

CMS Digital Health RFI Response

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About Fold Health

Fold Health is the first AI-powered operating layer for care delivery. Built by clinicians and technologists from some of healthcare's most trusted organizations, Fold integrates seamlessly with EHRs to unify the workflows that traditional systems leave behind - from care coordination and patient outreach to workflow automation and revenue enablement. Whether you're operating in fee-for-service or full-risk models, Fold helps teams do more with less - bringing consistency, connection, and control back to clinical operations. Learn more at <https://www.fold.health>.

A Note from Fold Health

The CMS Digital Health RFI reflects a bold and necessary vision: that technology, when designed with humanity in mind, can transform the experience of care for Medicare beneficiaries and those who support them. At Fold Health, we see this moment as a call to reimagine not just the tools we build—but the relationships, workflows, and outcomes those tools are meant to enable.

Fold was founded to solve the very gaps this RFI highlights: fragmentation of data, isolation of caregivers, and the overwhelming burden placed on patients and providers alike. In response, we've developed a unified operating layer that connects people, systems, and actions—across the continuum. With collaborative interfaces, omni-channel communication, real-time orchestration, and caregiver-inclusive design, we strive to offer not just access, but empowerment.

We believe the future of Medicare engagement will be defined by technology that listens, anticipates, and activates. This RFI is an invitation to shape that future together—and we are honored to contribute.

RFI Response Comments

*In an effort to prioritize clarity and conciseness, we have omitted the questions themselves. We've annotated our responses with question label(s).

Section 1: Patient Needs (PC-1 to PC-7)

PC-1. Health management and care navigation apps should enable patients and caregivers to access complete records, receive personalized health alerts, communicate with care teams, manage medications, and coordinate care tasks. Tools should integrate with Medicare benefits and support both digital novices and caregivers.

- a. Desired capabilities include scheduling and managing appointments, tracking health goals, receiving real-time care reminders, accessing test results, and managing chronic conditions.
- b. A personal assistant should help with medication reminders, symptom tracking, appointment coordination, understanding benefits, and navigating provider networks — all achievable through intelligent, voice-enabled, rules-driven digital tools.

PC-2. Most patients and caregivers do not have unified access to all health information in one place.

- a. When available, such access improves care coordination, reduces duplicative services, and empowers shared decision-making.
- b. A single portal would be especially valuable for chronic condition management, care transitions, and complex care planning involving multiple providers.
- c. Encounter notes, imaging, and referrals are often missing. Barriers include lack of interoperability, unfriendly interfaces, fragmented EHR systems, and limited caregiver access permissions.

PC-3. The digital health market for Medicare beneficiaries is fragmented, with most solutions offering narrow functionality (e.g., appointment scheduling, lab results, or medication reminders) within isolated portals. Few platforms enable end-to-end care navigation, personalized outreach, or true interoperability across provider, caregiver, and patient workflows. While many tools provide partial access to health information, they often fall short on usability, caregiver support, and real-time care coordination—particularly for beneficiaries managing multiple chronic conditions, navigating transitions of care, or receiving services across both fee-for-service and value-based models.

PC-4. Missing features include: cross-provider integration, caregiver delegation, task-based navigation, real-time alerts, care gap nudging, and AI-powered triage.

- a. A national Medicare Care Companion app and a universal caregiver management tool are needed but absent due to technical fragmentation, unclear business models, and regulatory complexity.
- b. CMS is uniquely positioned to offer workflows around eligibility verification, benefit navigation, risk stratification, care plan orchestration, and social services referrals.

PC-5. CMS and partners can promote digital adoption through trusted branding, reimbursement incentives, provider education, and accessible interfaces.

- a. CMS should create a voluntary certification pathway focused on usability, clinical impact, interoperability, and caregiver support. Policy enablers include Blue Button expansion, reimbursement for app-based care, and simplified caregiver proxy enrollment.
- b. Real-time FHIR APIs, unified patient identifiers, and expanded Blue Button coverage (e.g., risk scores, care programs) would improve access.

PC-6. Key features for accessibility include simple navigation, large buttons, multilingual voice support, caregiver modes, offline access, and intuitive design with guided workflows. Thinking beyond feature functionalities, we should reflect on whether dominant devices in the consumer market are the right ones to retro-fit for healthcare use cases and for Medicare beneficiaries in particular. Perhaps a rethink of the hardware is also an important consideration. Ex/ use of Grandpads in the PACE model.

PC-7. CMS should use claims data, FHIR logs, app usage metrics, patient surveys, and provider feedback to track real-world impact, ideally supported by a national digital health outcomes registry.

