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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–0042–NC

To Whom It May Concern:

I appreciate the opportunity to comment on the Request for Information: Health Technology Ecosystem (CMS–0042–NC), published May 16, 2025. I am submitting this comment in my capacity as a healthcare technology entrepreneur, with direct experience navigating the challenges and opportunities associated with digital health tools and data interoperability.

In my work, first at Epic Systems, and more recently as the founder of Moxe Health – a leading payer/provider data exchange and network provider - I have witnessed firsthand both the promise and the persistent barriers associated with integrating health data across systems to support patient care, empower individuals, and reduce inefficiencies. Building on my time at Epic, I founded Moxe to focus on how digital clinical data can drive new efficiencies in healthcare payment and operations—a mission I've pursued for the past 13 years.

My mission is to significantly lower the cost of comprehensive healthcare services for the American people, and my response here is focused on those areas of the RFI where I am qualified to have an opinion, where the market requires governmental assistance to achieve an ideal outcome, and which could have a demonstrated impact on our overall healthcare expenditures if well implemented.

The questions posed in this RFI reflect a critical and overdue effort to assess whether current regulations and infrastructure are delivering on the goals outlined in the 21st Century Cures Act—and whether new policy action is needed to accelerate progress.

My comment centers on three key themes:

1. CMS must clearly define the *specific problems* it seeks to solve with each interoperability initiative to guide optimal investment and solution development.
2. Government action should focus first on *targeted, solvable use cases* where measurable cost savings and consumer empowerment are achievable.
3. Policies that reward real-world data exchange—rather than theoretical compliance—will drive broader adoption and help lower healthcare costs.

My aim is to provide constructive, evidence-informed recommendations that reflect lived experience and practical implications, with the goal of supporting CMS and ASTP/ONC in designing a more effective, and affordable patient-centered health environment.

PC-1 (b): An advocate who helps streamline referrals and benefit checks would reduce unnecessary procedures, duplicate testing, and patient/provider abrasion.

In today's healthcare system, if you lack a patient advocate it's extremely unlikely you will end up with the ideal care quickly and at a reasonable price. The idea of an empowered patient who is rationale and consumes services responsibly is only possible when patients have information *and* capacity to make good decisions. While there are many things a software-based advocate could support in the future, I recommend starting with one concrete objective – that a patient can use a referral order to decide which course of action to take, with whom, and at what cost. While the ordering provider should remain responsible for helping the patient navigate the system, this support is too inconsistent today and should not be assumed.

Effectively, allow a patient to seamlessly receive an electronic referral/order with enough supporting detail to conduct electronic authorization and benefit checks, shop around and release that order with complete auth and insurance verification details to the performing location of their choice. Maintain chain of trust so results can post back to the referring provider without burden on the patient. This would be relevant across medications, procedural, diagnostic, DME, medical services, and more.

On this foundation many other services can evolve in response to market demand, but setting off the initial push would be greatly aided through government stimulation and would simultaneously put significant market pressure on payers and providers to design and maintain competitive networks, contracts and consumer-friendly services as patients become empowered to take their business to wherever works best for them.

PC–10 (g): Yes and no. There are many ways patients *can* obtain their records today. Nearly none of this is happening via TEFCA. But there remains too much friction and inconsistency in the process today. The prevailing model requires patients to log into each patient portal and via manual or electronic means, extract and organize their discrete records. It is a worthwhile objective to drive a consistent and universal mechanism for patients and their advocates to accomplish this aggregation and organization in a much-streamlined fashion. In my view, if TEFCA efforts are focused exclusively on solving patient record access issues and in driving each provider organization not currently sharing data electronically to participate in electronic exchange for Treatment and IAS purposes TEFCA has the potential for broad adoption and success.

When TEFCA is stretched to support too many competing use cases—beyond treatment and individual access—it risks dilution of focus, stakeholder resistance, and fragmented adoption.

PC-11 (d): HIEs should be one mechanism provider organizations elect to use to meet any/all mandated data exchange requirements. They should be left to compete in the broader market for data exchange solutions. While I don't see any reason to subsidize HIEs, if a state chooses to do

so as a mechanism to support smaller or otherwise disadvantaged provider organizations in meeting data exchange requirements, they could continue to exist as a public/private convening or technology operation. They are competitive with QHINs yet have a distribution advantage with currently connected groups where a reimplementation with a new onramp partner is not likely to yield significant efficiency gains. Let the market determine what the role of the HIEs should be but create enough clarity and focus on the required outcomes so provider organizations don't need to implement an EHR vendor solution, QHIN, and (one or more) HIE connection just to meet their minimum IAS and Treatment data exchange requirements.

PC–12 (a): Binding cost estimates tied to Medicare rates could reduce out-of-network billing, surprise costs, and overhead, which represent billions in preventable spending.

