaging stakeholders in shaping a more connected, equitable, and patient-centered digital health infrastructure.

ntst.com
11100 Nall Avenue
Overland Park, KS 66211
800.842.1973

Netsmart's Comments on Health Technology Ecosystem RFI

C. Providers

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 reporting, clinical documentation, and billing tasks? How could these obstacles be mitigated?

One of Netsmart's biggest obstacles related to the development and deployment of innovative applications are CMS's frequent updates to quality measures and workflow expectations. These updates require health IT vendors to divert resources from innovative projects to complete work with limited timelines for implementation. Often the updates in question create small variations on existing quality measures per program. These changes make it difficult to track and maintain quality measures across multiple programs. Additionally, the ability to understand the usefulness of a measure is subsequently hindered.

We recommend CMS develop a more predictable approach via scheduled releases for quality measures across reimbursement programs. We also recommend CMS continue their work to align measures, and measure specifications across programs, such as the Merit-based Incentive Payment System (MIPS) program, quality reporting programs and other federal reimbursement programs. Alignment of both measure deployment, and measure specification creates uniformity and predictability allowing health IT vendors to spend time developing workflows that are provider, and patient centric.

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

We recommend the Trusted Exchange Framework and Common Agreement (TEFCA) as the go forward strategy for data interoperability. TEFCA represents a significant step towards providing clinicians access to necessary health information through a standardized and scalable framework. TEFCA can unify stakeholders

across the healthcare ecosystem and improve consistency and reduce fragmentation of data.

PR-6a. Please provide specific examples

TEFCA is of specific importance to providers in Human Services and the Long Term and Post-Acute Care (LTPAC) community, sectors which Netsmart supports. TEFCA will allow the providers in Human Services and LTPAC community the ability to access a nationwide network supporting interoperability, at a cost that is affordable. These markets were not included in the Meaningful Use program. And as a result, the adoption of health IT, and interoperability lags other markets. TEFCA creates an opportunity for these providers and the communities they serve to participate in a standardized data exchange. Moreover, TEFCA offers a uniform way to exchange data as opposed to state or regional Health Information Exchanges (HIEs) which may vary in the standards they support, creating further barriers to the exchange of data.

PR-6b. What changes would you suggest?

We recommend expanding the eligibility criteria under TEFCA, to better align with the Health Insurance Portability and Accountability Act (HIPAA) and impact entities beyond the covered entities. For example, including areas like research would increase the utilization of TEFCA and increase overall adoption.

PR-6c. What other options are available outside of TEFCA?

While we acknowledge other options exist to enable data exchange and interoperability, we recommend TEFCA as the go-forward data exchange platform. In reviewing the other available options such as State and Local HIEs, DirectTrust networks, and consumer-facing applications, we determined these options perpetuate the existing fragmented approach to interoperability and generally require point-to-point agreements. Using Qualified Health Information Networks (QHINs) expands the interoperability of data across the nation, ensuring that necessary information is shared at the right place and at the right time.

PR-12. Should ASTP/ONC consider removing or revising any of the information-blocking exceptions or conditions within the exceptions (45 CFR part 171, subparts B through D) to further the access, exchange, and use of electronic health information (EHI) and promote market competition?

We strongly recommend maintaining all existing information blocking exceptions as defined under section 45 CFR Part 171 Subpart B through D. These exceptions provide critical flexibility for healthcare actors to navigate complex data-sharing scenarios, ensuring compliance without stifling innovation. However, clearer guidance is needed on their practical real-world settings to ensure consistent interpretation and implementation.

Specifically, the TEFCA Manner Exception (45 CFR 171.403), which allows actors to limit EHI exchange to TEFCA without being considered information blocking under certain conditions, requires detailed instructions. We propose CMS provide guidance on:

- What constitutes "being part of TEFCA"?
- How to determine a requestor's capability, potentially through standardized checks.
- Clarifications on fees and licensing terms in the context of TEFCA to ensure compliance.