Section 2: Data Access and Integration (PC-8 to PC-12)

PC-8. Readily available data includes lab results, immunization records, and medication lists.

- a. Hard-to-access data includes claims, encounter notes, referral records, real-time schedules, and cost information.
- b. High-value non-claims sources include SDOH data, patient-reported outcomes, remote monitoring data, and caregiver task data.
- c. Opportunities include FHIR-based standardization, real-time APIs, and AI-driven data normalization. Challenges include data silos, EHR vendor variability, and fragmented patient identifiers.

PC-9. Developers value access to RAF/HCC scores, real-time care attribution, prior auth data, D-SNP program enrollment, and behavioral health utilization.

- a. Current barriers include latency, data silos, limited APIs, and complex patient consent workflows.
- b. Suggestions include better developer documentation, expanded data scope, FHIR alignment, caregiver APIs, and real-time payloads.
- c. Non-CMS data sources of value include EHR clinical data, pharmacy fill history, wearable data, and community-based organization data.

PC-10. TEFCA establishes trust and framework consistency for national exchange.

- a. Examples include Health Gorilla and eHealth Exchange acting as early QHINs, enabling multi-stakeholder access.
- b. CMS should enforce patient-facing access endpoints and caregiver delegation.

- c. High-impact use cases include national longitudinal record retrieval, emergency access, and Medicare program onboarding.
- d. Effective standards include FHIR R4, USCDI, SMART on FHIR, OAuth 2.0.
- e. Underused but valuable: FHIR Subscriptions, Bulk FHIR, USCDI+.
- f. Redundancies include overlapping APIs and patient identity methods.
- g. Alternatives include Apple Health, CommonHealth, and regional HIEs, but lack TEFCA's comprehensiveness.

PC-11. HIEs improve data liquidity locally but vary widely in effectiveness.

- a. Data can be valuable but often lacks standardization or real-time relevance.
- b. CMS should promote technical and governance alignment across HIEs.
- c. Models like CRISP (Maryland) or Manifest MedEx (California) offer replicable best practices.
- d. HIEs should complement TEFCA by filling gaps in local, post-acute, or behavioral health data.

PC-12. Valuable use cases include real-time provider availability, care cost estimates, benefit utilization tracking, appointment scheduling, and guided quality navigation.

- a. Many of these use cases are possible in limited pilots or systems today.
- b. Near-future possibilities include AI-based provider matching, seamless plan integration, and delegated caregiver tools.
- c. Difficult but high-value goals include real-time pricing, universal SDOH exchange, and dynamic quality-score-based navigation.

Section 3: Information Blocking and Digital Identity (PC-13 to PC-14)

PC-13. CMS can promote awareness of the Information Blocking Portal through educational campaigns in Medicare communications, patient portals, and provider-facing materials. Increased reporting would improve transparency and help target enforcement, although care must be taken to avoid burdening compliant organizations with frivolous complaints.

PC-14.

- a. Challenges include low digital literacy, identity verification friction, and lack of a unified credentialing experience.
- b. Benefits include simplified access, enhanced security, and shared caregiver permissions across systems.
- c. Downsides include potential exclusion of digitally underserved populations and over-reliance on a small number of credential providers.
- d. Digital identity credentials would streamline data exchange and minimize fragmented login systems.
- e. CMS, payers, and app developers should collaborate on outreach, embed credential prompts in enrollment flows, and offer incentives for adoption.
- f. CMS can promote digital credentials through Medicare onboarding, pharmacy pickups, or care manager touchpoints.

Section 4: Provider-Focused Questions (PR-1 to PR-14)

PR-1. CMS can encourage rural and other providers to adopt digital tools through grant programs, technical assistance, and integration incentives.

- a. Obstacles include budget constraints, workforce shortages, and lack of integrated systems.
- b. Providers should inform patients about how digital tools work, their privacy protections, and how they enhance care.
- c. Providers must vet tools for quality, provide support, and monitor digital engagement outcomes.

PR-2. Obstacles include proprietary EHRs, inconsistent data standards, and burdensome documentation requirements. Solutions include API-first mandates, open-source clinical logic libraries, and CMS-led standardization.

PR-3.

- a. Scanned docs and faxes are often not structured or retrievable.
- b. This fragmentation leads to missed diagnoses and delays.
- c. Barriers include unstructured formats and lack of indexing standards.

- d. Privacy concerns are manageable with audit trails; costs should not hinder access.
- e. This is a top-tier priority for interoperability.