Binding Cost Estimates are specifically mentioned in the RFI and if such a change were made to cost transparency regulations the downstream implications on patient experience and overall healthcare affordability are hard to overstate. This would provide the type of incentive structure for more logical fee and ultimately contract structures to potentially emerge. If paired with reasonable new regulation permitting Americans to purchase services directly by paying cash at the Medicare rate, the ability to get a binding quote could drive the market efficiency and consumerization we've long sought.

PC-14: I would only advocate that the government avoid pushing specific commercial solutions to the identity credentialling solution. Login.gov should be enhanced to provide a compelling and viable baseline solution for beneficiaries to use across various government programs. Other CSPs can compete with Login.gov without any sort of federal push.

You ask what the challenge in driving signup is – I can only speak to my own reservations, and hope they are informative. I am a CLEAR subscriber for travel benefits where I only signed up because it was included as a benefit with a credit card I have. Four years ago, it provided meaningful benefits at most airports, and I used it nearly every trip. Then, DHS and TSA introduced PreCheck Touchless ID and now CLEAR is only valuable (time savings on screening) in maybe 10-15% of cases. If it were removed as a credit card benefit, I wouldn't pay for it.

During COVID restrictions when various groups were requiring proof of vaccination or negative COVID tests for venue entrance, CLEAR was often put forward as the easiest way to validate your status *and* I already had an account. I didn't use CLEAR. I didn't want one group to have both my biometric data for travel and my medical data. Secondly, in the case of CLEAR and PreCheck Touchless ID, the right sort of public/private competition has driven significant consumer benefit.

Getting consumers to do anything with a cost forces honest assessment of value. If we agree that consistent patient credentialling is important we need to then figure out who should pay for it. If a Medicare member saved $5 on their monthly premium for paying electronically but the only way to authenticate themselves for making payment was using Login.gov or an approved CSP, I suspect adoption would be high very quickly. Is getting every Medicare beneficiary onto a CSP

worth $60 a year in estimated savings from lower admin expenditures or FWA avoidance? If so, we can use that to rationalize the investment.

PR-3: All data being available solves some problems and creates others. I do think erring on the side of "everything" is generally good, but it creates a significant amount of work on both the EHR vendor and the data recipients. There's a lot of noise in "everything" and there's precedent for burying requestors in an overwhelming amount of data that is nearly unusable (see MRF files for an example of this).

Overall, I put the priority of "all" as being significantly lower than other interoperability needs. When it's not clear what use case(s) we're trying to solve for, it's hard for implementers to make the right tradeoff decisions during any required development. I think requiring all EHI is significantly different from requiring all data and should be pursued and enforced at scale before expanding requirements to include an even broader swath of data.

As one of many examples, there are significant design and implementation challenges to making things like scanned fetal heart tracing strips available electronically in anything close to a scalable way. While there are situations where a parent or specialist may want access to this data, the incidence and value is not greater than focusing on onboarding the next cohort of primary care providers who do not yet share core USCDI data in an electronic manner.

There are tradeoffs here and I would be most supportive of focusing on ensuring EHI is available via API, and at scale before moving onto an even more ambitious scope. If there's a specific critical use case we don't believe is possible to streamline without moving beyond EHI then we can expand the next USCDI version to add the missing data elements and communicate the importance of adding this requirement using a real-world use case.

PR-4: Require that certified vendors permit any Covered Entity customer to authorize any of their Business Associates to use any administrative workflow the Covered Entity's own employees have access to. This should not differentiate between human and bots but should make clear that the Covered Entity bears all liability for the Business Associate's use or abuse of the workflow and/or system access. If a Covered Entity is willing to take on that risk, they should be allowed to do so. I think this is the only scalable way to apply this sort of pressure and will likely drive certified vendors to expose more standard APIs and workflow interfaces to these third-party developers who are achieving product market fit. This ensures very expensive and hard to scale workflow integration is targeted to the use cases that are seeing the most market interest and need.

PR-6: For the use cases I am most familiar with – payer and provider data exchange – TEFCA has no bearing on data access. I don't see much value yet for providers engaged in sourcing data for Treatment use either as most TEFCA participants were already engaged in other national or regional exchange initiatives (Commonwell/Carequality/HIEs).

Generally, I think TEFCA benefits the ecosystem best by remaining laser focused on expanding network participants to include all certified EHR users for Treatment and IAS purposes. Unless TEFCA pulls new network participants into the fold it's unclear what value it drives beyond

what was already in place. In trying to expand TEFCA to support all stakeholders and more contentious use cases it's hard to see how it succeeds. There is a cost to developers to build the interoperability infrastructure we're asking them to take on and if we limit their ability to find a sustainable business model to cover this investment we are pushing unfunded mandates and hoping to end up with a robust and scalable set of infrastructure. I would like to see us focus our regulatory efforts on expanding electronic access to data for Treatment and IAS purposes while allowing vendors to explore other approaches to meeting the market's demand for data for non-Treatment and IAS use. Once we're happy with the availability of data for Treatment and IAS we can assess the markets maturity around supporting other use cases and decide at that point where the market requires additional regulatory push to achieve the outcomes we expect.