Additionally, defining what makes a request 'actionable' is essential to start the response process period clearly. We recommend ASTP/ONC specify criteria, such as the receipt of a complete and verifiable request, to eliminate ambiguity and ensure timely responses occur, reducing the overall burden on the actors. We recommend CMS/ASTP review and provide guidance on the Sequoia Project's work to define what constitutes an "actionable request."

E. Technology Vendors, Data Providers, and Networks

Section 1. Ecosystem

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?

We recommend CMS promote the adoption of APIs that provide seamless integration into Medicare data systems. The expansion of Blue Button 2.0 should be configured to provide data that can be consumed and used by vendors and providers. To that end, we recommend CMS take steps to enable digital health products to provide near real time cost utilization, by category, for measures CMS uses for program scoring, like the Cost Category in MIPS. Visibility to this type of data would give providers insight into how they are scoring, and how they might adjust practices in real time to achieve higher incentives.

Looking forward, CMS should develop reimbursement models that support the integration of digital health technologies into care delivery and quality improvement programs. This includes establishing end-to-end alignment across stakeholders, defining certification requirements, and enforcing interoperability standards that apply not only to EHR developers and providers, but also to payers, public health entities, and other data users. Additionally, CMS should implement incentive structures to promote widespread, consistent, and effective use of digital tools across the healthcare ecosystem.

TD-2.a. Regarding CMS Data, to stimulate developer interest-- What additional data would be most valuable if made available through CMS APIs?

To increase developer engagement, CMS should continue expanding access to data sets through standards-based APIs. We recommend the continued expansion and adoption of the HL7 Fast Healthcare Interoperability Resources (FHIR) US Core Profiles as well as the United States Core Data for Interoperability (USCDI). Additionally, making provider directory data available via API would facilitate the

development of tools that improve care coordination, and enhance patient navigation across the healthcare ecosystem. Last, as previously mentioned, enabling real-time access to cost data would empower health IT vendors to build solutions that help providers monitor and improve their overall performance during the year instead of relying on retrospective feedback. Today, cost scores tied to APMs are not visible until long after performance periods end. Together, these steps would help to further a more responsive and proactive healthcare ecosystem and align priorities between CMS and the digital health communities.

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Section 2. Digital Identity

TD-3 Regarding digital identity implementation, what are the challenges and benefits?

One of the main benefits to the implementation of digital identity requirements via CLEAR, ID.me or other forms of digital identity is the ability to facilitate identity verification across disparate systems. Netsmart recognizes digital identity requirements exist in the pharmacy space today. And if done thoughtfully, digital identity implementation would improve interoperability and strengthen protection against unauthorized access to health data.

However, there are significant challenges and complexities involved with the implementation of digital identity. This would require significant integration and workflow changes, especially for those who are operating internal systems across external applications. Within the industry, data connections must be trusted and credentials verified. This would require building these connections in a trusted way across the various applications. Which would result in an increased burden on providers and vendors as more applications become available. We recommend, if CMS/ASTP goes down this route, you take time to develop clear governance and implementation standards that everyone abides by as they join in sharing the data.

Section 3. Technical Standards and Certification

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

We recommend the adoption of open, standards-based, publicly available APIs over proprietary APIs. However, CMS must ensure standards-based, publicly available APIs are proven ready for widespread use. While CMS has introduced standard data points via HL7 FHIR, the absence of real-world examples, and metrics demonstrating successful implementation has hindered API adoption. We recommend CMS incentivize vendors, providers, and payers who adopt FHIR standards-based APIs, and can provide evidence of successful data exchange. By rewarding early adopters and sharing tangible success stories, CMS can build confidence in the adoption of FHIR standards and drive broader implementation across the 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 the cost?

We recommend a nationwide provider directory of FHIR endpoints, as that would significantly enhance access to health information for patients, providers, and payers by streamlining the discovery and connection to healthcare data sources. However, the challenge lies in maintaining the accuracy and reliability of the directory's data.