PR-4. CMS should require EHR vendors to support patient-authorized API access to intake forms, provider schedules, and visit logistics through certified third-party apps.

PR-5. Response dependent on system implementation, but most organizations report limited use of bulk APIs, minimal integration with CDS Hooks, and need support to scale SMART on FHIR apps.

PR-6.

- a. TEFCA is improving provider exchange readiness, but still early.
- b. CMS should enforce participation deadlines and streamline onboarding.
- c. Private exchanges and HIEs can supplement but not replace national interoperability.
- d. Redundant frameworks (e.g., bespoke point-to-point interfaces) should be consolidated.

PR-7. CMS can embed data-sharing into existing reporting workflows, simplify consent, and align incentives with existing APM/Star measures.

PR-8.

- a. Bulk FHIR could reduce manual entry and improve accuracy of quality reports.
- b. Interoperability efforts should align with existing ACO or MSSP measures to maximize reuse.
- c. Registries should be API-enabled and support real-time data submission and feedback loops.

PR-9.

- a. Providers will need EHR integration support and simplified credentialing workflows.
- b. CMS must ensure privacy is preserved while reducing login fatigue and friction.

PR-10.

- a. Benefits: simplified access, better audit trails. Challenges: provider readiness and vendor variability.
- b. Required use would standardize access and strengthen trust.
- c. Downsides include onboarding complexity for smaller orgs.
- d. It would validate provider identities and enable secure exchanges.
- e. Implementation could reduce fraud and improve trust signals.
- f. Yes—identity + FHIR endpoints would optimize routing and matching.

PR-11. TEFCA participants and trust communities should adopt shared credentialing services, reduce duplicative verifications, and align identity policies with FHIR-based exchanges.

PR-12. CMS should revisit exceptions that are overly vague or allow loopholes (e.g., "infeasibility"). Standardize interpretation to reduce provider confusion.

PR-13. The most effective disincentives are financial penalties tied to MIPS/APM participation or exclusion from incentive programs.

PR-14. CMS should simplify the reporting interface and educate provider organizations. Increased complaint visibility would deter blocking and accelerate standard adoption.

Payer-Focused Questions (PA-1 to PA-7)

PA-1. TEFCA's lack of payer-specific APIs and limited real-time access to clinical data are major hurdles. CMS should require TEFCA to support claims, risk adjustment, and care management workflows directly.

PA-2. CMS can accelerate payer API adoption by linking participation to Star Ratings, bonus payments, and MA compliance reviews.

PA-3. Payers need standard credentialing APIs and CMS-approved workflows to accept digital identities without legal exposure.

PA-4. A nationwide provider directory with FHIR endpoints would improve network accuracy, referrals, and prior auth routing. It should include NPI, specialties, affiliations, endpoints, and credentialing status.

PA-5.

- a. Payers are highly interested in offloading quality data collection from providers to payers via EHR extraction and Bulk FHIR. This reduces burden and improves standardization.
- b. CMS should unify submission formats and timelines between Medicare and commercial payers.
- c. Real-time access to structured EHR data would enable payers to close gaps faster and reduce over-reporting.

PA-7. Complaint reporting by payers should be encouraged via contract audits and Star incentive levers. This would create pressure on non-compliant providers to adopt standards.

Technology Vendors, Data Providers, and Networks (TD-1 to TD-19)

TD-1. Short term: CMS should fund innovation challenges and sandbox access. Long term: establish interoperability certification incentives and API mandates for data access.

TD-2.

- a. Additional CMS data: HCC scores, prior auths, hospice/home health use, MA encounter data.
- b. Most valuable data alongside Blue Button: pharmacy fills, lab data, SDOH inputs, prior auth status.
- c. Access barriers: siloed systems, limited APIs, inconsistent consent frameworks.
- d. CMS should extend program alignment to include ADT, remote monitoring, and social services APIs.

TD-3.

- a. Challenges: onboarding friction, trust barriers; benefits: unified access, fraud reduction.
- b. Requiring credentials improves security posture and user experience.
- c. OpenID Connect could enable standard auth flows but may need broader industry adoption.

TD-4. CMS should make open API support a condition of EHR certification.

TD-5. A nationwide FHIR endpoint directory would streamline referrals, data routing, and API discovery. CMS or ONC should publish it, and access should be free to providers/payers and low-cost to vendors.

TD-6.

- a. TEFCA uniquely creates a common legal/technical trust framework.
- b. Alternatives: Carequality, CommonWell, DirectTrust.
- c. Proprietary networks and legacy protocols should be phased out in favor of FHIR-based exchanges.

TD-7.