PR-7: If data sharing were tied to getting paid – by incorporating into new patient referral or claim submission workflows – providers would apply the necessary pressure for their vendors to invest in missing data APIs. In terms of mitigating the burden of working with increasingly available data, if CMS created a clean and organized data repository of clinical and administrative data received from the various payment and audit programs CMS oversees and made that cleansed data available to all providers via the renewed Data at the Point of Care program it could remove substantial burden from providers who otherwise need to invest in the data quality and analytics infrastructure themselves. This will be most beneficial to smaller groups who are unable to invest in their own infrastructure and is in line with work previously undertaken with Blue Button and DPC efforts.

PR-8: Bulk FHIR doesn't work today in any meaningful/scalable way and it's unclear to me that further investment in this approach is worth pursuing at this time when there are so many other technical shifts currently underway. While I am cautious on pushing Bulk FHIR, I am very supportive in automating the submission of data to CMS so that quality and risk scores can be automatically calculated.

Quality measures should be reviewed and further simplified to focus on outcome vs. process measures. If we simplify the measures, we can drive greater alignment as most market participants today don't believe current quality programs deliver much value. We've been running HEDIS for over 30 years and per KFF "the United States has a lower life expectancy than peer nations and has seen worsening measures of health outcomes" [1].

Let's not pour more technical resources into streamlining measurement of metrics we no longer believe in. Instead, CMS should lead a reinvention of quality measurement focused on outcomes that matter.

[1]https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/

PA-1: TEFCA isn't valuable for payers today. Payers are looking for medical records for risk adjustment, followed by quality program administration, payment integrity (when providers permit this) and increasingly UM use – none of these are supported by TEFCA today. Further, if support for these use cases is added into TEFCA, it's unclear what implications that will have on broader adoption of the framework. What payers are most worried about today is how to establish network connectivity with the longtail of providers – the same providers who aren't

participating in non-TEFCA exchange today and are not likely to be early adaptors of TEFCA even if the supported use cases expand. This is why I think TEFCA should first focus on broadening the number of providers and EHR vendors who participate in electronic exchange of records for Treatment and IAS. Once the longtail of providers is connected at greater scale we can evaluate whether TEFCA use cases should be expanded to cover P&O use or whether the market has arrived at another workable solution that doesn't require regulatory intervention.

If EHR vendors need to mature their APIs to connect to a QHIN for Treatment and IAS use, those same APIs can be repurposed to address payer use cases – and by not mandating inclusion in TEFCA you enable a more competitive set of business models to emerge. Ultimately, I believe this will yield the best infrastructure for patients as it will not be limited by the lowest common denominator of TEFCA.

PA-3: If payers could obtain more medical records ("higher yield") because record location and member-patient match rates was improved through implementation of digital identify credentials, they would adopt such tools quickly. Solving member-match and record location problems directly reduces payer administrative costs, improves risk coding accuracy, and minimizes payment-related burden.

PA-4: A nationwide directory with FHIR end points would be extremely valuable for record location if that directory included enough detail to use NPI type 2, type 1 and/or TIN to determine which location for the provider to query for data. Further, there would need to be a cross reference of provider location to the EHR or EHRs that are in use at that location along with the FHIR end point for each. Since the FHIR end points are not provider specific it is inadequate to just build a directory that assumes each provider is tied to one location and that each location only has one FHIR endpoint behind which everything sits. To be clear, these are all solvable problems, and doing so would be very beneficial. It's just critical that the architectural decisions behind the directory are outlined correctly at the onset.

PA-5 (a): Payers are very interested in ways to get bulk data for calculations – this is generally how programs are run today. While there are certainly providers running risk adjustment and quality calculations, often this function is performed by the payer. While Payers are very interested in bulk access, providers have a lot of reservations about enabling this. Prover apprehension is a major part of the challenge in expanding TEFCA (or other existing networks) to support Payment and Operational purposes of use.

At Moxe, our core offering has been helping Payers and Provider navigate this specific set of conversations, data governance agreements and enabling automated data exchange. Without Bulk FHIR we've managed to exchange millions of medical records for use in risk adjustment, quality program administration and payment/revenue integrity use cases. While we would benefit from better support for bulk exchange, we've managed to engineer around many of the most extreme limitations and the biggest roadblocks remain economic vs. technical.

As you promote greater use of clinical data in driving efficiency and cost reduction in our healthcare ecosystem, I welcome the opportunity to share more about what I've learned in the

last ten years helping exchange tens of millions of clinical records for payment and operational use across Medicare Advantage, Medicaid and Commercial populations.

Thank you for the opportunity to participate in the listening session and to submit this written comment. CMS's willingness to seek input on these critical issues is commendable. I hope this feedback supports your efforts to focus on targeted, high-impact reforms that can unlock real market efficiencies and reduce the total cost of care in the United States.

I am available to support the administration's efforts however I can best serve.