Current efforts, such as those under TEFCA and QHINs, represent a starting point, but outdated or untrustworthy data could undermine their effectiveness. We propose that TEFCA take responsibility for developing, testing, and maintaining this directory, ensuring it is rigorously validated and consistently updated in real-world settings before being designated as the authoritative source. To maximize accessibility, users should not bear the cost of accessing this critical resource.

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

TEFCA's standards and broad reach position it uniquely to enforce conformance across all stakeholder groups, fostering consistent and reliable data exchange. We support TEFCA's capability to link an accurate provider directory, which enhances its value to providers. Furthermore, we encourage CMS to expand TEFCA's participation to include payers, patients, and other stakeholders, as this would improve interactions across the healthcare ecosystem. By enabling all parties to participate, TEFCA can standardize data flow across care settings, thereby alleviating the burden on vendors to maintain custom, non-standard connections and promote a more cohesive ecosystem.

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

USCDI has markedly improved interoperability and health information exchange by establishing a standardized data framework. However, its scope remains incomplete. We recommend expanding USCDI to include elements related to behavioral health, maternal health, and Social Determinants of Health (SDOH) to better address diverse care needs. Additionally, aligning USCDI more closely with HL7 standards would mitigate implementation challenges and enhance technical consistency.

The current "all-or-nothing" adoption approach is a limitation, particularly for specialty practices and health IT vendors serving these providers. For example, requiring pregnancy status in geriatric care or occupation in pediatric settings imposes unnecessary data collection burdens. We urge CMS to adopt a modular

approach, tailoring USCDI requirements to the specific needs of different care venues to improve relevance and reduce vendor workload.

TD-7a. Does it contain the full extent of data elements you need?

USCDI does not yet encompass all data elements essential for comprehensive care delivery. Including additional behavioral health, maternal health, and SDOH elements would enhance its utility across various settings. We commend the ongoing expansion process as a step in the right direction but advocate for a modular adoption model for specialty practices to avoid irrelevant data requirements. Furthermore, consolidating USCDI and USCDI+ into a unified standard would streamline implementation, reducing complexity and enabling vendors and providers to focus on the most impactful data elements.

TD-7c. If so, would adding more data elements to USCDI add value or create scoping challenges? How could such challenges be addressed?

We recommend adding more data elements to USCDI to promote consistency in data exchange and improve care coordination. While this expansion would introduce development and implementation challenges, these can be addressed by providing a longer runway for mandatory inclusion. This extended timeline would allow vendors to build and deploy new elements thoughtfully, ensuring they integrate seamlessly into provider workflows. Such an approach balances the need for progress with practical considerations for adoption.

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

The (g) criteria and FHIR adoption under the ONC Health IT Certification Program stand out as the most effective criteria for supporting interoperability and data access. The adoption of FHIR standards, and the introduction of APIs enable seamless communication and empower patients and providers with critical health information. We recommend broadening the certification process to encompass all

stakeholders—payers, patients, and others—to maximize the health ecosystem's effectiveness and ensure inclusiveness in interoperability efforts.

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 fully realize the API condition of certification under the 21st Century Cures Act (42 U.S.C. 300jj-11(c)(5)(D)(iv)), ASTP/ONC should continue expanding the required data elements while offering incentives for vendors who enhance access to these elements and facilitate exchange with other systems. Clear guidance on conformance requirements is essential to ensure that data sharing aligns with applicable laws. Incentivizing compliance will accelerate adoption and foster a more connected healthcare environment.

TD-11b. Are there specific workflow aspects that could be improved?

We do not attribute EHI export challenges to workflow issues. Instead, the focus should be on ensuring that the functionality meets certification requirements and operates reliably. Certification efforts should prioritize system performance and data integrity over dictating specific internal workflows, which vary across health IT systems and should remain flexible.

Section 4. Data Exchange

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

CMS should prioritize driving the adoption of existing ASTP-backed networks like TEFCA rather than endorsing multiple, competing data networks. Fragmentation from additional networks would hinder centralized adoption, increase complexity, and raise costs for vendors and providers. Moreover, if non-CMS networks hold patient data that vendors cannot access, patients may struggle to retrieve their information. We advocate for a unified focus on TEFCA to ensure consistent, standards-based data exchange across the ecosystem.