- a. USCDI improves standardization.
- b. It lacks behavioral health, SDOH, and device data.
- c. Adding more fields is valuable but must be domain-specific to avoid complexity.
- d. A semi-structured open standard could balance flexibility and usability.

TD-8. The best certification standards focus on API readiness, FHIR conformance, and auditability.

TD-9.

- a. API-focused certification ensures flexibility and modularity.
- b. Risk: fragmentation if not implemented consistently.
- c. ASTP/ONC should require full EHI API support with role-based access.
- d. CMS can enforce this via payment and quality program alignment.
- e. Bulk data access enables scalable quality measurement; concerns include governance and performance.

TD-10. ONC should enforce no “special effort” language by requiring vendors to expose full EHR access via open APIs with common formats and complete documentation.

TD-11.

- a. Yes, standardized APIs should be required to ensure consistent exports.
- b. CMS should mandate real-time export options and common schemas.
- c. Yes, CMS should create reimbursement incentives for EHI export adoption.

TD-12. CMS should endorse non-CMS networks based on criteria like FHIR conformance, national reach, and provider participation.

TD-13.

- a. Full EHI access allows comprehensive care coordination and AI insights.
- b. Obstacles: consent management, data fragmentation.
- c. USCDI provides standardization; full EHI enables innovation but is harder to govern.

TD-14.

- a. Endpoint volume varies widely; rural and post-acute providers remain underrepresented.
- b. Most use TEFCA/IHE or direct FHIR connections.
- c. Networks typically use private agreements or TEFCA QHIN pathways.

TD-15.

- a. Bulk FHIR improves population health, quality reporting, and analytics.
- b. Risks include data sprawl and increased infrastructure costs.

TD-16.

- a. Current rules favor direct connections; this limits scalability.
- b. CMS should require reciprocal access and standardized FHIR endpoints.

TD-17. CMS should support sustainability of exchanges via funding mechanisms tied to outcomes and usage-based performance metrics.

TD-18.

- a. Blocking examples: excessive fees, delayed responses, refusing FHIR connections.
- b. CMS/ONC should increase transparency and penalties for persistent offenders.
- c. Non-certified actors and certain specialists lack accountability under current rules.

TD-19.

- a. Price data often lacks specificity, is hard to compare, or outdated.
- b. Pre-visit planning, chronic condition management, and provider shopping would benefit most.

- c. Improvements: structured formats, searchable interfaces, real-time updates.
- d. Incentivize payer-provider collaboration and patient-facing tool integration.

Value-Based Care Organizations (VB-1 to VB-15)

VB-1. Incentives such as bonus payments for digital adoption, aligned quality measures, and API-ready certification credits can drive ACO usage. Obstacles include workflow fragmentation, data lag, and lack of tailored tools.

VB-2. APMs should embed AI-enabled population stratification, care gap detection, and dynamic risk-based task routing into reporting and care delivery workflows.

VB-3.

- a. Essential capabilities: longitudinal care planning, patient event feeds, HCC analytics, and quality metric auto-calculation.
- b. Tools that aid in patient activation, behavioral health coordination, and claims reconciliation have shown strong ROI.

VB-4. Critical data types include: EHR clinicals, SDOH, claims, ADT feeds, HCC codes, device data, and patient-reported outcomes.

VB-5. Current ONC criteria provide basic interoperability but fall short on programmatic care coordination, outcomes tracking, and performance optimization.

VB-6. ONC certification should include requirements for care coordination engines, cohort management, and value-based program logic libraries.

VB-7. APM tech requirements should favor flexible modules that plug into existing systems without requiring a monolithic platform.

VB-8. CMS could expand Conditions of Participation to require real-time event feeds and API availability for APM participants.

VB-9. APMs need enhanced quality measurement, more flexible APIs, and attribution-aware tooling compared to non-APM entities.

VB-10. Certification criteria should reflect APM context (e.g., care program attribution, condition-based enrollment) and offer streamlined paths for rural groups.

VB-11. Challenges include aligning attribution data, real-time data access, and cross-provider collaboration.

VB-12. CMS should promote modular data standards for SDOH, chronic care, and claims reconciliation while preserving APM-specific flexibility.

VB-13. Improvements: reduced vendor lock-in, real-time bulk APIs, and quality reporting automation.

VB-14. Digital identity reduces duplication, improves caregiver visibility, and streamlines attribution and access control.

VB-15. A nationwide provider directory with FHIR endpoints would aid attribution, referral management, and cross-system data reconciliation. Key elements: NPI, taxonomy, affiliations, API availability.