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 providing access to a patient's entire EHI would unlock opportunities for personalized care, advanced analytics, and enhanced coordination. We support USCDI's trajectory toward full data set adoption, though compatibility with existing standards like FHIR and NCPDP poses challenges. Current data models in care records may not fully accommodate all EHI, risking interoperability issues if standards misalign. A gradual, standards-aligned expansion of USCDI is key to realizing these opportunities.

TD-13a. What are the primary obstacles to this?

The main obstacles to full EHI access via APIs are content-driven rather than workflow-related. Current APIs excel at data retrieval but lack bidirectional functionality, such as updating records or completing tasks like questionnaires or medication updates. Patients must still rely on provider portals for these actions, limiting API utility. We recommend evolving APIs to support two-way data exchange, empowering patients to both access and contribute to their health records seamlessly.

TD-13b. What are the primary tradeoffs between USCDI and full EHI, especially given more flexible data processing capabilities today?

The key tradeoff between USCDI and full EHI is standardization. Specialty practices often collect unique, non-standardized EHI that does not fit within USCDI's framework yet remains critical to care. We support efforts to harmonize USCDI with full EHI, ensuring flexibility for specialties while advancing a unified standard.

TD-15a. How would increased use of bulk FHIR improve use cases and data flow?

Increased use of Bulk FHIR APIs will improve patient access to their full medical records based on available standards, promoting better care through easy data retrieval. It also enhances use cases like digital quality measurement, population health analytics, and efficient payer-provider data exchange. These advancements strengthen data-driven decision-making across the ecosystem.

TD-15b. What are the potential disadvantages of their use?

Bulk FHIR calls can strain system resources, particularly when querying large datasets from EHRs. This could impede system performance, especially if patients or providers request extensive EHI simultaneously. To mitigate this, we suggest encouraging streamlined requests tailored to specific needs, reducing the resource burden while maintaining functionality.

TD-16a. Do current rules encourage scalable network participation?

Current rules support scalable network participation by leveraging shared infrastructure, which lowers provider barriers to entry and accelerates installation at scale. This foundation fosters broader adoption and should be reinforced to ensure equitable access to interoperable networks.

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?

CMS and ASTP/ONC should play active roles in ensuring the viability of healthcare data sharing networks, such as TEFCA, by driving supply, demand, and measurable outcomes. Participation by CMS in healthcare data sharing networks coupled with ASTP/ONC conformance validation and enforcement would promote utilization of the networks for improved access and outcomes. Providing testing tools to align data platforms on interpretation and communication of standards is also critical to maintaining consistency and trust in these networks.

Section 5. Compliance

TD-19b. Regarding Price Transparency Implementation, which workflows would benefit most from functional price transparency?

Functional price transparency has significant potential to improve key healthcare workflows, particularly medication prescribing and care referrals. Real-time access to cost and coverage data at the point of care enables providers to offer lower-cost alternatives to patients, such as generic medications or covered formulary options, based on the individual patient and their insurance and pharmacy pricing. This supports informed decision making, which increases the likelihood that the patient will fill the prescription or adhere to the care recommendations. Thus, improving the clinical outcomes and reducing downstream costs that are tied to non-adherence to medical advice.

For example, knowing different settings of care within a patient's insurance network and close to their home can streamline referrals, enhancing convenience and adherence to seeking the right treatment. Without functional price transparency, providers are often unaware that a prescribed treatment may be unaffordable, leading to abandoned prescriptions, unanticipated out-of-pocket expenses, or follow-up calls seeking changes in the patient's treatment. Providers are often penalized in

value-based care model participation when the cost barriers impede patient adherence, despite having no control over drug pricing or formulary coverage.

Hospitals are required to provide price transparency due to CMS mandates, but extending this information to the EHR would be integral and crucial in ensuring accurate, patient-specific pricing data. We recommend CMS encourage health IT vendors to integrate real-time benefits comparison tools into clinical workflows, ensuring providers can access up-to-date cost information seamlessly. We also recommend CMS incentivize providers to generate the same pricing transparency for their services and incorporate that data within the EHRs as well. This would enhance overall patient care and improve the knowledge of the provider and patient as they are formulating a care plan the patient can achieve.

F. Value-Based Care Organizations

Section 1. Digital Health Adoption

VB-1. What incentives could encourage APMs such as accountable care organizations (ACOs) or participants in Medicare Shared Savings Program (MSSP) to leverage digital health management and care navigation products more often and more effectively with their patients? What are the current obstacles preventing broader digital product adoption for patients in ACOs?

To encourage Accountable Care Organizations (ACOs) and Medicare Shared Savings Program (MSSP) participants to leverage digital health management and care navigation products, CMS should offer financial incentives tied to tool adoption, similar to past EHR incentives under the Merit-based Incentive Payment System program. These tools improve outcomes by better predicting and stratifying risk, providing care at less expense, which aligns with value-based payment (VBP) goals. Our EHR tools enable providers to prioritize high-risk patients, addressing care needs timely and efficiently. CMS needs to consider that many of the specialty practice clinicians were not included in the early rounds of incentive dollars for EHR adoption and are now competing with those clinicians who have been participating in

these programs for years, and who the programs were truly designed for in terms of providing care.

For example, Physical Therapists and Speech Therapists are not prescribing medications to their patients yet still have to purchase and maintain access to e-prescribing functionality to meet the Promoting interoperability requirements. They can take the exception on the measure as well, but it then only enhances the importance of other measures like the exchange of health information which is much more difficult to achieve a higher scoring for, thus putting them at a disadvantage in overall scoring in the PI category of MIPS.

Current obstacles preventing wider digital product adoption include inconsistent technology standards and limited payer data sharing. We recommend alignment to a specific set of standards within the ecosystem, and shared responsibility with payers, who often hold significant data. Payers should adopt similar interoperability standards as healthcare organizations to facilitate seamless data exchange, reducing adoption barriers and enhancing care coordination.

VB-2. How can key themes and technologies such as artificial intelligence, population health analytics, risk stratification, care coordination, usability, quality measurement, and patient engagement be better integrated into APM requirements?

To better integrate key themes and technologies such as artificial intelligence, population health analytics, risk stratification, care coordination usability, quality measurement, and patient engagement into APM requirements, CMS should establish streamlined standards. Currently, standards adopted in innovation models are not consistently applied in value-based care agreements, creating gaps. We recommend:

- Standardizing quality care measures to ensure consistency and clarity on what constitutes a quality outcome across all programs.
- Mandating interoperability between solutions to get data to the right care setting at the right time which would enable better risk stratification.

- Incentivizing care coordination to foster collaboration across clinician practices.

Gathering data across different venues and care settings will allow for better risk stratification strategies. EHRs can then share this information across systems, as long as they have clear standards and ways to communicate, to enhance overall care. We suggest focusing on key performance indicators first, and then ensuring providers have a strong understanding of the quality measures that drive improvements in care.

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

Essential health IT capabilities for value-based care arrangements include interoperability and care coordination elements. Utilization management, such as knowing when care is no longer effective and a transition out of care treatment is critical. EHR systems should support assessments demonstrating the need for diligent care decisions, indicating when care progress has stopped or slowed significantly, and predicting when other care settings would be better options or alternatives. Developing functionality to enhance the data available for decision support interventions is crucial to determining the best care for the patient.

We also recommend bidirectional exchange of information between providers, payers, and CMS, as highlighted in CMS Transparency in Coverage. This ensures all stakeholders have access to necessary data for informed decisions, enhancing care coordination and outcomes.

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

We recommend focusing on essential data types like outcome information, claims data, and care plans as the elements needed to promote successful participation in value-based care arrangements. These components clarify the risk of a patient's health and how to properly care for them, enabling tailored care interventions and improved outcomes.

VB-5 to VB-8. What are the certification and technology requirements that will benefit value-based care and APMs?

Current ONC Health IT Certification Program criteria, such as View, Download, and Transmit (VDT) and usability standards, support value-based care but face incomplete adoption. Expanding these to include payers for interoperability would enhance data access. Additional capabilities like SDOH tracking and unstructured data analysis should be included, as they drive outcomes but are currently underutilized.

To reduce complexity in APM technology requirements, CEHRT should prioritize decision support interventions, delivering actionable insights without overwhelming providers. HHS policies, such as expanding Conditions of Participation to include decision support, can optimize digital health product use, with realistic measures reflecting real-life clinical work.

VB-10. In the Calendar Year (CY) 2024 Physician Fee Schedule final rule (88 FR 79413), CMS established that CEHRT requirements for Advanced APMs beyond those in the "Base EHR" definition should be flexible based on what is applicable to the APM that year based on the area of clinical practice. What certification criteria should CMS identify under this flexibility for specific Advanced APMs, or for Advanced APMs in general? Are there specific flexibilities or alternatives to consider for smaller or resource-constrained (such as rural) providers in meeting CEHRT requirements without compromising quality of care or availability of performance data?

We recommend CMS be more prescriptive in their use of Certified EHR Technology (CEHRT) across APMs. For example, within CMS innovation model programs, participants are often required to have a portion of their provider base use Certified EHR Technology. But CMS does not provide clear guidance on how CEHRT is utilized in the program requirements.

Furthermore, current certification requires USCDI data elements be supported in programs like MIPS or Promoting Interoperability. USCDI data elements are

beneficial in helping risk stratify patient populations for value-based care, but not all settings of care are incentivized or required to implement these data elements. This results in clinicians not having all aspects of the patient's record information from all settings. We recommend CMS require incorporation of USCDI data elements in all CMS programs. Incorporation of this data improves risk stratification algorithms operating in the background. A comprehensive assessment of elements is needed to develop a complete picture of an individual patient's care needs.

VB-15 How could a nationwide provider directory of FHIR endpoints help improve access to patient data and understanding of claims data sources? What key data elements would be necessary in a nationwide FHIR endpoints directory to maximize its effectiveness?

For smaller or resource-constrained providers, such as rural areas, CMS should allow exceptions to CEHRT requirements through a formal application process, maintaining care quality and data availability. Interoperability challenges often focus on structured clinical data, neglecting non-clinical data like SDOH, which drives outcomes. We recommend expanding interoperability to include these data types.

To reduce the clinician's burden, CMS should designate clear points of contact for technical assistance, ensuring they know whom to reach for support. A nationwide provider directory of FHIR endpoints would improve access to patient data and claims data sources, with key elements including provider type, care setting, and specific endpoint details (e.g., therapy or behavioral health notes) to support diverse care needs. We recommend CMS work with TEFCA to be the driver of this directory and then require a search ability that will provide relevant information for the patient based on known demographic and clinical data.

Conclusion

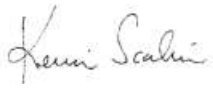
We appreciate the opportunity to provide feedback on the CMS Health Technology Ecosystem RFI. As an EHR technology vendor, we support CMS's efforts to enhance health care delivery through a robust health technology ecosystem. Timely access to accurate health information is critical for clinicians to improve patient outcomes, and a seamless ecosystem is essential to achieving this goal.

We strongly endorse the Trusted Exchange Framework and Common Agreement (TEFCA) and the role of Qualified Health Information Networks (QHINs) in enabling standardized, interoperable health information exchange across care settings. Clear standards and governance will facilitate connectivity between care venues and empower patients through accessible health applications outside clinical settings.

We also support the continued advancement of value-based care, which benefits from comprehensive health data access to improve patient outcomes and reduce resource utilization. We encourage CMS to incentivize EHR adoption in care settings previously excluded from such programs to enhance data accuracy and interoperability.

Thank you for your commitment to improving health care nationwide. We look forward to supporting CMS in building a robust health technology ecosystem.

Sincerely,



Kevin Scalia
Executive Vice President
Netsmart Technologies